

Public Board of Directors Meeting

Thursday 4th April 2019

12noon – 2.45pm

Meeting room 7 & 8,
Clinical Education Centre,
1st Floor, South Block

Our vision: Trusted to provide safe, caring and effective services because people matter



BOARD MEETINGS PUBLIC INFORMATION SHEET

The Dudley Group meets in public every month and welcomes the attendance of members of the public and staff at its Board meetings to observe the Board's decision-making process.

1. Introduction

This sheet provides some information about how Board meetings work.

Name signs for each board member are displayed on the table in front of the member to enable you to identify who is speaking at the meeting.

Some items are confidential (for example if they concern an individual or a commercial contract) – these are dealt with in part II (confidential) of the meeting.

Copies of the agenda and papers are available at the meetings, and on our website <http://dudleygroup.nhs.uk/> or may be obtained in advance from:

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2. Board Members' interests

All members of the Board are required to declare if they have any interests (e.g. financial) which are relevant to the work of the trust and these are recorded in a register. If you would like to see the register, please contact the Company Secretary or visit our website.

Members are also required to state at the start of the meeting if they have an interest in any of the items under discussion. Special rules govern whether a member who has declared an interest may take part in the subsequent discussion.

3. Opportunity for questions

Members the public, should raise any questions directly to the Chair at the conclusion of the meeting.

4. Debate

The board considers each item on the agenda in turn. Each report includes a recommendation of the action the board should take. For some items there may be presentation; for others this may not be necessary. The board may not actively discuss every item – this does not mean that they have not received careful consideration; it means that nobody at the meeting considers it necessary to debate the subject. A formal vote need not be taken if there is a general consensus on a suggested course of action.

5. Minutes

A record of the items discussed and decisions taken is set out in the minutes, which the board will be asked to approve as a correct record at its next meeting.

The minutes as presented to the next meeting of the Trust Board for approval are added to the website at the same time as the papers for that meeting.

6. Key Contacts

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THE SEVEN PRINCIPLES OF PUBLIC LIFE

The Committee has set out '**Seven Principles of Public Life**' which it believes should apply to all in the public service. These are:

Selflessness

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example. This document should be read in association with the NHS Code of Conduct.

Board of Directors
Thursday 4th April, 2019 at 12.00noon
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion/decision except where noted

	Item	Enc. No.	By	Item Related to Strategic Objective	Action	Time
10.	Chairmans Welcome and Note of Apologies		J Ord		To Note	12.00
11.	Declarations of Interest Standing declaration to be reviewed against agenda items.		J Ord		To Note	12.00
12.	Announcements		J Ord		To Note	12.00
13.	Minutes of the previous meeting					
	13.1 Thursday 7 March 2019	Enclosure 11	J Ord		To Approve	12.05
	13.2 Addendum to the February Minutes	Enclosure 12	J Ord		To Approve	12.10
	13.3 Action Sheet 7 March 2019	Enclosure 13	J Ord		To Action	12.10
14.	Staff Story	Video	L Abbiss		To Note & Discuss	12.15
15.	Chief Executive's Overview Report	Enclosure 14	D Wake	All	To Discuss	12.25
16.	Safe and Caring					
	16.1 Clinical Quality, Safety and Patient Experience Committee Exception	Enclosure 15	C Holland	SO1&2	To note assurances & discuss any actions	12.35
	16.2 Chief Nurse Report including Safer Staffing	Enclosure 16	M Sexton	All	To note assurances & discuss any actions	12.45
17.	Responsive and Effective					
	17.1 Integrated Performance Dashboard	Enclosure 17	K Kelly	SO1,2,4,5,6	To note assurances & discuss any actions	12.55

	17.2 Finance and Performance Committee Exception report	Enclosure 18	J Hodgkin	SO6	To note assurances & discuss any actions	1.05
18. Well Led						
18.1	Brexit Contingency Plan Update including 100 at Risk Drugs	Enclosure 19	K Kelly		To note assurances & discuss actions	1.15
18.2	Guardian of Safe Working Report	Enclosure 20	B Elahi		To note	1.25
18.3	Charitable Funds Committee Exception Report	Enclosure 21	J Atkins		To note	1.35
18.4	Trust Constitution	Enclosure 22	G George		To Approve	1.45
18.5	Scheme of Delegation	Enclosure 23	G George		To Approve	1.55
18.6	Board and Committee Effectiveness Review	Enclosure 24	G George		To note	2.05
18.7	Audit Committee Exception Report	Enclosure 25	R Miner		To note	2.15
18.8	Responsible Officer Report	Enclosure 26	P Hudson		To note	2.25
18.9	Clinical Excellence Awards Annual Report	Enclosure 27	A McMenemy		To note	2.35
19. Any other Business			J Ord			2.45
20. Date of Next Board of Directors Meeting			J Ord			2.45
	2 nd May, 2019 Clinical Education Centre					
21. Exclusion of the Press and Other Members of the Public			J Ord			2.45
	To resolve that representatives of the press and other members of the public be excluded from the remainder of the 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).					

Quorum: One Third of Total Board Members to include One Executive Director and One Non Executive Director

**Minutes of the Public Board of Directors meeting held on Thursday 7th March, 2019, in
the Clinical Education Centre.**

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Tom Jackson, Director of Finance
Julian Hobbs, Medical Director
Karen Kelly, Chief Operating Officer
Andrew McMenemy, Director of HR
Diane Wake, Chief Executive
Mary Sexton, Interim Chief Nurse
Catherine Holland, Non Executive Director
Jonathan Hodgkin, Non Executive Director

In Attendance:

Helen Forrester, EA
Mark Stanton, Chief Information Officer
Gilbert George, Interim Director of Governance
Natalie Younes, Director of Strategy and Business Development
Mark Hopkin, Associate Non Executive Director
Adam Thomas, Interim Chief Operating Officer Designate
Becky Cooke, Staff Engagement and Inclusion Lead (Item 19/033.1)
Rachel Andrew, Head of Learning and Organisational Development (Item 19/033.1)
Paul Hudson, Interim Deputy Medical Director (Item 19/033.4)
Philippa Brazier, Speak Up Guardian (Item 19/035.3)

**19/026 Note of Apologies and Welcome
12.25pm**

Apologies received from Richard Welford.

The Chairman welcomed Adam Thomas, Interim Chief Information Officer Designate and Claire Pacey, Improvement Director, to their first Board meeting.

**19/027 Declarations of Interest
12.29pm**

Dr Hopkin confirmed that he was a GP and Clinical Lead at the CCG and the Board noted that this did not conflict with any items on the agenda requiring a decision.

There were no other declarations of interest.

19/028 Announcements
12.30am

The Board noted that the meeting was Mark Stanton, Chief Information Officer's last Board meeting, The Chairman thanked Mark for his hard work and commitment during his time at the Trust.

The Board noted that Doug Wulff left the Trust on 3rd February. The Chairman thanked Doug for his hard work and commitment and particularly for his role as Chair of the Clinical Quality, Safety, Patient Experience Committee.

The Chairman confirmed that she is moving on from the Trust at the end of April and the process for finding her replacement is in progress.

The Board noted that Richard Welford, Non Executive Director, had resigned from the Board and will finish at the end of March. The Chairman thanked Richard for his work over the last year, in particular as Chair of the Digital Trust Committee.

The process is underway for replacing Doug Wulff and Richard Welford. A paper would be tabled by the Director of Governance at the end of the Public Board.

The Chairman confirmed that Catherine Holland, Non Executive Director, had been appointed as Senior Independent Director.

No further announcements to note.

19/029 Minutes of the previous Board meeting held on 7th February, 2019
(Enclosure 8)
12.34pm

The minutes were amended as follows:

Page 1 – The Interim Chief Nurse to be included as present.

Page 5, first paragraph - to read "tended to be about staff".

Page 5, Learning from Deaths, para 4 – to read "work arising from the Bewick Report highlighted the need for Palliative Care."

Top of page 6 to read "Chairman and Board noted the report".

Page 7 to read "very positive work being carried out by the Patient Experience Committee."

With these amendments the minutes were agreed as a correct record of the meeting and signed by the Chairman.

19/030 Action Sheet, 7th February, 2019 (Enclosure 9)
12.38pm

19/030.1 Board Assurance Framework

Date of the Board workshop to be confirmed to Board members.

All other actions were noted to be complete, work in progress or not yet due.

Date of the next Board Workshop to be confirmed to Board members.

19/031 Patient Story
12.48pm

The Director of HR presented the patient story. This related to a patient with COPD, who had drug, smoking and alcohol addictions. The patient had liver damage as a result of alcohol misuse. The patient had received excellent care from the Respiratory Service. She attended her local sports and social club twice a week for a respiratory class run by the Respiratory Service who supported her with managing her illness.

The team had given the patient support to make life changes and she wanted to thank them for enabling her recovery.

Dr Hopkin, Non Executive Director, confirmed that he works closely with the Rehab Team and was proud that Dudley was a forerunner in this service.

The Chief Executive stated this was an example of how the right care can take pressure off the whole health and care system.

The Chairman and Board welcomed the positive story and holistic support provided and commented that it is never too late to make life changes. The Board asked that their thanks are passed on to the patient.

The Board's thanks and good wishes for the future to be passed to the patient.

19/032 Chief Executive's Overview Report (Enclosure 10)
12.42pm

The Chief Executive presented her Overview Report given as Enclosure 10. This included the following highlights:

- Healthcare Heroes Awards received positively: Two team awards in February – Clinical Coding and Palliative Care.

- Trust Strategy: Launching next Tuesday, 12th March.
- Flu Campaign: Exceeded last year's results with 76% of staff vaccinated.

Mrs Holland, Non Executive Director, asked about the press extract on operations and effective scheduling. The Chief Executive confirmed that the Trust has looked at Theatre scheduling and performs very well in this area. The Trust is currently looking at the numbers cancelled operations and how to minimise these further.

Dr Hopkin, Non Executive Director, stated that the health system needs to work together around ambulance transfers through to the hospital to reduce demand. He also congratulated the Trust for achieving the flu vaccination target.

The Chairman and Board noted the report.

19/033 Safe and Caring

19/033.1 Staff Survey Presentation 1.02pm

Rachel Andrew, Head of Learning and Organisational Development and Becky Cooke, Staff Engagement and Inclusion Lead, presented the key Staff Survey findings and the current initiatives and other feedback underway,

The Board noted the following key issues:

- 46% of the workforce completed the survey.
- Make it Happen Events: These are informal engagement events enabling staff views to be offered and taken forward.
- What People love about working at Dudley Group: Feedback to this question was Dudley people, caring for patients.
- What would make it better: Feedback advised taking a break, more staff, to be part of decision making.
- Summary of staff Survey: Positives were recognition and award, dignity and respect from managers, appraisals, supporting diversity and compassionate leadership. Improvement were to get better at dignity and respect between colleagues, staff engagement and communication, supporting staff well-being and having the right staff in the right place at the right time.
- Benchmarking: Sandwell – only 26% of staff responded to the survey from just a sample number. Walsall have similar response. Nationally pay and recognition has seen an overall improvement.
- Recommendation as a place to work: Decrease seen in this area.

- Executive Summary being produced of the survey findings to share more widely.
- Plan for 2019: Make it Happen events are taking place again from 19th March/ Key areas for focus include; agreeing behaviour standards for all staff and collaboration across remains, anti-bullying campaign, enhancing well-being services, and a toolkit and training for managers.
- Actions already planned include hydration stations for staff, and additional recognition schemes.
- The Board can help by confirming commitment from the Trust to improvements participating in activities, telling people about the great work underway, follow the impacts on social media.

The Chairman asked that the bullet points from the presentation are shared with Liz Abbiss to incorporate into the presentation for the Council of Governors that evening.

The Chairman had spoken with the Leadership Academy who had offered a proposal around leadership development. The Director of HR confirmed that the Trust would be using some of this work to build on the work already. The Chairman asked that the Trust formally respond to the Academy.

Mr Miner, Non Executive Director, commented that career development, particularly for CSWs to become nurses is critical for the Trust. It was confirmed that this is a key priority for the organisation.

The Interim Chief Nurse stated that it can take around 7 to 10 years to effect real change.

The Chairman reminded Board members to respond to the Diversity and Inclusion survey, which would signal their commitment to involvement.

The Director of Strategy and Business Development asked how the impact of actions and changes are measured. It was suggested that improving Friends and Family Test scores is an indicator but this would need further thought.

Rachel stated that we have to move focus away from just the staff survey and look at the feedback collected from other sources too, as this would be more current.

The Chairman observed that leaders at all levels need to demonstrate curiosity and ask more frequently how matters could improve.

Mrs Holland, Non Executive Director, suggested the establishment of an internal mediation scheme. The Director of HR confirmed that 13 staff have been trained to do this. Mrs Holland suggested that the Board should look at its own behaviours and act as a role model in the way it aligns to its stated ambitions.

The Chairman and Board noted the presentation and thanked the presenters for their efforts and asked for an update back to the Board in 6 months time.

The Director of HR to formally feedback to the Leadership Academy on their proposal. Update to the Board in 6 months time.

**19/033.2 Clinical Quality, Safety, Patient Experience Committee Report (Enclosure 11)
1.50pm**

Mrs Holland, Committee Chair, presented the Clinical Quality, Safety, Patient Experience Committee Report, given as Enclosure 11.

The Board was asked to note the implementation of the blood tracking system, the arrangements for hip assessments for babies and uniform shortages.

These issues were being monitored by the Committee.

Risks contributed to the Committee's oversight were discussed at the beginning of the meeting.

Mrs Holland and the Interim Chief Nurse were looking at improving the operation of the meeting.

The Chief Operating Office updated the Board on the position with Laminar Flow within theatres. This was a maintenance responsibility of Interserve. The system had failed within theatre 10 and therefore all joints surgery in this theatre had to be ceased. A Vanguard Theatre is being set up on site which is a temporary arrangement. Theatre 9 is being tested in March. A full replacement programme is to be put in place from April. If Theatre 9 fails a 2nd Vanguard Theatre will need to be put on site.

Mr Miner, Non Executive Director, highlighted the risk relating Interserve. The Chairman confirmed that the Trust had made the position clear relating to compliance and contingency.

The Chairman and Board noted the report and assurances provided and asked that all Chair's of Committee's follow the above approach. Mr Hodgkin asked that transferable actions are shared with other Committee Chair's.

Action: Committee Chair to share transferable actions with other Committee Chairs.

**19/033.3 Chief Nurse Report (Enclosure 12)
2.05pm**

The Interim Chief Nurse presented the Chief Nurse Report given as Enclosure 12.

The Board noted the following key issues:

- Nursing Strategy to be refreshed.
- Nursing conference being arranged on the 9th May 2019 to coincide with national nursing day late that week

- Safer Staffing: Remains a challenge. Details were at Appendix 1. This had been discussed in full at the Finance and Performance Committee.
- Recruitment: Positive work ongoing with some success.

Mr Atkins, Non Executive Director, stated that there was not much information on retention within the report. The Chief Nurse confirmed that work was ongoing with HR. The Trust does not have a high turnover of nursing staff.

Mr Atkins asked about the approach to scholarships across the Trust. The Chief Nurse confirmed that there are not large funds to support this. Some bursary support can be provided from Charitable Funds. The Chairman suggested that we need to drive opportunities to inflate bursary funds.

The Chief Nurse stated that we need to take action to access external grants and funds.

Mr Miner, Non Executive Director, raised the upward trend line for Agency CSWs although the predictor tool shows staff in post to be at maximum establishment. The Chief Nurse confirmed that she had asked for work to be undertaken around fill rates to understand the position.

The Chief Nurse confirmed that the Chief Nurse for England will be undertaking a formal visit to the Trust during the year.

The Chairman recognised the work of Pam Ricketts for AHP recruitment, retention and collaborative working.

The Chairman and Board noted the report and the actions underway.

19/033.4 7 Day Services Report (Enclosure 13) 1.40pm

Paul Hudson, Interim Deputy Medical Director presented the 7 Day Services Report, given as Enclosure 13.

The Board noted that there were 4 clinical priority standards for 7 day working with the greatest impact on patient care. There were 10 clinical standards overall. Reports were previously undertaken by annual audits and submitted to NHSI. This will be now completed through the Board Assurance Framework.

The Trust is to be compliant with 4 priority standards by March 2020. The Trust is compliant with 2 of the clinical priority standards currently.

The Trust has trialled compliance with the Perfect Fortnights. Significant change to services will be required and will entail business case development for the investment needed.

Achievement for the time to first Consultant review stands at 67%.

Achievement for daily review stands at 72%.

The Trust will be appointing a further 2 Orthopaedic Consultants starting in October, General Surgery also need to increase their Consultant numbers. Neonatal services will be split from the Paediatric consultative on call. Critical Care and ITU will be combined.

Acute Medicine has commenced twice daily ward rounds.

A 7 Day Services Delivery Board has been established and a Standard Operating Procedure is being produced.

Mr Atkins, Non Executive Director, asked about benchmarking. Paul Hudson confirmed that the Trust was below the national average and behind other Black Country Trusts. This is mainly because as the Trust's workload has increased it has not expanded its capacity to meet extra demand. Funding and workforce constraints remained as issues.

The Chief Executive stated that each Division and Directorate needs to show what needs to be done to reach the standard and this should be monitored at the Performance Review meetings.

The Chairman and Board noted the report and thanked Paul for his comprehensive review. A further update will be provided to the Board in June.

Update on 7 Day Services to the Board in June.

**19/033.5 Patient Safety Strategy (Enclosure 14)
2.13pm**

The Medical Director presented the Trust Patient Safety Strategy, given as Enclosure 14.

The Board noted the following key highlights:

- The Board noted that it is not possible to eliminate all harm but it needs to be managed to its lowest possible level.
- Staff need the right training and right equipment to deliver safe and effective patient care.
- Job planning is a focus for improving the delivery of care.
- Actions underway are having a positive effect on mortality, never events and sepsis identification and treatment.
- Patient Safety culture survey will be repeated.
- The strategy is a live document and will continue to evolve.

The Chairman commented that the strategy was marked as a draft and needs to link into the Trust Strategy which is being launched next week. The Medical Director confirmed they were working with the Service Improvement Team to ensure linkages with the Trust Strategy.

The Chief Executive confirmed that the document needs to align itself with other organisation strategies before it is approved. The language in the strategy needs to be understandable for all staff.

The Strategy will be represented to the April Board for formal approval and launch.

Mr Miner, Non Executive Director, commented that the Board needs to understand how the strategy will be monitored and judged as successful.

The Chairman and Board noted the current position with the Strategy.

The Strategy will be presented back to the April Board for formal approval.
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19/034 Responsive and Effective

19/034.1 Integrated Performance Report (Enclosure 15) 2.25pm

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 15.

The Board noted the following key issues for January 2019 performance.

- ED Emergency Access Standard: Performance reflects acuity and capacity demands on the service. Performance nationally is at an all time low. The Trust is examining at frailty pathways and ambulance triage arrangements in order to secure further improvements.
- Cancer key metrics: January in month target not met. Year to date position is 87%.
- RTT: Continued good performance.
- DM01: Performing well so far in February which demonstrates recovery from January position.
- DNA: Below national average, so improvements in appointment process appear to be impacting.
- Appraisals: The Trust will operate a 3 month window again.
- Mandatory Training: Continued good performance noted, albeit some pockets of improvement required.

- Sickness Absence: Above target, which suggests retention initiatives are having an effect.
- Turnover: Better than national average.

The Chief Executive asked about mixed sex accommodation breaches and the local target. Clarification to be provided to the Board by email.

The Chief Executive raised mandatory training for infection prevention and asked for focus to be given to this.

The Chairman and Board noted the report.

<p>Clarification around mixed sex accommodation to be provided to the Board by email</p>

19/034.2 Finance and Performance Committee Exception Report (Enclosure 16) 2.33pm

Mr Hodgkin, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 16.

The Board noted the following key issues:

- £8.8m deficit target. Risks to achieving this target remained particularly around commissioner income.
- Focus on cash position for next year. There are fewer opportunities to manage cash going forward. The Board noted the month on month increase in agency use and that despite efforts to contain this was not working.
- Staffing: Nurse Recruitment Business Plan was approved.
- AMU medics: Increases were advisable but the risk was that the Trust will not be able to appoint staff. Team to bring back options for a contingency approach. The Chief Executive stated that the Trust needs to review its staffing model for this area.

The Medical Director agreed that the Trust needs to look its model for AMU and this had been highlighted by ECIST. The 7 days services report looked at the separation of elective and non elective activity for Surgery and this could also be used by Medicine.

The Chief Operating Officer confirmed that the winter ward from last winter was still open and this would account for some of the requirement for additional staffing. There was also an issue with delayed discharges and this did not help the position.

The Chief Executive advised that the Interim Chief Nurse is analysing acuity factors and this will help with the consideration of staffing profiles. The Chairman asked that the tool is presented to the Board.

The Chairman and Board noted the report.

The Chief Nurse to present the new real time acuity tool to Board members.

19/035 Well Led

19/035.1 Brexit Contingency Plan Update (Enclosure 17) 2.45pm

The Chief Information Officer presented the Brexit Contingency Plan Report given as Enclosure 17.

The Board noted the following key issues:

- Emergency Workshop the previous week had been attended by the Chief Operating Officer.
- National Stockpiling was taking place to ensure minimum supplies of medical devices and medications are available to all Trusts.
- Daily templates are to be submitted to the centre so they can monitor the position.
- The Chief Operating Officer will keep the Board updated.
- Organisation walk rounds are taking place to ensure contingency plans are focused and evident to staff.

Mr Hodgkin, Non Executive Director, asked about Interserve. The Chief Operating Officer confirmed that they are involved in meetings. The Chairman confirmed that this assurance was sought at the monthly meeting with Summit.

The Chairman had discussed the Pharmacy situation with the Chief Pharmacist and there around 100 drugs at risk and asked for further assurance in this respect.

The Director of Finance commented that there will be some medium term issues that need to be considered, particularly around operational management. The Chief Operating Officer confirmed that rotas are being established to ensure appropriate on-site coverage.

The Chairman and Board noted the report.

Further update on Brexit to the April Board to include assurance around 100 at risk drugs.

**19/035.2 Workforce Committee Exception Report (Enclosure 18)
2.55pm**

Mr Atkins, Committee Chair presented the Workforce Committee Report given as Enclosure 19.

The Board noted the following key issues:

- The majority of the meeting was devoted to the further development of the Workforce work.
- Good sub group discussions had been held and the feedback is being collated to influence the Strategy.
- There was agreement that there should be greater focus on diversity and inclusion.
- The Plan will be presented to the June Board.

The Chairman and Board noted the report.

Workforce Strategy to be presented to the June Board.

**19/035.3 Freedom to Speak Up Guardian's Report (Enclosure 19)
2.55pm**

The Freedom to Speak Up Guardians presented their Report given as Enclosure 19.

The Board noted the following key issues:

- Numbers on page 3 had increased from previous quarter and this is due to the Speak Up Champions being in place across the Trust.

- Numbers remain consistent with other local Trusts.
- Champions are up to date with training. There are some issues with undertaking the role In addition to their normal jobs.
- Training needs had been considered but not required currently. One of the FTSU Guardians will be attending the Speak Up national conference.
- The Speak Up Policy has been updated following feedback from NHSI.
- Mr Atkins, Non Executive Director has replaced Dr Wulff as the Non Executive Director lead.
- The engagement lead from the staff survey has shared improvement approaches on bullying and harassment issues and this will be taken forward by the Guardians.
- Gosport and Guardian's survey have been released and recommendations will be picked up in the next quarterly report.

The Chairman asked about learning and adaptation that might need to be applied to processes. The FTSU Guardians confirmed that the National Guardian's office will be providing guidance around how it displays learning given the confidential nature of contacts.

The Chairman confirmed that she would like to see opportunities to learn and adapt provided to the Board. It was not just about outcomes from individuals, rather it was needed to make improvements Trust wide.

Philippa Brazier confirmed that the Guardians are working closely with HR in this respect.

The Chief Nurse confirmed that there are different ways to present the information and this will be considered.

The Chairman and Board noted the report.

The Chief Nurse to consider how the Board sees triangulation around learning and adaptation and for the approach to be brought back to the Board.

19/036 Any Other Business

19/036.1 Board Committee Interim Arrangements (Tabled)

3.10pm

The Chairman tabled the suggested interim arrangement for the Workforce and Digital Trust Committees reporting to the Finance and Performance Committee whilst the Trust undertakes recruitment to appoint to the current Board vacancies.

The Chief Information Officer commented that a number of decisions are clinically based and decisions would need to be referred to the Clinical Quality Patient Experience Committee and not the Finance and Performance Committee. It was suggested that this could be done by a Chair's log. The Medical Director highlighted that there are clinical and financial risks for the Digital Programme.

It was agreed that Digital Trust will report to the Finance and Performance Committee and any clinical risk elements would be reported to the Clinical Quality, Safety, Patient Experience Committee by the use of a Chair's log.

The Board approved the recommendation.

There were no other items of business to report and the meeting was closed.

19/0375 Date of Next Meeting

3.20pm

The next Board meeting will be held on Thursday, 4th April, 2019, in the Clinical Education Centre.

Signed

Date

Trust Board Minutes Addendum**Trust Board Minutes - query from member of the public:**

I have read the recent board papers of Dudley Group and was quite alarmed to read the minutes in relation to the Diabetes patients story.

The minutes are written for the public and I believe that these could be misunderstood to say that all Type 1 Diabetics will be able to have a Libre machine in the next year. There was also a comment about financial benefit but it has been proven that the cost of Libre is actually higher than the normal machines. I appreciate that better management of diabetes should result in less complications and the cost benefit of this, but as yet this has not been demonstrated.

The CCG were one of the first CCGs to commission the machine and we have embraced the new technology.

As you are aware new guidance came out yesterday: <https://www.england.nhs.uk/2019/03/nhs-england-publishes-guidance-on-flash-glucose-monitors-for-type-1-diabetes-patients/> again it specified specific groups of patients not all Type 1 Diabetics. I was also concerned to see the comment about primary care not having the correct skills - giving again an interpretation of incompetencies and therefore more work being transferred to secondary care. Obviously the work that we are doing in the MDTs should bridge this and if there are concerns about lack of skills in primary care, maybe we can have some education in one of the Dudley Diabetic Discussion forums.

Please can you ensure that all colleagues in the department are fully sighted of the current guidelines and proposed future for libre and encourage not to give false expectations.

Extract from Trust Board Minutes - 19/019 Patient Story

Dr Jane Dale, Consultant in Diabetic Medicine and Sister Julie Taylor, Lead Nurse for Diabetes presented the patient story. This related to the Libra device used for treating Diabetes patients. The story was from a Diabetes patient who had successfully given birth following a previous miscarriage.

The story was very positive and a good example of self-management and the care provided by the hospital.

The Chief Operating Officer asked about the criteria for use. The Board noted that a plan is being put in place to offer the device to all patients with type 1 Diabetes by 2020. It was suggested that there should be a linkage to the Ambulance Service around the use of the device.

Mr Atkins, Non-Executive Director, asked about benefits. Dr Dale confirmed that there were cost benefits of use for the NHS but also quality of care benefits for patients. The Interim Director of Governance welcomed the positive news. Dr Dale shared her hopes that the device will be accessible by all Diabetes patients in the future. Currently, the criteria agreed with the CCG set limitations on its use.

The Medical Director asked about technology advancements in other treatments. Dr Dale confirmed that any new treatments such as this take time to establish. This related particularly to progress through Information Governance criteria. The Medical Director commented that it positive to see the advancements being made in remote monitoring.

Dr Hopkin, Non-Executive Director, asked about the long term plan for more services in the community. Dr Dale confirmed that it requires a significant level of expertise to support the patients and this could be difficult to provide within primary care.

The Chairman suggested that the experience of introducing self-management with a technology enhanced solution could be shared across the Trust and with other colleagues.

The Chairman and Board welcomed the positive story.

In view of the query raised and having consulted with Jane Dale, the board is asked to approve the following as an addendum to the published minutes:

The Board noted that a plan is being put in place to offer the device to all appropriate patients with type 1 Diabetes who are pregnant or planning a pregnancy by 2020.

The Board acknowledges the support of Dudley CCG in being one of the first CCGs nationally to commission Libre and also note that there is currently an annual cap on the number of devices that can be issued to patients, to be reviewed in the new financial year. The Board were further informed that new national guidance widens the criteria for Flash Glucose Monitoring, and the expectation is that up to 1 in 5 patients with Type 1 diabetes will meet the new criteria.

Action Sheet
Minutes of the Board of Directors Public Session
Held on 7 March 2019

<i>Item No</i>	<i>Subject</i>	<i>Action</i>	<i>Responsible</i>	<i>Due Date</i>	<i>Comments</i>
19/030.1	Board Assurance Framework	Date of the next Board Workshop to be confirmed to Board members.	HF	March 19	Done – 26 th March, invitations sent.
19/007	Board Assurance Framework	Further discussions on the Board Assurance Framework to take place at the next Board Workshop.	GG	April 19	Done - Board Workshop taking place on 26 th March.
19/031	Patient Story	The Board's thanks and good wishes for the future to be passed to the patient.	LA	April 19	Done.
19/033.1	Staff Survey Presentation	The Director of HR to formally feedback to the Leadership Academy on their proposal. Update on the Staff Survey to the Board in 6 months.	AM	4/4	Not Due.
			AM	5/9	
19/033.5	Patient Safety Strategy	The Patient Safety Strategy to be presented back to the April Board for formal approval.	JH	4/4	To May Board
19/034.1	Integrated Performance Report	Clarification around mixed sex accommodation to be provided to the Board by email.	KK	4/4	Done.
19/034.2	Finance and Performance Committee Report	The Chief Nurse to present the new real time acuity tool to the Board.	MSe	4/4	To May Board
19/035	Brexit Contingency Plan Update	Further update on Brexit to the April Board to include assurance around the 100 at risk drugs.	KK	4/4	On Agenda.
19/023.3	Digital Trust Committee Report	Population Health to be included on a future Board Workshop agenda.	MS/GG	May 19	Not Due

19/033.2	Clinical Quality, Safety, Patient Experience Committee	CQSPE Chair to share transferable actions with other Committee Chairs.	CH	May 19	Not Due
18/139.5	Research and Development Report	The next report to Board to include further detail on commercial opportunities and comparisons with research levels undertaken at other Trusts.	JN	6/6/19	Not Due
19/033.4	7 Day Services	Update on 7 Day Services to the Board in June	P Hudson	6/6/19	Not Due
19/035.2	Workforce Committee Exception Report	Workforce Strategy to be presented to the June Board.	AM	6/6/19	Not Due
19/035.3	Freedom to Speak Up Guardian's Report	The Chief Executive to consider how the Board sees triangulation around learning and adaptation and for the approach to be brought back to the Board.	DW	6/6/19	Not Due
19/021.4	Organ Donation Report	Results of work on tissue donation to be included in the next report.	K Lazenby	Jan 2020	Not Due

Paper for submission to the Board of Directors on 4th April 2019

TITLE:	Public Chief Executive's Report		
AUTHOR:	Diane Wake, Chief Executive	PRESENTER	Diane Wake, Chief Executive
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>	<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>	
ACTION REQUIRED OF BOARD			
Decision	Approval	Discussion	Other
		X	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input checked="checked" type="checkbox"/> <p>High level of confidence in delivery of existing mechanisms / objectives</p>	<input type="checkbox"/> <p>General confidence in delivery of existing mechanisms / objectives</p>	<input type="checkbox"/> <p>Some confidence in delivery of existing mechanisms / objectives, some areas of concern</p>	<input type="checkbox"/> <p>No confidence in delivery</p>
RECOMMENDATIONS FOR THE BOARD			
The Board are asked to note and comment on the contents of the report.			
CORPORATE OBJECTIVE:			
SO1, SO2, SO3, SO4, SO5, SO6			
SUMMARY OF KEY ISSUES:			
<ul style="list-style-type: none"> • Visits and Events • Healthcare Heroes • Two exciting new Chief Registrar posts • Chief of Interviews • Charity Update • National News • Regional News 			

IMPLICATIONS OF PAPER:			
RISK	N		Risk Description:
	Risk Register: N		Risk Score:
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Safe, Effective, Caring, Responsive, Well Led
	NHSI	N	Details:
	Other	N	Details:

Chief Executive's Report – Public Board – April 2019

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and a highlight a number of items of interest.

Items below are not reported in any order of priority.

Visits and Events

7 th March	Council of Governors
13 th March	Chris Hopson Visit
	Transition Board
14 th & 15 th March	Aspire Together Talent Board
18 th March	Vital Sign Guiding Board
20 th March	A&E Delivery Board
	Chief Executive Live Chat
21 st March	Dudley Health and Wellbeing Board
25 th March	Dudley System Oversight and Assurance Group
27 th March	Winter System Review Event
1 st April	Collaborative Leadership Team

Healthcare Heroes March 2019

Congratulations to March's healthcare heroes! The volunteers received the award after being nominated by a member of the public for being incredibly helpful to patients, visitors and staff all around the hospital. The volunteers provide vital help to our departments and wards with patient experience such as tea rounds, chaperoning patients and with escorting patients to their appointments.



Deborah Roch, a nurse practitioner in Ophthalmology, received the individual award through a nomination from a parent of a patient who left very positive feedback regarding the dedication she showed to her child who has autism and learning disabilities. Deb took them under her wing and gave them lots of reassurance as they often get overwhelmed at appointments. The patient and the parent were very thankful to Deb as she helped them to feel valued and so well looked after during the appointment.



Two exciting new Chief Registrar posts

We are seeking to appoint two chief registrars, a new senior leadership role for trainee doctors, ST4 or above, to practice leadership and quality improvement while remaining in clinical practice.

With a focus on delivering high quality, safe care, the successful applicants will receive protected time to provide managerial support to junior doctors.

The chief register for surgery, women and children, and chief registrar for medicine will be supported by a bespoke 10-month leadership development programme designed and delivered by the Royal College of Physicians.

You will report to either the chief of medicine or chief of surgery and receive mentorship from the medical director's office and senior clinical lead.

If you have an interest in medical engagement, are passionate about service improvement and you like a challenge, please apply!

You can be in programme or out of the programme.

Check out NHS Jobs for more detail:

Interviews for Chief of Medicine and Integrated Care, Surgery and Women and Children and Core Clinical Support Services

The interviews for the Chief of Surgery, Women and Children and Chief of Core Clinical Support Services takes place on 12th April and Chief of Medicine and Integrated Care on 15th April, 2019.

We would like to extend our thanks to Matt Weller, Matt Banks and Alec Wolinski for their support during their term of office the last 3 years in these roles. Their dedication and desire to improve care, quality and performance at the Trust is truly appreciated by the Board

DGFT Charity Update

Million Steps Challenge

We are now three quarters of the way through the challenge with a few of the team reaching the 1,000,000 steps already!

21 teams around the Trust are taking part, raising funds for either their department or one of our charity appeals.

2019 Neon Dash - Sunday 9 June at Himley Hall

Things are starting to get colourful! Registration is now open for this year's Neon Dash – online registration can be found on the charity facebook page @DudleyGroupNHSCharity We are also looking for willing volunteers to help support the fun packed day please contact Karen.phillips5@nhs.net

Staff Lottery

You've got to be in it to win it! Any person employed by the Dudley Group, on the monthly payroll, can enter at £1 per go. Prizes each month are 1 x £500, 2 x £200, 3 x £50. All money raised goes to the charity to help support the patient amenities fund. Details can be found on the hub.

National NHS News

Setting up the NHS' Long Term Plan for success

David Green, Director & Co-Founder, Remedium Partners, highlights why the success of the NHS' Long Term Plan will rely on smart strategic workforce planning
Open Access Government (28.02.19)

Patient groups fear scrapping of four-hour waiting limit for A&E

Patient leaders have criticised "very worrying" plans to axe the key NHS target for A&E patients to be treated within four hours. The Times revealed today that NHS England wants to scrap the measure, which has been in place for 15 years, claiming it does not promote the most up-to-date care.

The Times (01.03.19)

NHS to banish pagers from its hospitals – but is this a rash act?

Remember pagers? Simple devices that were used fairly widely before the advent of mobile phones and SMS messaging. If you had a pager, you could receive simple messages, but you couldn't reply. One of the few places you will find a pager today is in a hospital. The UK's National Health Service has over 130,000 pagers in use.

That's about 10% of the total number of pagers in the world. The NHS is not alone. But the pager's days in the NHS could be numbered. As part of his mission to digitise the service, UK health secretary Matt Hancock wants to ditch pagers. Getting rid of antiquated technology seems like an obvious thing to do. But is it in this case?

The Conversation (01.03.19)

Health Secretary reviewing NHS transgender patient rules

The Health Secretary has said he is reviewing NHS rules which allow patients who have legally changed their gender to be cared for on women's wards. Transgender patients are currently treated "as they present" regardless of whether they have undergone a medical procedure to transition, Matt Hancock told LBC. The policy, which was "set some years ago", means patients with male genitalia can be treated on women's wards, he said.

News and Star (04.03.19)

The NHS apprenticeships offering a new route to health and social care

As health and social care faces ongoing recruitment woes, new degree-level apprenticeships put clinical careers back in reach for more applicants. The first degree-level apprenticeships in physiotherapy and occupational therapy are due to be launched in April, offering an alternative earn-while-you-learn route to professional qualification. And this autumn the first apprentices are expected to start the new degree-level qualification in social work. These new professional apprenticeships are creating alternative career paths in health and social care and are also addressing the continuing workforce recruitment and retention problems. They fit alongside a growing and diverse portfolio of other new lower-level apprenticeships. The NHS alone has 350 different job roles – 120 of which have an apprenticeship route, 30 are degree-level.

The Guardian (05.03.19)

New cervical cancer campaign launched with smear tests at 20-year low

A new cervical screening campaign has been launched by the government in the hope of reversing a 20-year low in women going for smear tests. Two women every day in England die from cervical cancer and more than 200,000 women every year are diagnosed with abnormal cell changes which could lead to the disease. However, official figures show that the proportion of women aged 25 to 64 who go for smear tests is currently at its lowest for two decades. **ITV News (05.03.19)**

Hundreds more deaf people eligible for 'life-changing' implants on NHS

Hundreds of deaf children and adults will receive hearing implants on the NHS after changes to official guidelines. A review of eligibility criteria by the National Institute for Health and Care Excellence (NICE) means many more will now benefit from the technology. The mother of a four-year-old boy who was refused cochlear implants by the NHS said she was "delighted" by the announcement.

The Mail (06.03.19)

NHS trials 5G to keep patients away from hospital

The National Health Service (NHS) has opened a digital testing space in Liverpool – the Liversnerds Lab – aimed at trying out the latest healthcare technologies over 5G. The idea is to monitor patients in their own homes rather than have them traipse into hospital. Fewer hospital admissions promises a more efficient use of NHS resources and, potentially, better healthcare for patients. The lab is kitted out with a ‘smart room’, which simulates a hospital room, and a ‘smart house’, which plays the part of a patient’s home. The lab is putting a variety of digital technologies through their paces – sensor technology, virtual reality, telehealth and health care – and uses 5G to connect the ‘smart room’ with the ‘smart house’. The goal is to develop ways in which health professionals can remotely monitor important changes to a patient’s health. Heart rate and blood pressure are among the things being looked at, while alarms can also apparently be raised if a patient takes a fall.

5G.co.uk (06.03.19)

Transforming the way we treat trauma

In this article, Bevan Exemplar and trauma surgeon Oliver Blocker explains why the NHS needs to change to survive in the way it treats and admits trauma patients. He discusses how new models of care are vital to meet the needs of patients with injuries in an overstretched hospital service. Right now, in many UK cities such as my own in Cardiff, if you have an injury that requires treatment in hospital – such as a serious cut or a broken bone in your hand that requires surgery – then you are about to have what is known as a ‘patient experience.’ What is often best for patients is to return to have their operation at an arranged time and go home the same day, where they can be much more comfortable. But is the system equipped to give them that option?

National Health Executive (06.03.19)

Staff shortages driving down public satisfaction with NHS

The latest British Social Attitudes poll for 2018 shows satisfaction levels with the health service have dropped to the lowest level since 2007, with just 53% of people either “very” or “quite” satisfied with how it runs. The score is a 3% drop from 2017 and continues a downward trend seen in recent years. Not enough staff featured in the top three reasons for dissatisfaction with the NHS, with 52% of respondents unhappy with the situation. Long waiting times (53%) and lack of government funding (49%) were the other two.

Nursing Times (07.03.19)

Vaping restrictions ‘should be lifted in hospitals’ – report

Restrictions on vaping on hospital grounds should be lifted, a pro-smoking group has said. More than half (55%) of NHS trusts did not allow e-cigarettes to be used outdoors last year, according to a report by the Freedom Organisation for the Right to Enjoy Smoking (Forest). This is despite Public Health England (PHE) advice that it should be made easier for people to vape on site, the group said. Forest is also calling for greater freedom for patients, visitors and staff who want to smoke cigarettes at hospitals.

News and Star (10.03.19)

NHS hospitals could face fines for breaches of new sepsis rules

Hospitals could face financial penalties if they fail to meet new guidelines for detecting and treating sepsis. The guidance, mandated by NHS England, includes a requirement for staff to alert senior doctors if patients suspected of having the deadly condition do not respond to treatment within one hour. All NHS trusts in England will be contractually obliged to fully comply with the advice from April, in an effort to improve accountability. Sepsis, which is hard to spot, occurs when the body responds poorly to a bacterial infection and attacks its own tissue and organs.

The Guardian (11.03.19)

NHS poised to drop 4-hour A&E treatment target

The four-hour target, in place since 2004, has not been met nationally for almost four years: in January only two big emergency departments in England achieved it. NHS leaders believe its rigidity can lead to unnecessary admissions, however, as doctors strive to meet it. NHS England said that around one-fifth of all emergency admissions from A&E happened in the final 10 minutes before the four-hour deadline, “suggesting that hospitals are being driven to focus on the target, rather than what is the best approach for each patient”.

Financial Times (11.03.19)

A&E waiting times hit record low again as February becomes the ‘toughest month to date’ for the NHS

The NHS has reported its worst ever performance figures for the second month in a row in the wake of new proposals scrapping the flagship four-hour A&E target, according to the latest NHS statistics. The “overwhelmed” health service had its “toughest month to date” in February with only 84.2% of A&E visits seen within the NHS’s four-hour waiting time target, dropping from 84.4%. The figures showed a big increase in demand compared to this time last year, but the NHS hasn’t hit its A&E target since July 2015.

National Health Executive (14.03.19)

NHS chiefs attack plans to scrap four hour A&E targets, warning against attempts to ‘keep ministers happy’

Hospital chief executives have attacked plans to scrap four hour A&E targets, suggesting the moves are being politically driven because deadlines are not being met. Last week NHS England said it would test a new system, which officials said would mean speedier care for the most urgent cases. The Royal College of Emergency Medicine expressed alarm that the plans could mean most patients have no deadline for treatment, leaving millions to wait longer. On Tuesday chief executives spoke out against the plans, which are due to be piloted at around 12 trusts before being rolled out nationally.

The Telegraph (19.03.19)

NHS could end up short of 70,000 nurses and 7,000 GPs, warns report

The NHS could be short of 70,000 nurses and 7,000 GPs within five years unless urgent action is taken to address a growing staffing crisis, according to analysis by health think tanks. The report warns that existing nursing shortages could double and the shortfall of family doctors treble unless urgent measures are adopted in a new NHS workforce strategy, expected later this year.

The report, co-authored by the Nuffield Trust, the King's Fund and the Health Foundation, estimates the budget for training and developing staff will have to rise by at least £900m to address the widening workforce gap. It recommends offering a £5,200 grant for living expenses to nurses in training, and tripling the number of postgraduates in training and bringing 5,000 more students onto nursing courses every year.

Sky News (20.03.19)

More than half of NHS authorities rationing cataract operations

Patients are being left in pain and misery amid widespread rationing of cataract operations and hip and knee surgery, research suggests. The study shows that more than half of NHS authorities are restricting access to cataract surgery, with many refusing operations until patients are almost blind. Charities said the findings were "shocking," warning that vulnerable pensioners were being left at increasing risk of suffering harm such as falls.

The Telegraph (20.03.19)

Expect a rise in patients suing NHS over long waits, watchdog warns

The NHS should expect a surge of medical negligence claims because of longer waiting lists in areas including cancer care and planned operations, Whitehall's spending watchdog has said. The National Audit Office said two in five compensation claims were due to delays in treatment or diagnosis

The Guardian (22.03.19)

Patient monitor technology cuts falls and saves nurse time

The installation of a digital patient monitoring system on two dementia wards in the West Midlands cut falls by a third and saved nurses a considerable amount of time, a clinical study found. Coventry and Warwickshire Partnership NHS Trust introduced the Oxehealth Digital Care Assistant in half of the bedrooms across Manor Hospital's Pembleton and Stanley wards, and measured the impact over eight months. Using an optical sensor, the software detects and alerts staff to patient movement and can also measure their vital signs. During the clinical study that ran from March to October last year, there were 33% fewer falls at night than in the same period of 2017.

Nursing Times (18.03.19)

Exclusive: NHS trusts dismiss Brexit impact on staff retention

Indicative data obtained through the Freedom of Information Act reveals only a small number of trusts have seen a reduction in their EU workforce since the referendum, with more trusts instead reporting an increase in the number of EU nationals joining since June 2016. The UK is set to leave the EU at 11pm on 29 March, unless an extension is agreed in the next few days. As part of preparations for a no-deal Brexit, all trusts were told to send self-assessments of the impact of a no-deal Brexit on their workforce and non-clinical goods and services.

HSJ (20.03.19)

Measles warning: Virus cases rise almost 400% in one week - UK areas most at risk MAPPED

Eighty-six people became infected with measles in England and Wales between March 10 and 17, according to latest Public Health England figures. That's almost a 400 per cent rise on the 22 cases reported the week before, between March 3 and 10. More than half of the cases were reported in London, and Hackney was the largest hot spot. Some 23 measles cases were reported in the London district - more than the entire East of England, South East and South West altogether. Barnet reported nine cases over the past seven days, while four cases were reported in Islington. Both the South West and West Midlands had the lowest number of cases reported, each with one.

Express (20.03.19)

Regional NHS News

More than 40 per cent of GPs intend to quit in next five years, research finds

MORE than 40 per cent of GPs intend to quit within the next five years, Warwick University research shows. It is an increase of nearly a third since 2014. The survey of 929 GPs has revealed recent national NHS initiatives are failing to address unmanageable workloads for GPs. It claims many are unconvinced the NHS can respond to the increasing challenges facing general practice. Published yesterday (February 28) in the journal BMJ Open, it reveals workload was identified as the most significant issue with 51 per cent of GPs reporting they were working longer hours than in 2014. It suggests the GP workforce is not keeping pace with the growing healthcare needs of the population, with an increase in complex long-term conditions such as diabetes, hypertension and stroke.

Solihull Observer (01.03.19)

NHS: Forcing out senior doctors

At a time when the National Health Service is faced with growing staff shortages, senior and highly experienced GPs and hospital doctors in the North East are cutting back on their work or leaving the profession entirely. This is partly because of stress and an ever-increasing workload, but is also because of the current damaging tax and pension regulations, which severely penalise them for working longer hours. The current lifetime and annual allowance pension limits are resulting in large and often unexpected financial burdens for the most senior and experienced of doctors. And the problems are made worse if these doctors work more hours, to try to reduce patient waiting lists for example.

Northumberland Gazette (04.02.19)

Shropshire baby deaths: Panel pulled over family concerns

A scrutiny panel has been pulled from an inquiry into baby deaths after families raised concerns. Parents objected to the Royal College of Obstetricians and Gynaecologists (RCOG) being part of the panel for the inquiry into maternity failings at Shrewsbury and Telford NHS Trust. NHS Improvement said the decision to abandon it was made after "feedback from the families". Mother Rhiannon Davies said she was glad parents' voices had been heard.

More than 200 families have raised concerns about maternity care at the trust as part of the review, conducted by senior midwife Donna Ockenden. NHS Improvement invited the RCOG to participate in the scrutiny panel despite questions about its recent history at the health trust.

BBC News (04.03.19)

Thousands of NHS workers suffering from stress

Thousands of NHS workers across the region are suffering from stress-related illnesses, new figures show. Around 40 per cent of staff at healthcare trusts across the Black Country and Staffordshire reported stress-related illnesses last year, with half of these admitting they felt pressured into turning up to work despite feeling like they could not cope. At the University Hospitals of North Midlands, Walsall Healthcare NHS Trust, Sandwell and West Birmingham Hospitals NHS Trust and Dudley Group NHS Foundation Trust that figure was 42 per cent. Around half of those in the region who said they suffered from a stress-related illness admitted they had felt pressured into turning up at work despite feeling too unwell to cope.

Express and Star (07.03.19)

Ambulance service getting to patients faster than ever

NEW figures show that West Midlands Ambulance is getting to more patients more quickly than ever before. The data, which was published by NHS England shows that the Trust has improved its performance in each of the four categories of calls that it is measured on. It also remains the only Trust in the country exceeding all of the standards. Trust Chief Executive, Anthony Marsh, said: "This is excellent news for patients and is down to the incredible efforts of our staff, who work so hard in often difficult circumstances to ensure patients get the best possible care.

Stratford-Upon-Avon Express (21.03.19)

Health trusts missing cancer treatment time targets

Hundreds of cancer patients across the Black Country and Staffordshire are not starting their treatment on time, new figures show. Patients should be starting treatment within 62 days of an urgent GP referral, but in a number of cases across the region this is not happening. The NHS sets trust a target of 85 per cent of patients starting treatment within the 62 days, but only one local trust achieved this target in January. In Dudley, 78.2 per cent of cancer patients at the borough's health trust were seen within the target time. **Express and Star (23.03.19)**

Paper for submission to the Board 4th April 2019

TITLE:	26th March 2019 Clinical Quality, Safety and Patient Experience Committee Meeting Summary		
AUTHOR:	Mary Sexton – Interim Chief Nurse	PRESENTER	Catherine Holland – Committee Chair
CLINICAL STRATEGIC AIMS			
<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>			
ACTION REQUIRED OF THE BOARD			
Decision	Approval	Discussion	Other
			Y
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE BOARD			
The Board should note the assurances provided by the Committee and the actions they took at the last meeting. The Board should also note that there are three matters requiring referral to The Board from the March meeting.			
CORPORATE OBJECTIVE:			
SO 1 – Deliver a great patient experience SO 2 – Safe and caring services			
SUMMARY OF KEY ISSUES:			
The attached provides a summary of the assurances received at this meeting, the decision taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.			

IMPLICATIONS OF PAPER:			
RISK	Y		Risk Description: covers many risks, key are those related to the Trust quality priorities, deteriorating patient and patient experience
	Risk Register: Y		Risk Score: numerous across the BAF, CRR and divisional risk registers
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Links all domains
	NHSI	Y	Details: Links to good governance
	Other	N	Details:

Clinical Quality, Safety and Patient Experience Committee Summary Report to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	26 th March 2019	Catherine Holland Non-Executive Director	yes	no
			Yes	
Declarations of Interest Made				
None				
Assurances received				
<p>The Committee received assurances from the following: Risk And Assurance Group Highlight Report Integrated Quality And Performance Report</p> <p>Board Assurance Framework- Further work is required to refine the BAF and ensure all risks identified and their mitigating actions are updated.</p> <p>DIVISIONAL GOVERNANCE MEETING UPDATE</p> <ul style="list-style-type: none">Medicine and Integrated Care <p>Templates have been provided for future Divisional Governance Updates and the Committee decided that the three divisions will present reports on a rotational basis.</p> <p>Reports were provided to the Committee from:</p> <p>Quality and Safety Group Internal Safeguarding Board Infection Prevention and Control Forum Medicines Management Group Clinical Approvals Group Health & Safety Group</p> <p>Progress on items being monitored by these Groups will be reported to the Committee at future meetings.</p> <p>Summary of Assurance and Risk in relation to NPSA Alert of resources to support safer modification of food and drink. The Committee noted some exceptional work which has been done in relation to this. The report provided an excellent example of extensive collaborative working in response to the</p>				

NPSA Alert which demonstrates the commitment of the group members, in particular Jenny Glynn, to manage risk and ensure patient safety is maintained at all times. It was agreed that there should be more Trust Learning from these good examples.

Decisions Made/Items Approved

- Divisional Updates to be provided on a rotational basis
- Terms of Reference to be discussed and meeting structure to be evaluated.
- Reduction of action plans submitted with papers was requested

Actions to come back to Committee (items the Committee is keeping an eye on)

- Implementation of Blood Tracking System.
- Medicines Supply and substitutions (relating to Brexit and changes in national legislation)
- Air purification units in Theatres 8, 9 and 10. A report was circulated after the meeting. This will be monitored through Execs.
- Complaints performance and review paper to come back to Committee

Items referred to the Board for their attention, decision or action

- Strategic Action Plans
- April meeting to be cancelled due to Bank Holiday Weekend. The allotted time to be used by Chair and Chief Nurse to discuss and shape the reporting structure and agenda of future meetings. It has also been discussed that the meeting takes place less frequently.
- Non-Compliance of COSHH regulations.



The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors April 2019

TITLE:	CHIEF NURSE REPORT		
AUTHOR:	Carol Love-Mecrow, Deputy Chief Nurse	PRESENTER:	Mary Sexton Interim Chief Nurse
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>	<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>	
ACTION REQUIRED OF BOARD			
Decision	Approval	Discussion	Other
		X	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE BOARD			
The Board is requested to review and note the report and the work being undertaken to address areas of risk associated with complaints activity.			
CORPORATE OBJECTIVE:			
SO1: Deliver a great patient experience, SO2: Safe and Caring Services, SO3: Drive service improvements, innovation and transformation, SO4: Be the place people choose to work, SO5: Make the best use of what we have, SO6: Deliver a viable future			
SUMMARY OF KEY ISSUES:			
The Chief Nurse has professional responsibility for nurses, midwives and allied health professionals (AHPs) within the Trust however, does not operationally manage the majority of these staff. The oversight and management of staff within the Trust is within the divisional management structure, which reports to the chief operating officer (COO) via the divisional directors. Appendix 1 Provides this month's detailed update on safer staffing, agency controls and recruitment and retention.			

NURSING AND PROFESSIONAL COMMITTEE

- The first meeting of the Nursing and Professional Committee took place on the 20th March 2019. This meeting, chaired by the Chief Nurse, is a joint meeting for Matrons and Lead nurses, with representation from AHPs. At this initial meeting attendees agreed the Terms of Reference and discussed plans for the Nursing Strategy and skill mix review.

NURSING STRATEGY

- A full review of the nursing strategy has taken place at a Development Session attended by nursing and midwifery leads held on the 27th March and the revised strategy will be launched in May 2019 as part of the Trust programme of celebrations to mark 'International Nurses Day'.

CELEBRATING NURSING WEEK

- Preparation continues for a series of events to be held in celebration of International Nurses Day (on 12th May) and to recognise and celebrate the contribution of nursing staff.
- The events will showcase the work of nurses across our organisation as part of the celebration we will be holding a Nursing Conference on 9th May.

AHP UPDATE

- Speech and Language Therapy (SLT) team recently submitted a paper to the National Sentinel Audit competition regarding the Stroke Listening into action (LiA) which SLT facilitated and delivered. This paper won an award for improving patient experience and patient care.
- The Enhanced Care Team has been diversifying its delivery of training. Recently the Speech and Language Therapist within that team held a tea party for staff at some of Dudley's nursing homes. Staff at the Brambles and Holbeache were treated to tea, cakes and some mocktails of varying consistencies, to give ideas on different ways thickened drinks can be made more appealing. Staff were given information on how to correctly thicken drinks and the signs to look out for if someone has a swallowing problem. It also provided a forum for staff to ask questions about the different food consistencies, which now have new terminology (effective 1st March 2019).
- Dietetics have introduced a new departmental patient experience questionnaire, developed to provide feedback specific to dietetics.
- The Therapy Services audit: Reviewed the extended work day with additional staff on B2 to treat fractured neck of femur (NOF) patients to provide daily rehab from dedicated NOF suite staff. The current service is unfunded and for ½ day only. Therapy input increased and length of stay reduced compared to 2017. As the audit only ran for one month, Surgery has agreed to fund a three month trial (commenced beginning of February) before making a decision on how to proceed.
- The AHP Strategy summary document is now available on the AHP Hub page.

SAFER STAFFING

- The Registered Nurse fill rates for February 2019 were 82% during the Day and 87% during the Night. Overall staff fill rates for Day shifts was 83.5% and 90% during the Night shifts. The target fill rate for qualified staff is set at 90% since December 2018.
- Meetings with Lead Nurses/Midwives and Matrons continue focusing on recruitment and retention of staff to deliver the reduction in bank and agency usage.
- 45 staffing incidents were reported in February 2019, none reported as causing harm. 4 out of the 45 incidents were reported as near misses whilst the remaining 41 incidents were of no harm.
- 16 out of 45 incidents were reported from Maternity services. Mitigations include Midwifery daily response meeting and staff redeployment.

AGENCY CONTROLS

- There was a slight decrease in February 2019 (4,105) usage in comparison to previous month. There was a significant increase in RN bank and agency usage in January 2019 (4,152) in comparison to December 2018 (3,614).
- Contributory factors include winter pressures, unfunded capacity and high number of patients requiring increased level of observation and/or providing 1-1 patient care.

- All bank and agency requests continue to be assessed daily by the Divisional Chief Nurses to ensure continued patient safety and financial balance.
- Use of non-framework agency remains an Executive only authorisation

PATIENT ACUITY TOOL

- Work on National Quality Board Safer Staffing paper is in progress which includes validation of data from the Divisions, Health roster (Allocate) and finance with regards to the wards planned staffing. Support and challenge meeting is scheduled to take place next month with regards to the latest patient acuity and dependency study results, to inform the nursing staffing skill mix review for the Trust Board to consider.
- Conduct of patient daily acuity and dependency started in bedded units in March 2019. It is envisaged that the information will be utilised for a trust wide daily safety huddle to manage available staffing resources on the day including staff redeployment and plan mitigation for staffing shortfall at night.

RECRUITMENT AND RETENTION

- At the time of the report, a total of 33 new staff are currently going through recruitment clearances
- 18 graduate nurses due to commence on the 1st April 2019, we expect a level of attrition.
- There are currently 61.8 FTE currently live on NHS Jobs and 56.1 FTE are closed and in process of shortlist to interview. This equates to 118.9 FTE advertisements for the organisation.
- Attendance to RCN Recruitment fayre in March has resulted in the offer of 35 substantive RN posts, however some of these staff will not be available until September 2019.
- Targeted and monthly recruitment events continue.

REVALIDATION

- The revalidation process continues and has now become fully embedded within the Trust. It is now nearly three years since its introduction which means that every nurse and midwife has had to revalidate during the three year cycle. Those who had to revalidate nurses and midwives that had to revalidate during its first month of introduction in April 2016 will be completing their second revalidation this month.
- Monthly revalidation data continues to be sent to all Lead and managers detailing all staff who have been revalidated and those that require to be within the next three months.

RESUSCITATION

- A full review of provision and placement emergency equipment availability has been undertaken and will be reported to Deteriorating Patient Group as a response to feedback received from Care Quality Commission.

PROFESSIONAL DEVELOPMENT

Sepsis Practitioners

- One additional sepsis practitioner is due to start on the 1st April 2019 with a second practitioner due to start 21st April.

Pre-Registration

- The Pre-Registration team won the best poster presentation at the RCN Education and Leadership conference held in Bristol on 12 and 13th March. The presentation, in collaboration with the University of Wolverhampton detailing the Pre-registration challenge day which focuses on simulated emergency situations, leadership and management.
- Four student nurses studying at Worcester University have commenced placements at the Trust in March.

SAFEGUARDING

- The newly appointed Named Safeguarding Midwife is expected to commence her post in May 2019.

FALLS

- Falls (without harm) demonstrate a consistent trajectory of remaining below the national average of falls

per 1,000 occupied bed days (as given by the Royal College of Physicians (RCP) National Falls audit 2015). Falls with harm remain consistently below the national average with February being completely free of any patient falls resulting in fracture.

- Falls prevention remains focussed on high risk areas (such as Acute Admissions) by the staff in these areas supported by the Falls lead.

DEMENTIA

- The Trust remains above the target of 90 % for find/assess, investigate and refer patients who present with cognitive impairment.

COMPLAINTS

- During February 2019, the Trust received 48 new complaints, in comparison to 46 opened for January 2019 and 47 opened for December 2018. This is a 4.34% increase from January 2019 for open complaints.
- All 48 complaints were acknowledged within 3 working days. The Trust currently works to a 40 working day timeframe to respond to complaints.
- As at the end of February there were 216 complaints outstanding awaiting response. Work is ongoing with the Divisions in relation to Complaint Management and producing timely reviews and responses to people who have raised concerns or made complaints.

CHAPLAINCY

- Catherine Beasley, hospital chaplain, has been nominated for a Healthcare Hero Award this month.

PATIENT EXPERIENCE

- Interviews, for the patient engagement lead post have taken place on 26th March; this is to replace Helen Board who is moving to Corporate Governance shortly.

TISSUE VIABILITY

- There was one avoidable grade 3 pressure ulcer reported from B2 (acute) in February 2019. RCA is underway to identify learning.

RISK	Y		Risk Description As detailed within the BAF under the chief nurse
	Risk Register: Y		Risk Score As detailed within the BAF
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y/N	Details
	NHSI	Y/N	Details:
	Other	Y/N	Details:

Paper for submission to the Finance and Performance Committee March 2019

TITLE:	Nurse Staffing		
AUTHOR:	Mitchell Fernandez - Deputy Chief Nurse & CNIO	PRESENTER	Mitchell Fernandez - Deputy Chief Nurse & CNIO
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	
ACTION REQUIRED OF Finance and Performance COMMITTEE			
Decision	Approval	Discussion	Other
		y	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE Finance and Performance Committee			
To receive the report and note the contents.			
CORPORATE OBJECTIVE:			
SO1: Deliver a great patient experience SO2: Safe and Caring Services SO4: Be the place people choose to work SO5: Make the best use of what we have SO6: Deliver a viable future			
SUMMARY OF KEY ISSUES:			
Safer Staffing <ul style="list-style-type: none"> The qualified staff fill rates for February 2019 were 82% during the Day and 87% during the Night. Overall staff fill rates for Day shifts was 83.5% and 90% during the Night shifts. The target fill rate for qualified staff is set at 90% since December 2018. All areas are within the agreed variation of 6.3 or more for the CHPPD. Overall Trust CHPPD is 8.4 			

(qualified and unqualified) in February 2019. Trust CHPPD in December 2018 was 8.6, slightly above against national (8.0) and peer (7.6) median. February 2019 data in Model Hospital is not yet available at the time of the report.

- A number of quality indicators (NHS Safety Thermometer) have been included from the Model Hospital. The trust compares positively in all indicators in comparison to national median and peers. (Model Hospital data as of January 2019)
- Meetings with Lead Nurses/Midwives and Matrons continue focusing on recruitment and retention of staff to deliver the reduction in bank and agency usage.
- 45 staffing incidents were reported in February 2019, none reported as causing harm. Four out of the forty five incidents were reported as near misses whilst the remaining 41 incidents were of no harm.
- 16 out of 45 incidents were reported from Maternity services. Mitigations include Midwifery daily response meeting and staff redeployment.
- Work on National Quality Board Safer Staffing paper is in progress which includes validation of data from the Divisions, Health roster (Allocate) and finance with regards to the wards planned staffing. Support and challenge meeting is also scheduled to take place next month with regards to the latest patient acuity and dependency study results.
- Conduct of patient daily acuity and dependency started in bedded units in March 2019. It is envisaged that the information will be utilised for a trust wide daily safety huddle to manage available staffing resources on the day including staff redeployment and plan mitigation for staffing shortfall at night.

Agency Controls

- There was a slight decrease in February 2019 (4,105) usage in comparison to previous month. There was a significant increase in RN bank and agency usage in January 2019 (4,152) in comparison to December 2018 (3,614).
- Contributory factors include winter pressures, unfunded capacity and high number of patients requiring cohorting or providing 1-1 patient care.
- All bank and agency requests continue to be assessed daily by the Divisional Chief Nurses to ensure continued patient safety and financial balance. A breakdown of the main areas using agency staff is included.
- Use of non-framework agency remains an Executive only authorisation.

Recruitment and Retention update

- At the time of the report, a total of 33 experienced staff are currently going through recruitment clearances
- 18 graduate nurses due to commence on the 1st April 2019
- There are currently 61.8 FTE currently live on NHS Jobs and 56.1 FTE are closed and in process of shortlist to interview, with 1 FTE currently in draft. This equates to 118.9 FTE advertisements for the organisation
- Targeted and monthly recruitment events continue.
- Predictor tools are within the paper as requested. Vacancies have reduced in month by 9 WTE to 281 WTE.

IMPLICATIONS OF PAPER:

RISK	Yes		<ul style="list-style-type: none"> • Risk Description: <ul style="list-style-type: none"> ➤ Nurse Recruitment – unable to recruit to vacancies to meet NICE guidance for nurse staffing ratios ➤ Finance – Unable to remain within divisional Budget due to spend on Temporary Staff.
	Risk Register: Yes		Risk Score: 20
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Yes	Details: <ul style="list-style-type: none"> ➤ Safe- Are patients protected from abuse and avoidable harm ➤ Effective- Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence ➤ Caring - Staff involve and treat people with compassion, kindness, dignity and respect ➤ Responsive - Services are organised so that they meet people's needs ➤ Well Led - The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture
	NHSI	Yes	Details: Capping of agency
	Other	Y/N	Details:

Safer Staffing

The Safer Staffing Summary (Appendix 1) shows the actual and planned hours for qualified staff and unqualified staff for both day and night shifts for each area of the Trust based on the establishments that commenced in July 2018. As well as showing the actual and planned hours the report shows the fill rates. The totals for the Trust are also indicated. In addition, the last three columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in informing the National Model Hospital data.

As previously indicated, the report is based on the new establishments with the data coming from Allocate. The agreed plan was to achieve 90% fill rate from December 2018. The table 2 below indicates fill rates have been improving when taking a Trust wide view. This month there has been a 1.5% increase in the qualified fill rates compared to January 2019. Appendix 1 shows the details of all the wards staffing fill rates during the day and night. An additional column has been added to appendix 1 that states the occupancy which can be a contributing factor to low fill rates. Triangulation of data against staffing incidents and quality dashboard KPIs provides the oversight that safe, quality care is being delivered to our patients.

Table 2 – Trust position against fill rates

	Planned Qualified	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
April 2018		97%	96%	98%	98%
May 2018		95%	97%	97%	97%
June 2018	80%	81%	90%	84%	96%
July 2018	80%	80%	89%	84%	94%
Aug 2018	80%	77%	89%	84%	94%
Sept 2018	85%	78%	84%	83%	90%
Oct 2018	85%	82%	87%	88%	92%
Nov 2018	85%	84%	91%	88%	96%
Dec 2018	90%	81%	87%	86%	91%
Jan 2019	90%	83%	83%	87%	93%
Feb 2019	90%	82%	85%	87%	93%

Mitigation /action

- Matrons review staffing numbers; patient acuity and skill mix each shift when they mitigate any immediate shortfalls by moving staff between wards and then plan for the night and following day. If mitigation within the division is not possible discussions occur with other divisions for support. Staffing issues also occur at the capacity meetings and support is requested when required.
- Each ward and department has a bespoke recruitment and retention action plan with monthly rolling adverts on NHS jobs.
- Matrons review staffing numbers twice daily, patient acuity and skill mix each shift when they mitigate any immediate shortfalls by moving staff between wards and then plan for the night and following day. If mitigation within the division is not possible discussions occur with other divisions for support. Staffing issues also occur at the capacity meetings and support is requested when required.

- Lead Nurses and Matrons continue to meet regularly with the Associate Chief Nurses to discuss staffing challenges, whilst maintaining patient safety and sustaining financial balance. Monitoring and contingency processes are in place daily to ensure that staffing does not fall below an absolute minimum (which are based on the old establishments). Timely filling of bank shifts continues to be a challenge; however the Divisional Chief Nurses are reviewing this daily to avoid late requests for staff that cannot be filled.

Care Hours per Patient Day (CHPPD)

Following the publication of the Carter Review (2016) NHS Improvement have issued new guidance which requires all Trusts to report Care Hours per Patient Day. From May 2016 CHPPD has become the principle measure of nursing and care support deployment. CHPPD provides a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units. Care hours per patient day (CHPPD) (Appendix 1) for the majority of ward areas remain within the nationally agreed variation of 6.3 CHPPD and 16.8 CHPPD for general wards (Carter Review, 2016). Overall Trust CHPPD is 8.4 (qualified and unqualified) in February 2019. Trust CHPPD in December 2018 was 8.6, slightly above against national (8.0) and peer (7.6) median. February 2019 data in Model Hospital is not yet available at the time of the report.

Quality Indicators

Rather than considering staffing numbers in isolation, it is useful to compare the Trust to its peers and national figures with regards to the quality of care being provided. A number of quality indicators (NHS Safety Thermometer) have been listed below. These come from the Model Hospital (with latest data remaining January 2019, which was reported last month). It can be seen that the Trust compares favourably against its peers and the national median. In addition February 2019 quality Heat Map has been included within the appendices.

Table 4

Quality Indicator : Model Hospital Data: January 2019	Trust %	Peer Median %	National Median %
Proportion of patients on day of survey with “harm-free care”	94.2	95.7	94.1
The proportion of patients with harm from a fall in care - The proportion of patients with evidence of harm from a fall in a care setting in the last 72 hours	0.1	0.3	0.3
The proportion of patients being treated clinically for a new VTE.	0.1	0.3	0.4
Proportion of patients on the day of survey with one or more new pressure ulcers of grade 2 to grade 4, where the pressure ulcer developed at least 72 hours after admission to the trust .	0.3	0.7	0.8
Proportion of patients with an indwelling urethral urinary catheter also receiving treatment for a urinary tract infection (on the basis of notes, clinical judgement and patient feedback), including UTIs that developed before admission to the trust.	0.1	0.3	0.7

Summary situation of staffing and potential recruitment over the next year

Internal Recruitment Events

The next corporate recruitment event is scheduled for the 15th March 2019 9am -12pm in main reception health hub. The event will advertise for experienced nurses, staff looking to return to the NHS from the private sector localities such as nursing homes, practice nursing and other care settings, as well as student nurses due to qualify.

Local recruitment events held and recruited to are:

Recruitment Event	Date of Event	Number of conditional offers made
Corporate recruitment event	15 th March 2019	Report completed before event, data to follow on next report

The following areas have local events booked for April and May 2019:

- C5– 30th April 2019
- CCU – 30th April 2019
- ED – 15th May 2019
- AMU – 23rd May 2019

External Recruitment

Booked Events

- RCNi event NEC Birmingham 13th March 2019 Cost £4950
- Worcester University jobs fair 14th March 2019 Cost Free
- Birmingham City University careers event - 8th May 2019 Cost Free

No further external events with costs attached have been booked until analysis of the success of these has been completed to monitor the expenditure against the successful recruitment activity, as recruitment expenditure does not have a specific budget and all activity is currently aligned to the chief nurses` budget.

Recruitment Activity

At the time of the report, a total of 33 experienced staff are currently going through recruitment clearances.

Below is a breakdown of this activity.

Experienced Nurses completing recruitment clearances

Head Count	Band	Area	Hours WTE	Potential Start Date
1	5	ED	1	March 2019
1	5	NNU	0.96	March 2019
1	5	T&O Outpatients	1	March 2019
1	6	Community	1	March 2019

Head Count	Band	Area	Hours WTE	Potential Start Date
2	5	AMU	2	April 2019
1	5	B1	1	April 2019
1	5	B3	1	April 2019

1	5	C2	0.96	April 2019
1	5	Community	1	April 2019
2	5	ED	2	April 2019
1	5	Theatre	1	April 2019
1	6	AMU	1	April 2019
1	7	AMU	1	April 2019
1	7	Cardiac Assessment Nurse	1	April 2019
2	7	Sepsis Nurse	2	April 2019
1	5	B4(a)	1	May 2019
2	2	C2	2	May 2019
1	5	CCU	1	May 2019
1	5	Community	1	May 2019
2	5	Day Case Theatre	2	May 2019
2	5	ED	2	May 2019
3	6	C8	3	May 2019
1	6	Colorectal/Stoma Nurse	1	May 2019
1	6	ED	1	May 2019
1	6	Safe guarding associate nurse adults	1	May 2019

18 graduate nurses due to commence on the 1st April 2019 into the following areas:

Area/Department	Head Count	Hours WTE
AMU 1	3	2.76
B2 Hip	1	1
B2 T&O	2	2
B4 (b)	2	2
B5	1	0.64
C1 (b)	2	2
C7	1	0.64
CCU	1	1
Community Nurses	1	0.8
Critical Care	1	1
FAU	1	1
ED	2	1.28
Total	18	16.12

These allocations are subject to change due to withdrawals or deferrals for non-completion of nurse training, personal reasons and external candidates taking posts in their training Trusts. The RN nursing predictor is now including an attrition rate of 15% to mitigate this.

Recruitment Processes

NHS Jobs activity is indicated in the table below, 61.8 FTE are currently live on NHS Jobs and 56.1 FTE are closed and in process of shortlist to interview, with 1 FTE currently in draft. This equates to 118.9 FTE advertisements for the organisation. Monitoring of this is continuing with the resourcing team and recruitment and retention lead weekly reviewing advertised vacancies. High vacancy areas who are not

advertising are being targeted and the recruitment and retention lead is continually working with lead nurses, matrons, HR business partners and staff engagement lead on their specific recruitment and retention action plans.

Job Title	Band	FTE	Area of Work	Department	Current vacancy status
Staff Nurse - Frailty Assessment Unit	5	1	Elderly Care Medicine	Elderly Care	Advert Closed
Diabetes Specialist Nurse	6	0.4	Diabetes	Diabetes & Endocrinology	Advert Closed
Staff Nurse - Ward C8 Stroke	5	1	Stroke	Stroke	Advert Closed
Staff Nurse Rotation	5	9	Acute Internal Medicine	Acute medicine	Advert Closed
Staff Nurse - Ward C3 Elderly Care	5	1	Elderly Care Medicine	Elderly Care	Advert Closed
Staff Nurse	5	13	Gastroenterology	Gastroenterology	Advert Closed
Community Staff Nurse	5	1.6	Community Health Services	Community Nursing	Advert Open
Staff Nurse Rotation	5	9	Acute Internal Medicine	Acute medicine	Advert Open
Staff Nurse	5	4	Surgery	Surgery	Advert Open
Community Staff Nurse	5	13	Community Health Services	Community Nursing	Advert Open
Clinical Skills Educator	6	0.8	Education	Undergraduate	Advert Open
Shift Lead	6	0.96	Vascular Medicine	Vascular	Advert Open
Community Staff Nurse	5	1	Community Health Services	Community Nursing	Advert Open
Sister/Charge Nurse	6	1.76	Paediatric Surgery	Paediatric - Surgery	Advert Open
Learning Disabilities Liaison Nurse	5	1	Administration	Learning Disabilities	Advert Open
Staff Nurse	5	1	Trauma and Orthopaedic Surgery	Trauma and Orthopaedics	Advert Open
Staff Nurse	5	0.96	Medicine	C4 Ward	Advert Open
Bank Theatre Practitioner – Anaesthetics & Recovery	7	10	Anaesthetics	Anaesthetics & Recovery	Advert Open
Pulmonary Rehabilitation Practitioner	6	1	Rehabilitation	Acute Specialist Medicine	Advert Open
Staff Nurse	5	2	Critical Care	Medical High Dependency Unit	Advert Open
Staff Nurse	5	7	Trauma and Orthopaedic Surgery	Trauma and Orthopaedics	Advert Open
Theatre Practitioner	5	1.72	Trauma and Orthopaedic Surgery	Trauma & Orthopaedic	Advert Open
Bank Theatre Scrub Practitioner	7	5	Operating Department	Operating Theatres	Advert Open
Senior Sister Paediatric ED	7	1	Administration	Paediatric and Emergency	Draft
Staff Nurse	5	2.5	Outpatients	Discharge Lounge	Recruitment Closed
Staff Nurse	5	10	Critical Care	Critical Care	Recruitment Closed
Theatre Practitioner	5	2	Surgery	Day Surgery	Recruitment

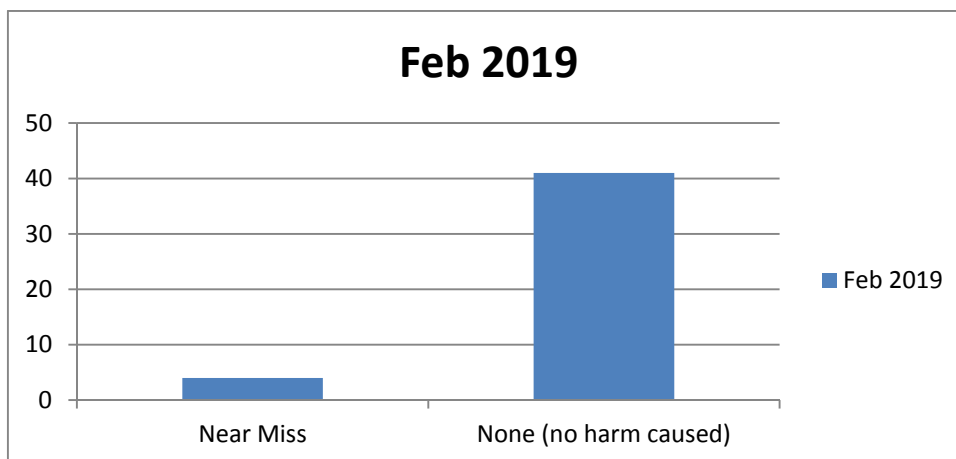
				Theatre	Closed
Staff Nurse	5	10	Paediatrics	Paediatric	Recruitment Closed
TB Nurse Specialist	6	0.4	Respiratory Medicine	Respiratory	Recruitment Closed
Staff Nurse	5	4.8	Vascular Surgery	Vascular Surgery	Recruitment Closed
Theatre Practitioner	5	1	Surgery	Day Surgery	Recruitment Closed

Clinical Incident staffing analysis

Tables 5 and 6 below detail the number of clinical incidents during February 2019 that related to staffing. In total there were 45 incidents reported during the month of February 2019. Forty one of these were recorded as no harm and four incidents were reported as near misses. Sixteen out of 45 incidents were reported from Maternity services. Mitigations include Midwifery daily response meeting and staff redeployment.

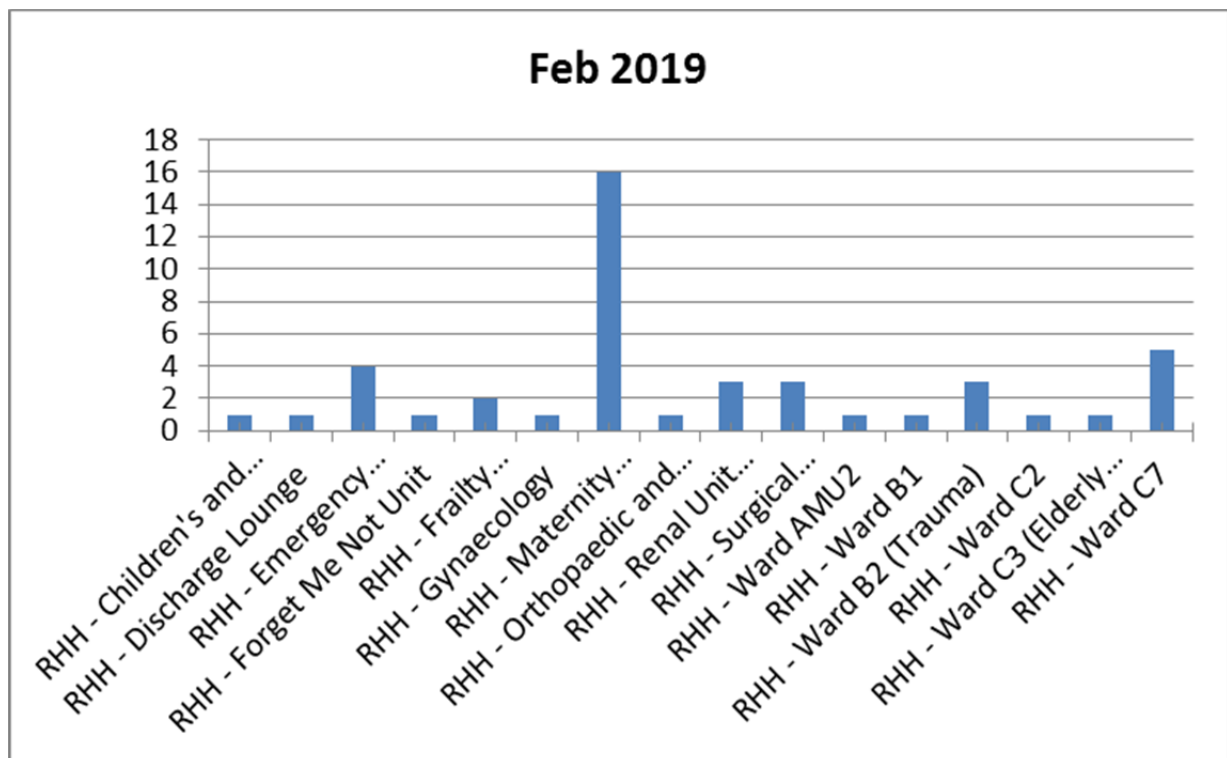
There were no staffing incidents reported during February 2019 that was stated as causing harm.

Table 5



	Feb 2019	Total
Near Miss	4	4
None (no harm caused)	41	41
Total	45	45

Table 6



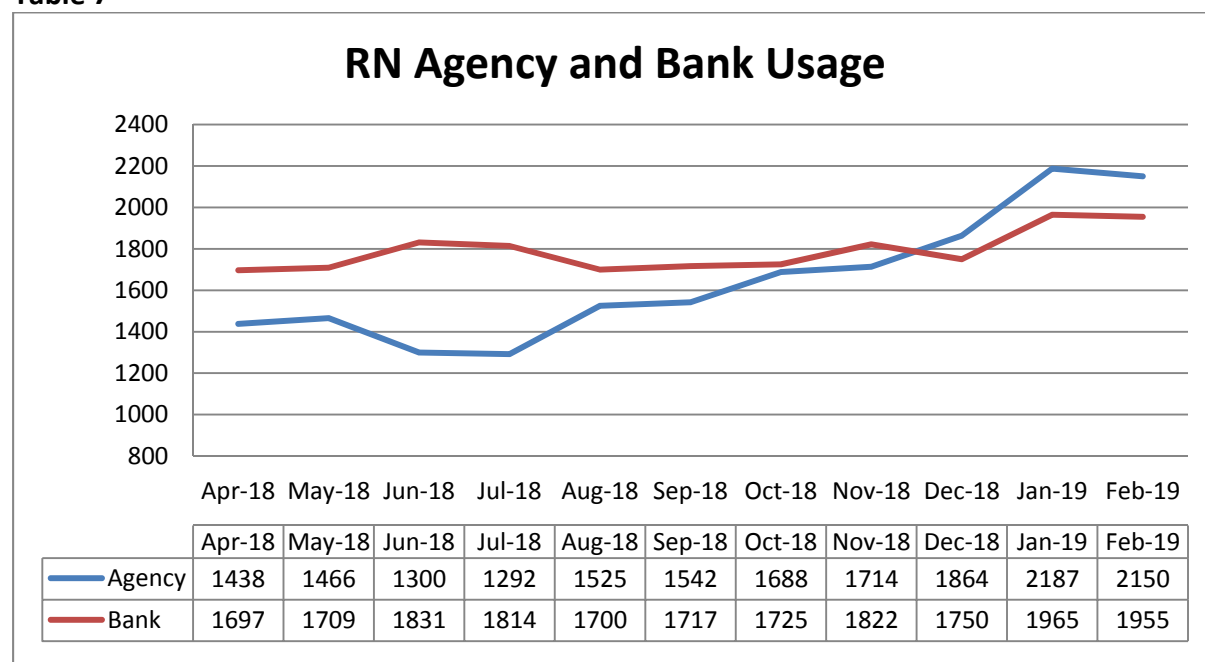
Agency Controls

All bank and agency requests continue to be risk assessed by the Associate Chief Nurses to ensure continued patient safety and financial balance supporting the overall reduction in agency use. Requests for non-framework agency can only be made in exceptional circumstances and authorised by an Executive Director.

Table 7 shows the comparison usage of bank and agency. During February 2019 Bank and agency usage for qualified and unqualified has seen a slight decrease in comparison to previous month. A contributing factor relates to winter pressures, unfunded capacity and high numbers of 1-1 care. The controls against agency usage for CSW staff have been maintained with zero shifts during this period (table 8).

Agency and Bank RN monthly usage

Table 7



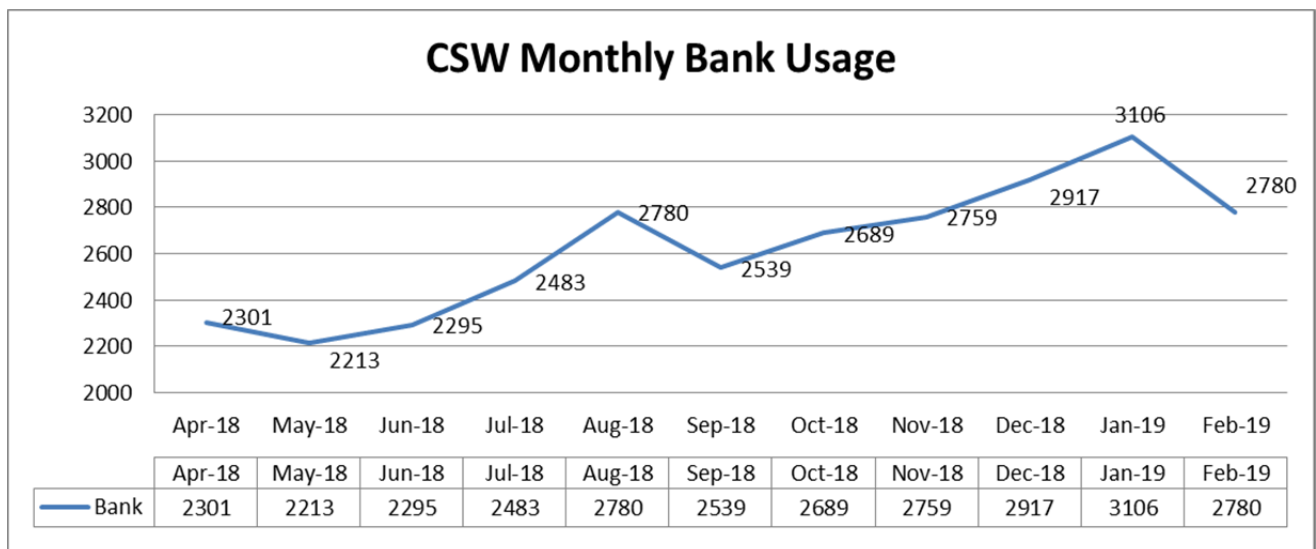
Top 5 areas for Agency use in the last three months

Ward	Dec-18
Emergency Dept Nursing Dept	439
B3 Emergency Surgery	167
C8 Stroke Rehab Dept	147
AMU 1	108
AMU 2	108

Ward	Jan-19
Emergency Dept Nursing Dept	485
Critical Care (ITU)	222
C8 Stroke Rehab Dept	163
B3 Emergency Surgery	159
AMU 2	140

Ward	Feb-19
Emergency Dept Nursing Dept	392
Critical Care (ITU)	187
C8 Stroke Rehab Dept	164
B3 Emergency Surgery	163
AMU 2	102

CSW monthly bank usage
Table 8



RN Predictor Tool Current and New Establishments

The summarised version of the RN predictor tool (Appendix 2) reflects all nursing vacancies across the Trust within clinical and non-clinical roles. It enables a clearer picture of the staffing situation across each group and the whole organisation. Currently there are 290 WTE vacancies against the new establishment following the staffing review.

The Clinical Support Worker Predictor Tool

The Clinical Support Worker Predictor Tool data (Appendix 4) is attached as requested.

Appendix 1 – Percentage Fill rates by ward and CHPPD

Safer Staffing Summary	Feb Days in Month 28																
	Day RN	Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW					Actual CHPPD				
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	UnQual		UnQual		Sum	Average			
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	Day	Qual N	N	24:00 Occ	Occupancy	Registered	Care staff	Total
A2 AMU 2	251	193	211	152	197	171	178	163	77%	72%	87%	92%	1,113	95%	3.93	3.39	7.32
B1	109	86	59	49	77	62	56	50	79%	83%	80%	90%	458	63%	3.78	2.55	6.32
B2(H)	142	120	241	173	112	94	197	185	84%	72%	84%	94%	798	95%	3.14	5.16	8.31
B2(T)	113	89	161	129	84	54	137	126	79%	80%	64%	92%	618	92%	2.71	4.95	7.66
B3	227	168	195	166	196	163	144	138	74%	85%	83%	96%	984	84%	4.03	3.62	7.65
B4	225	185	229	202	168	146	184	170	82%	88%	87%	92%	1,295	96%	2.99	3.45	6.44
B5	216	188	149	130	169	166	96	92	87%	87%	98%	96%	610	91%	6.80	4.36	11.17
B6																	
C1	224	166	262	234	168	151	200	193	74%	90%	90%	96%	1,323	98%	2.85	3.88	6.72
C2	239	212	66	62	168	165	29	29	88%	93%	98%	100%	586	70%	7.53	1.70	9.23
C3	196	168	330	298	167	161	420	375	86%	90%	96%	89%	1,443	99%	2.73	5.60	8.33
C4	148	140	57	55	112	90	58	71	94%	96%	81%	122%	603	98%	4.46	2.50	6.97
C5	221	153	244	255	168	149	181	171	69%	104%	89%	95%	1,315	98%	2.70	3.84	6.54
C6	109	98	64	56	56	56	65	59	90%	87%	100%	91%	496	89%	3.63	2.77	6.40
C7	216	168	176	151	139	113	136	125	78%	86%	81%	92%	977	97%	3.28	3.32	6.59
C8	318	209	237	204	261	193	218	206	66%	86%	74%	94%	1,181	96%	4.00	4.16	8.16
CCU_PCCU	223	173	55	48	196	136	29	26	77%	87%	69%	90%	585	80%	6.33	1.52	7.86
Critical Care	369	371	75	70	342	341			100%	94%	100%		325	73%	25.72	1.97	27.69
EAU AMU 1	260	186	307	213	248	210	302	253	72%	70%	85%	84%	1,254	93%	3.71	4.47	8.18
Maternity	575	512	219	190	476	449	140	133	89%	87%	94%	95%	721	59%	15.28	5.11	20.39
MH DU	162	135	49	38	158	121	9	6	84%	77%	76%	67%	188	67%	15.99	2.08	18.07
NNU	173	135			140	133			78%		95%		315	63%	9.81	0.00	9.81
TOTAL	4,714	3,852	3,387	2,875	3,802	3,324	2,779	2,571	82%	85%	87%	93%	17,188		4.90	3.74	8.64

Appendix 2 - Registered Nurse Predictor Tool- Detail New Establishments

Qual Nurses Band 5 and Above				February 2019		To end of February 2019		March 2019				April 2019				May 2019				June 2019				July 2019				
Div	Team	Contracted Vacancy Vs OLD ESTABLISHMENT	Contracted Vacancy Vs NEW ESTABLISHMENT	Adjustments to end of month	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	All Recruit	Net Leave (8%)	Agency RAG	Vacs	Targeted Recruit	General Recruit (4.3%)	Net Leave (8%)	Agency RAG	Vacs		
Medicine & Integrated Care	Ward A2 AMU 2 Incl EAU	0.00	0.00	0.00	0.00	0.00	0.00	●	0.00	0.00	0.00	●	0.00	0.00	0.00	●	0.00	0.00	0.00	●	0.00	0.00	0.00	●	0.00			
	Ward C1	4.33	12.00	0.09	11.91	0.00	0.18	●	12.09	1.70	0.18	●	10.57	0.00	0.19	●	10.76	0.00	0.19	●	10.95	0.00	0.10	0.19	●	11.03		
	Ward C3	8.67	10.38	0.00	10.38	0.00	0.17	●	10.55	0.00	0.17	●	10.73	0.00	0.17	●	10.90	0.00	0.17	●	11.07	0.00	0.09	0.17	●	11.15		
	Ward C4	0.17	1.71	0.00	1.71	0.00	0.17	●	1.88	0.00	0.17	●	2.05	0.00	0.17	●	2.22	0.00	0.17	●	2.38	0.00	0.09	0.17	●	2.46		
	Ward C4 Onc Day OP	3.56	3.60	0.00	3.60	0.00	0.08	●	3.68	0.00	0.07	●	3.75	0.00	0.07	●	3.82	0.00	0.07	●	3.90	0.00	0.04	0.07	●	3.93		
	Ward C5 Area A	1.57	5.76	1.11	4.65	0.00	0.09	●	4.74	0.00	0.09	●	4.83	0.00	0.09	●	4.92	0.00	0.09	●	5.01	0.00	0.05	0.09	●	5.05		
	Ward C5 Area B	3.18	7.37	(0.80)	8.17	0.00	0.08	●	8.25	0.00	0.08	●	8.33	0.00	0.08	●	8.41	0.00	0.08	●	8.49	0.00	0.04	0.08	●	8.53		
	Ward C7	8.73	13.39	1.00	12.39	0.00	0.14	●	12.53	0.54	0.14	●	12.12	0.00	0.14	●	12.26	0.00	0.14	●	12.40	0.00	0.07	0.14	●	12.47		
	Ward C8	13.03	29.39	1.00	28.39	0.00	0.17	●	28.56	0.00	0.16	●	28.72	2.55	0.16	●	26.33	0.00	0.18	●	26.51	0.00	0.10	0.18	●	26.59		
	Ward CCU	8.12	15.31	0.00	15.31	0.00	0.19	●	15.50	0.85	0.19	●	14.85	0.54	0.20	●	14.50	0.00	0.20	●	14.70	0.00	0.11	0.20	●	14.79		
	Acute Med Unit (EAU)	15.53	19.96	0.00	19.96	0.85	0.39	●	19.50	2.55	0.40	●	17.35	0.00	0.41	●	17.76	0.00	0.41	●	18.17	0.00	0.22	0.41	●	18.36		
	Ward MHDU	(8.84)	1.48	0.00	1.48	0.00	0.18	●	1.66	0.00	0.17	●	1.83	0.00	0.17	●	2.00	0.00	0.17	●	2.18	0.00	0.09	0.17	●	2.26		
	Ward Ambulatory Emergency Care	1.79	0.35	0.00	0.35	0.00	0.08	●	0.43	0.00	0.08	●	0.50	0.00	0.08	●	0.58	0.00	0.08	●	0.66	0.00	0.04	0.08	●	0.69		
	Emergency Department Nursing	(8.26)	12.79	1.21	11.58	1.70	0.49	●	10.37	5.95	0.50	●	4.92	0.85	0.53	●	4.60	0.85	0.54	●	4.29	0.00	0.29	0.54	●	4.54		
	Community Nursing	22.41	11.71	0.89	10.82	0.85	0.87	●	10.84	3.23	0.87	●	8.47	0.68	0.88	●	8.68	0.00	0.88	●	9.56	0.00	0.47	0.88	●	9.96		
	All Other Med & Int Care Teams	4.84	24.71	0.16	24.55	1.70	1.60	●	24.45	0.77	1.61	●	25.29	2.13	1.60	●	24.77	0.43	1.60	●	25.95	0.00	0.86	1.60	●	26.69		
Surgery	Ward B1	4.47	5.62	0.00	5.62	0.00	0.09	●	5.71	0.00	0.09	●	5.80	0.00	0.09	●	5.90	0.00	0.09	●	5.99	0.00	0.05	0.09	●	6.03		
	Ward B2 (T)	2.88	7.58	0.00	7.58	0.00	0.08	●	7.66	1.70	0.08	●	6.04	0.00	0.09	●	6.13	0.00	0.09	●	6.22	0.00	0.05	0.09	●	6.26		
	Ward B2 (H)	2.60	7.07	0.00	7.07	0.00	0.14	●	7.21	0.85	0.14	●	6.49	0.00	0.14	●	6.63	0.00	0.14	●	6.77	0.00	0.07	0.14	●	6.84		
	Ward B3	14.28	24.91	0.96	23.95	0.00	0.11	●	24.06	1.63	0.11	●	22.54	0.00	0.12	●	22.67	0.00	0.12	●	22.79	0.00	0.07	0.12	●	22.85		
	Ward B4	1.68	5.49	1.00	4.49	0.00	0.09	●	4.58	0.00	0.09	●	4.68	0.85	0.09	●	3.92	0.00	0.10	●	4.02	0.00	0.05	0.10	●	4.06		
	Ward B4B	0.96	4.77	0.00	4.77	0.00	0.10	●	4.87	1.67	0.10	●	3.30	0.00	0.11	●	3.41	0.00	0.11	●	3.51	0.00	0.06	0.11	●	3.56		
	Ward B5	(1.94)	2.16	2.00	0.16	0.00	0.25	●	0.41	0.54	0.24	●	0.11	0.00	0.25	●	0.35	0.00	0.24	●	0.60	0.00	0.13	0.24	●	0.71		
	Ward C6	2.91	2.18	(0.57)	2.75	0.00	0.09	●	2.84	0.00	0.09	●	2.94	0.00	0.09	●	3.03	0.00	0.09	●	3.12	0.00	0.05	0.09	●	3.16		
	Ward C2	3.24	3.74	0.00	3.74	0.00	0.23	●	3.97	0.82	0.23	●	3.39	0.85	0.24	●	2.77	0.00	0.24	●	3.01	0.00	0.13	0.24	●	3.12		
	Neonatal Unit	2.52	2.22	0.96	1.26	0.00	0.25	●	1.51	0.82	0.25	●	0.94	0.85	0.25	●	0.34	0.00	0.25	●	0.59	0.00	0.14	0.25	●	0.71		
	I.T.U.	10.74	14.87	1.00	13.87	0.00	0.40	●	14.27	0.85	0.40	●	13.81	0.00	0.40	●	14.21	0.00	0.40	●	14.61	0.00	0.21	0.39	●	14.79		
	Theatres (Excl ODP's)	16.76	19.89	0.00	19.89	0.00	0.33	●	20.22	0.85	0.33	●	19.71	0.85	0.34	●	19.19	0.00	0.34	●	19.53	0.00	0.18	0.34	●	19.69		
	Day Case Theatres (Excl ODP's)	6.27	11.03	0.00	11.03	0.00	0.27	●	11.30	0.85	0.27	●	10.72	0.85	0.27	●	10.14	0.00	0.28	●	10.41	0.00	0.15	0.27	●	10.54		
	Maternity unit	3.76	4.28	0.00	4.28	0.00	0.67	●	4.95	0.00	0.67	●	5.62	0.00	0.66	●	6.28	0.00	0.66	●	6.94	0.00	0.35	0.65	●	7.25		
	All other Surgery Teams	(6.28)	(1.07)	(0.60)	(0.47)	1.70	1.07	●	(1.10)	0.77	1.07	●	(0.79)	2.13	1.07	●	(1.84)	0.43	1.08	●	(1.19)	0.00	0.58	1.07	●	(0.69)		
	Corp	All Corp Teams	(12.00)	6.17	(0.07)	6.24	0.00	0.27	●	6.51	0.00	0.27	●	6.78	0.00	0.27	●	7.05	0.00	0.27	●	7.32	0.00	0.31	0.58	●	7.58	
Total Qualified Nurses		131.67	290.82	9.34	281.48	6.80	9.33	●	284.01	26.93	9.31	●	266.39	13.12	9.43	●	262.70	1.70	9.45	●	270.45	0.00	5.22	9.71	●	274.94		

Notes:

- The above figures report on Trust start date rather than end of supernumerary period so new staff in a particular month are unlikely to work independently until the following month.

- Adjustments are required to bring current period up to date to the end of the month due to staff starting / leaving / transferring department mid way through the month
- Attrition rate of 15% applied to known future recruitment based on historic average
- Agency RAG Rating is used to guide approval of Agency requests:
Green = Under old budgeted establishment and high level of vacancies. **Amber** = 5-10% Vacancy rate, **Red** = Over old budgeted establishment or less than 5% vacancy rate
- New Establishment uses M12 2018/19 budgeted establishment which represents best fit to future planned level of staffing. This does not reconcile to in month WTE budget as reported in finance F&P report.

App 3	KPI																															
	Environmental Cleaning																															
	Hand hygiene																															
MRSA Screening - elective																																
MRSA Screening - emergency																																
HCAI CDIFF - due to lapses in care																																
Saving Lives - 02b peripheral lines																																
Saving Lives - 06b urinary catheter																																
Datax incidents reported																																
Falls, injuries or Accidents																																
Pressure Ulcers - Grade 3/4																																
Serious Incidents																																
Never Events																																
Nutrition Audit																																
Pain Score																																
Medicines Management Audit																																
% of Deaths with Priorities of Care																																
Deteriorating Patient Trolley Check (L)																																
Fluid Balance Management Audit																																
VTE Assessment Indicator (CON01)																																
NOA - Skin Bundle																																
FFT - Response Rate																																
FFT - Recommended %																																
Complaints																																
Compliments																																
Appraisals																																
Mandatory Training																																
RN Average Fill Rate (day shifts)																																
RN Average Fill Rate (night shifts)																																
Sickness Rate																																
Ward	Patient Safety & Quality															Clinical Indicators			Patient Experience			Workforce & Safer Staffing					Ward RAG Trend					
AMU2 (A2)			NA	90.0%				42	6		1				No Data					No Data	No Data	3	0						↓-1	↓-1	↑7	
B1			100%	Audit Not Done				7	2						No Data							0	0							↑2	↑3	↓-4
B2 Hip			100%	100%				20	1		1					NA						0	10							↓-1	↑2	↓-1
B2 Trauma			67%	100%				13	2													1	8							↑2	↑2	↓-3
B3			100%	94.5%				30	2							Audit Not Done						2	1							⇒0	↑1	⇒0
B4			100%	100%				17	5													1	0							↑1	↑4	↓-5
B5			100%	100%				12	1													2	2							↓-3	↑4	↓-1
C1		Audit Not Done	NA	80%				21	7													3	37							↓-2	↓-1	↑4
C2			NA	NA			NA	26	0										NA			0	2							↑2	↑2	⇒0
C3			NA	50.0%				42	5													2	58							↑2	⇒0	↓-2
C4			100%	82.6%				25	3													1	104							⇒0	⇒0	↑1
C5			100%	78.9%				30	6													2	0							↑1	⇒0	↑1
C6			85.7%	67%				10	0							No Data						3	0							↑2	↑3	↓-4
C7			NA	55.6%				19	5													0	1							⇒0	⇒0	↑2
C8			NA	88.1%				28	11													1	9							↑1	↑2	↑3
CCU & PCCU			NA	88.2%				15	4							Audit Not Done						0	3							↓-1	↑1	↑2
Critical Care			100%	Audit Not Done				22	2													0	10							↑2	⇒0	⇒0
Maternity			NA	NA				109	0		2					NA				NA		0	39							↓-2	↓-1	↑6
MH DU			NA	95.2%				22	0													0	4							↑2	↓-3	↑2
Neonatal			NA	Audit Not Done			NA	10	0							NA			NA	NA		0	0							↑2	↑1	↓-3
Trust Total		99.8%			1	95%	99%	1375	85	1	4	0				29.2%			95.0%	95.0%	36.2%	94.8%	48	522	95.6%	88.7%	83.1%	88.1%	5.5%			
RAG Rating	R: <85% A: 85%-95% G: ≥95%	R: <100% A: 100% G: 100%	No RAG rating for this indicator	No RAG rating for this indicator	R: <0 A: 0 G: 0	R: <75% A: 75%-95% G: ≥95%	R: <75% A: 75%-95% G: ≥95%	No RAG rating for this indicator	No RAG rating for this indicator	R: <0 A: 0 G: 0	R: <0 A: 0 G: 0	R: <0 A: 0 G: 0	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <30% A: 30%-60% G: ≥60%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <95% A: 95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <26% A: 26%-35.1% G: ≥35.1%	R: <96.3% A: 96.3%-97.4% G: ≥97.4%	No RAG rating for this indicator	No RAG rating for this indicator	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <4% A: 3.5%-4% G: ≤3.5%			

Appendix 4 - CSW Predictor tool.

CSW PREDICTOR TOOL (Band 2/3)	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Predicted
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Minimum Establishment	480.23	480.23	480.23	480.23	480.23	480.23	480.23	480.23	480.23	480.23	480.23	480.23
Maximum Establishment	557.99	557.99	557.99	557.99	557.99	557.99	557.99	557.99	557.99	557.99	557.99	557.99

Staff in Post at Start of Month	487.61	495.71	525.66	527.26	519.12	520.88	529.20	555.35	550.01	538.01	544.10	542.54
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Starters (predicted from active recruitment)	10.40	33.60	0.00	0.53	1.92	6.72	1.00	2.00	3.00	7.09	2.00	10.40
Leavers	-1.92	-4.16	-1.60	-3.84	-1.75	-2.40	-2.85	-7.34	-2.00	1.00	-3.56	-6.29
Other**	-0.38	0.51	3.20	-4.83	1.59	4.00	26.00		-13.00	-2.00		

Staff in Post at End of Month	495.71	525.66	527.26	519.12	520.88	529.20	553.35	550.01	538.01	544.10	542.54	546.65
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Predicted Vacancies Minimum Establishment	-15.48	-45.43	-47.03	-38.89	-40.65	-48.97	-73.12	-69.78	-57.78	-63.87	-62.31	-66.42
Predicted Vacancy % Rate (Minimum Estab.)	-3.2%	-9.5%	-9.8%	-8.1%	-8.5%	-10.2%	-15.2%	-14.5%	-12.0%	-13.3%	-13.0%	-13.8%

Predicted Vacancies Maximum Establishment	62.28	32.33	30.73	38.87	37.11	28.79	4.64	7.98	19.98	13.89	15.45	11.34
Predicted Vacancy % Rate (Maximum Estab.)	11.2%	5.8%	5.5%	7.0%	6.7%	5.2%	0.8%	1.4%	3.6%	2.5%	2.8%	2.0%

** Other includes graduates coded as band 2 initially who now have pin and transferred to RN posts, secondments, re-bands and internal transfers

Note: New starters via the novice programme are effectively supernumerary for 6 weeks whilst undergoing training

Paper for submission to the Board of Directors on 4 April 2019

TITLE:	Integrated Performance Report for Month (February) 2019		
AUTHOR:	Andy Troth Head of Informatics	PRESENTER	Karen Kelly Chief Operating Officer
CLINICAL STRATEGIC AIMS (delete the aim(s) not relevant to the paper)			
	<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>		
ACTION REQUIRED OF BOARD:			
Decision	Approval	Discussion	Other
		Y	
OVERALL ASSURANCE LEVEL (Please insert x in one of the boxes)			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery
RECOMMENDATIONS FOR THE BOARD			
To note the performance against the national mandated performance targets and were there has been non achievement to seek assurance on the plans to recover the expected position.			
CORPORATE OBJECTIVE:			
SO1: Deliver a great patient experience SO2: Safe and Caring Services SO4: Be the place people choose to work SO5: Make the best use of what we have SO6: Deliver a viable future			
SUMMARY OF KEY ISSUES:			
IMPLICATIONS OF PAPER:			
RISK	Y	Risk Description: High levels of activity could impact on the delivery of KPIs – particularly the emergency access target and RTT. The latter would be impacted by increased levels of outliers resulting in cancelled operations.	

	Risk Register: Y		Risk Score: 20 (CORO79)
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	N	Details:
	NHSI	Y	Details: A sustained reduction in performance could result in the Trust being found in breach of licence
	Other	N	Details:



Integrated Performance Report - Board



February 2019

Created by: Informatics.

Title of report: Integrated Performance Report

Executive Lead:	Performance	Chief Operating Officer, Karen Kelly
	Finance	Director of Finance, Tom Jackson
	Workforce	Director of HR, Andrew McMenemy



Executive Summary

Key Messages

CQSPE

FFT Response Rate / Recommend

For the nine months where national figures are available (45 areas were published for months of April to November 2018) the Trust is achieving the target on 32 occasions where the percentage response rate score is equal to or better than the national average percentage response rate. The areas missing the target are maternity birth for August 2018, community for April, May and August 2018 and outpatients for May, June, July, August, September, October, November, December 2018 and January 2019.

For the nine month period where national figures are available (71 areas were published for months of April to January 2019) the Trust is achieving the target on 30 occasions where the score is equal to or better than the national average percentage recommended. The areas missing the target are inpatients, A&E and outpatients for April to January, maternity antenatal for September, maternity birth for June, November and January 2019, and maternity postnatal ward for November, December and January, maternity post-natal community for September and December 2018 and community for September, October, November, December and January.

Complaints

During February 2019, the Trust received 48 new complaints, in comparison to 46 opened for January 2019 and 47 opened for December 2018. This is a 4.34% increase from January 2019 for open complaints. All 48 complaints were acknowledged within 3 working days. The Trust currently works to a 40 working day timeframe to respond to complaints. As at the end of February there were 216 complaints outstanding awaiting response.

The Surgical Division received 21 new open complaints for February 2019 compared to 18 for January 2019 and Medicine & Integrated Care Division received 26 new open complaints for February 2019 (no change from January 2019 (26)). Clinical Support division received one new open complaint compared to two for January 2019.

In terms of complaints by service, Medicine & Integrated Care Division received the most complaints for the Emergency Department (ED) (9) followed by AMU 2 and ward C6 (3). Surgery Division received one or two complaints across several areas with no area particularly standing out. The largest number of concerns raised across divisions related to the following:

- Patient Care including Nutrition and Hydration
- Clinical Treatment - Surgical Group
- Values and Behaviours (Staff)

Dementia

The Trust remains above the target of 90 % for find/assess, investigate and refer.

Falls

Falls (without harm) demonstrate a consistent trajectory of remaining below the national average of falls per 1,000 occupied bed days (as given by the RCP National Falls audit 2015). Falls with harm also remain consistently below the national average with February being completely free of any patient falls resulting in fracture. Falls prevention remains focussed on high risk areas (such as Acute Admissions) by the staff in these areas supported by the Falls lead.

Pressure Ulcers

There was 1 avoidable grade 3 pressure ulcer reported from B2 (acute) in February 2019.

MSA

During February there were 7 MSAs reported all within our level 2 level 3 clinical areas. Total YTD position 68 MSAs. Main contributing factor is the inability to step patients down after a 4 hr period (local target)

Infection Control

Interventions February 2019:

- HII 1: Ventilator Associated Pneumonia 100%
- HII 2a: Peripheral Vascular Access Devices - Insertion 100%
- HII 2b: Peripheral Vascular Access Devices - Ongoing care 95.7%
- HII 3a: Central Venous Access Devices - Insertion 100%
- HII 3b: Central Venous Access Devices - Ongoing Care 98%
- HII 4a: Surgical Site Infection Prevention - Preoperative 100%
- HII 4b: Surgical Site Infection Prevention - Intraoperative Actions 100%
- HII 5: Infection Prevention in Chronic Wounds 100%
- HII 6a: Urinary Catheter - Insertion 99%
- HII 6b: Urinary Catheter - Maintenance & Assessment 99%
- Hand Hygiene 100%
- Commode Audits 94%

There were zero C diff cases reported during February 2019.

Stroke

All targets for stroke achieved during February 2019.

- o Swallow screening
- o Stay compliance
- o TIA treated within 24 hours

Executive Summary

Key Messages

CQSPE

VTE

VTE compliance achieved against a Trust target of 95%. This remains a manual process until it is resolved as part of EPR as this will be a mandatory field as part of the patient assessment.

Incidents

During February 2019 a total of 1491 incidents have been reported. There were 4 reported serious incidents in month.

1. Pressure Ulcer grade 3 (B2)- Hospital Acquired category 3 Pressure Sore t
2. Air Embolism (Maternity)
3. Cooling of baby – Maternity /NNU
4. Delayed diagnosis – AMU2

Details of incidents below:

32 year old women attended the maternity unit for an elective caesarean section. The baby was delivered in a good condition. There was difficulty in delivering placenta which extended down into vaginal canal. The woman initially had a spinal anaesthetic which was converted to general anaesthetics following the delivery as the woman had a post-partum haemorrhage of 2000mls and bakri balloon was inserted. The woman had 4 units of blood transfused intra-operatively and was transferred to maternity HDU for observations postnatally.

The woman remained clinically stable, she was uncomfortable from the bakri balloon and she was commenced on PCA morphine which improved her discomfort. The woman remained on the PCA morphine which improved her discomfort. The woman was reviewed by the CT2 Anaesthetist and made a plan to continue with PCA and regular paracetamol, regular antiemetic’s, nil by mouth as per Consultant obstetrician advice, hourly observations fluid balance and bakri balloon, if increase loss from bakri balloon for obstetric review and repeat. The CT2 anaesthetist discussed the plan with the consultant anaesthetist who advised to insert A-Line as the woman needs regular continuous monitoring and bloods. 2 attempts were made to site the A-line which failed. The plan then was to return in 30 minutes with an U.S.S to re-insert the A-line.

1.30 hours later the Anaesthetist returned with a consultant anaesthetist and a line was inserted in left radial. Line attached but blood appeared to enter line therefore line flushed but line appeared unprimed. Line taken off and confirmed to be unprimed. The patient felt unwell, short of breath and visual disturbances were also reported.

Woman presented at 39+6 previous caesarean section for vaginal birth. Whilst still on ward, spontaneous rupture of membranes occurred - clear liquor. Transferred to delivery suite and handed over to delivery suite midwife. The labour proceeded to a precipitate delivery of a live male who was born in poor condition with cord gases <pH 7.0, required resuscitation, admission to neonatal unit and transfer to tertiary unit for therapeutic cooling therapy.

A 78 year old patient was admitted to ED with worsening back pain over the past 2 months with associated weakness in the legs and fatigue. The patient was reviewed by the medical team with a possible diagnosis of discitis and acute tenderness in the L1/L2 region. Following an abnormal lumbar X-ray a MRI of the lumbosacral spine was requested for possible discitis. The MRI did not happen until 7 days after the request, with significant findings having to be phoned through: 1) Acute discitis at L1/L2 with complex paravertebral and posterior epidural collection resulting in focal cord impingement 2) Bilateral psoas abscesses with the collection tracking into the abscesses. This has resulted in delayed diagnosis and further management in this patient’s care and the involvement of the neurosurgical team.

Safety Thermometer

Safety Thermometer for February 2019 – 97.98%
Contributing factors new VTE and pressure ulcer.

Executive Summary by Exception

Key Messages

1 Performance Matters

Committee: F&P

A&E 4 hour wait

The combined Trust and UCC performance was below target in month at 80.1%, whilst the Trust only (Type 1) performance was 67.6%.

The split between the type 1 and 3 activity for the month was:

	Attendances	Breaches	Performance
ED Dept Type 1	8277	2680	67.62%
UCC Type 3	5255	14	99.73%

Cancer Waits

The Committee is reminded that due to the time required to validate individual pathways, the cancer waiting times in this report are provisional only. In addition, the reporting of patients breaching 104 days is provided 1 month retrospectively.

Cancer – 62 Day from Urgent GP Referral to Treatment performed above target for the month at 89.3% (Provisional as at 21st March). Previous month confirmed performance was 78.2%

Cancer - 104 days - Number of people who have breached beyond 104 days (February)

No. of Patients treated on or over 104 days (DGFT)	4
No. of Patients treated on or over 104 days (Tertiary Centre)	4
No. of Patients treated on or over 104 days (Combined)	8

2WW

The target was achieved once again in month. During this period a total of 1191 patients attended a 2ww appointment with 17 patients attending their appointments outside of the 2 week standard, achieving a performance 98.5% against the 93% target.

Referral to Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained above target, with performance of 93.7% in month against a target of 92%, up from previous month. Ophthalmology is at 84.4% down from 84.8% in the previous month. General Surgery is 88.5% down from 90.5%. Also Plastic Surgery (87.7%) did not achieve the target. There were no 52-week Non-admitted Waiting Time breaches in month.

Diagnostic waits

The diagnostic wait was above target in month with a performance of 99.2%. The number of patients waiting over 6 weeks was 56

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters

Committee: F&P

Deficit of £6.760m for April-February (pre PSF), representing a £5.190m adverse variance in comparison to the control total following the consolidation of the pharmacy company and other technical changes. This position includes a pro rata benefit related to a new optimised alternative site evaluation. However, this remains at risk as the revised valuation has yet to be agreed by external auditors, particularly the extended lives element. The Trust has maintained the forecast at an £8.8m deficit as agreed at the Board. The other main financial risk to the delivery of this position relates to the CCG affordability/ability to pay for extra contract income. This results in additional challenge which has identified a problem with the recording and charging of rehab. The Trust continues to work on negotiating an amicable year end settlement with the CCG.

Executive Summary by Exception cont.

Key Messages

4 Workforce

Committee: F&P

Staff Appraisals

This includes all non-medical appraisals in the Trust. The window has now closed and we are pleased to announce a compliance rate of over 96%. This is the highest performance in this area for the Trust and puts Dudley as one of the leading Trusts in the country for staff engagement by way of the appraisal process.

The process to support the re-opening of the appraisal window has commenced in preparation for 1st April 2019. At this time, over 90% of appraisals have been booked to take place within the window. We are expecting at least the same level of engagement in 2019/20 as the Trust achieved in 2018/19.

Mandatory Training

The compliance rates continue at the stable level of 88.69%. This represents good performance without being excellent. The areas where more concentrated efforts are required are associated with Resus and manual handling training. In terms of staff groups the area of highest non-compliance continues to be medical staff, however their compliance rate has stabilised at 81.11%. The Clinical Support Division continues to be the team with the lowest compliance rates, however they are demonstrating improvements to 86.43%.

The Trust Lead for Mandatory Training has been asked to develop actions associated with particular areas of risk regarding training and staff groups. There continue to be trajectories in place for each Division with performance reviews focusing on compliance for every member of staff.

Sickness Rate

The absence rate increased in January to 5.7% and then has decreased in February 2019 to 5.48%. This is inconsistent with this time last year where the Trust experienced the rate of 4.51%. The main areas of concern associated to staff group are Care Support staff at 8.79% and nursing & midwifery staff at 5.81%. In terms of Divisional trends, medicine & Integrated Care continue to demonstrate the highest levels of absence at 6.15%. Therefore, focus is being provided on particular areas of high absence to ensure efficient turnaround of absence management and therefore staff returning to work.

Turnover Rate

The turnover rate continues to represent a positive retention of our staff and currently sits at 8.78% from 9.38% in the previous month. This demonstrates the largest single reduction in turnover in the last 12 months. This is still above our target of 8.5% but continues to be below the average turnover rate for acute NHS Trusts in England. The appointment of the Staff Engagement lead has demonstrated a particular focus on understanding the feedback from exit interviews, listening to staff and developing strategies to support improved retention at the Trust. The initial feedback is very positive and this will be developed further as we move into the feedback for the national staff survey.



Patients will experience safe care - "At a glance"

Executive Lead: Mary Sexton

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Jan-19	Feb-19	Actual YTD	Trend	Month Status
Friends & Family Test - Response Rate							
Friends & Family Test - ED	12.3%	19.4%	18.0%	18.5%	18.1%	↑	
Friends & Family Test - Inpatients	26.9%	37.0%	32.3%	36.3%	34.3%	↑	
Friends & Family Test - Maternity - Overall	21.9%	38.0%	33.4%	32.8%	32.1%	↓	
Friends & Family Test - Outpatients	4.9%	11.9%	5.7%	4.7%	5.3%	↓	
Friends & Family Test - Community	3.3%	8.1%	4.8%	4.1%	4.3%	↓	
Friends & Family Test - Percentage Recommended							
Friends & Family Test - ED	88.7%	94.5%	75.6%	74.4%	77.2%	↓	
Friends & Family Test - Inpatients	96.7%	97.4%	94.9%	94.9%	94.1%	↑	
Friends & Family Test - Maternity - Overall	97.1%	98.5%	95.1%	99.7%	97.6%	↑	
Friends & Family Test - Outpatients	95.3%	97.4%	91.1%	90.0%	89.9%	↓	
Friends & Family Test - Community	96.2%	97.7%	93.0%	92.9%	94.4%	↓	
Complaints							
Total no. of complaints received in month			46	48	534	↑	
Complaints re-opened			4	2	51	↓	
PALs Numbers			321	264	3186	↓	
Complaints open at month end			206	216	-	↑	
Compliments received			505	522	6578	↑	
Dementia (1 month in arrears)							
Find/Assess		90%	97.5%	-	96.9%	↑	
Investigate		90%	100.0%	-	100.0%	↑	
Refer		90%	96.9%	-	96.3%	↑	
Falls National average 6.63 per 1000 bed days							
No. of Falls			70	61	743	↓	
Falls per 1000 bed days		6.63	3.80	3.55	3.94	↓	
No. of Multiple Falls			5	4	63	↓	
Falls resulting in moderate harm or above			2	0	12	↓	
Falls resulting in moderate harm or above per 1000 bed days		0.19	0.11	0	0.06	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital Avoidable		0	1	0	8	↓	
Community Avoidable		0	0	1	10	↑	
Handwash							
Handwashing			99.6%	99.8%	99.1%	↑	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Jan-19	Feb-19	Actual YTD	Trend	Month Status
Mixed Sex Accommodation Breaches							
Single Sex Breaches		0	17	7	68	↓	
Mortality (Quality Strategy Goal 3)							
HSMR Rolling 12 months (Latest data Aug 18)	110	105	117	118	-		
SHMI Rolling 12 months (Latest data 18/19 Q1)	1.10	1.05	N/A	1.11	-		
HSMR Year to date (Not available)					-		
Infections							
Cumulative C-Diff due to lapses in care	28	-	-	-	19	↔	
MRSA Bacteraemia	0	0	0	0	1	↔	
MSSA Bacteraemia	0	2	0	0	15	↓	
E. Coli - Total hospital	0	5	1	33	↓		
Stroke Admissions - Provisional Figures							
Stroke Admissions: Swallowing Screen	75%	90.0%	80.0%	91.8%	↓		
Stroke Patients Spending 90% of Time on Stroke Unit	85%	89.8%	90.7%	91.4%	↑		
Suspected High Risk TIAs Assessed and Treated <24hrs	85%	100.0%	100.0%	91.3%	↔		
VTE - Provisional Figures							
VTE On Admission	95%	94.8%	95.0%	94.9%	↑		
Incidents							
Total Incidents		1447	1491	16414	↑		
Recorded Medication Incidents		434	0.950159	4045	↓		
Never Events		0	0	0	↔		
Serious Incidents		3	4	76	↑		
of which, pressure ulcers		1	1	24	↔		
Incident Grading by Degree of Harm							
Death		1	0	11	↓		
Severe		6	2	29	↓		
Moderate		20	18	198	↓		
Low		209	187	2081	↓		
No Harm		1211	1284	14095	↑		
Percentage of incidents causing harm	28%	16.3%	13.9%	14.1%	↓		
Safety Thermometer							
Patients with harm free care (and old harms)	-	-	98.04%	97.99%	-	↓	

Performance - "At a glance"

Executive Lead: Karen Kelly



Performance - Key Performance Indicators

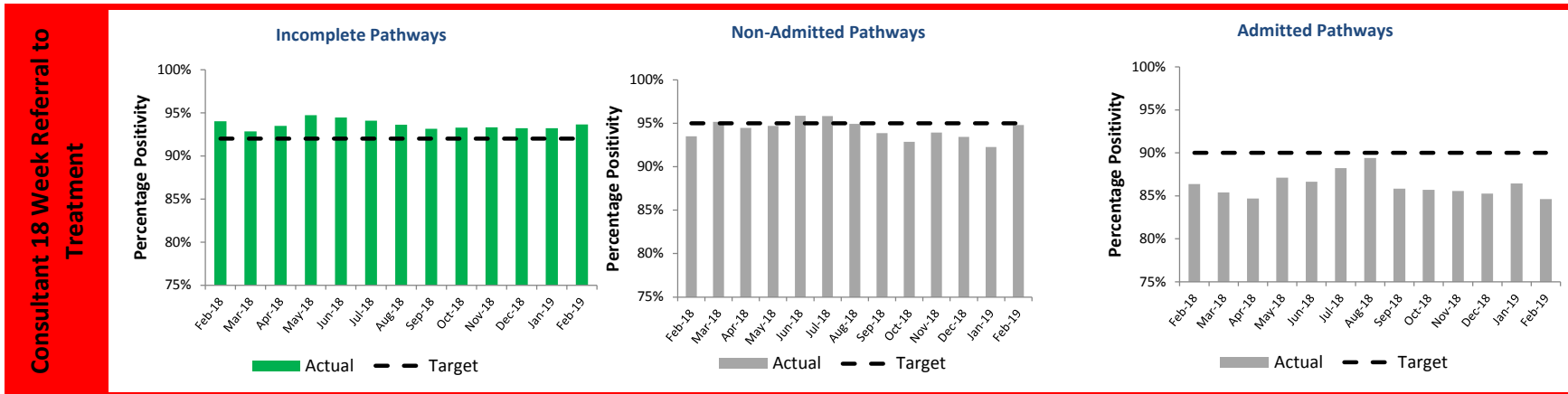
	Target	Jan-19	Feb-19	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	96.88%	98.6%	96.4%	↑	
2 week wait - Breast Symptomatic	93%	94.7%	98.1%	96.3%	↑	
31 day diagnostic to 1st treatment	96%	97.5%	99.4%	98.5%	↑	
31 day subsequent treatment - Surgery	94%	100.0%	100.0%	100.0%	↔	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	78.2%	89.4%	83.2%	↑	
62 day screening programme	90%	100.0%	100.0%	97.6%	↔	
62 day consultant upgrades	85%	92.0%	96.0%	93.7%	↑	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	93.2%	93.7%	93.3%	↑	
RTT Admitted - % treatment within 18 weeks	90%	86.4%	84.6%	85.5%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	92.3%	94.8%	93.4%	↑	
Wait from referral to 1st OPD	26	28	23	116	↓	
Wait from Add to Waiting List to Removal	39	46	41	213	↓	
ASI List		1079	1574	0	↑	
% Missing Outcomes RTT		0.02%	0.04%	0.1%	↑	
% Missing Outcomes Non-RTT		2.9%	2.5%	3.7%	↓	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	234	56	481	↓	
% of diagnostic tests waiting less than 6 weeks	99%	96.6%	99.2%	98.6%	↑	
ED - TRUST						
Patients treated < 4 hours Type 1 (Trust ED)	95%	67.2%	67.6%	71.5%	↑	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	80.2%	80.1%	82.6%	↓	
Emergency Department Attendances	N/A	9474	8277	44847	↓	
12 Hours Trolley Waits	0	8	16	25	↑	
Ambulance to ED Handover Time - TRUST						
30-59 minute breaches		503	473	2314	↓	
60+ minute breaches		101	93	434	↓	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		21	18	85	↓	
60+ minute breaches		11	10	32	↓	

Performance - Key Performance Indicators cont.

	Target	Jan-19	Feb-19	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	2.1%	2.0%	1.9%	↓	
Cancelled operations - breaches of 28 day rule	0	3	0	12	↓	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	83.0%	81.0%	83.2%	↓	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		74.3%	76.9%	75.4%	↑	
Theatre Utilisation - Main		85.6%	87.0%	86.4%	↑	
Theatre Utilisation - Trauma		89.0%	90.0%	90.2%	↑	
GP Referrals						
GP Written Referrals - made		7897	7476	35834	↓	
GP Written Referrals - seen		6414	5575	29850	↓	
Other Referrals - Made		3902	3516	18361	↓	
Throughput						
Patients Discharged with a LoS >= 7 Days		6.4%	6.5%	6%	↑	
Patients Discharged with a LoS >= 14 Days		3.3%	3.1%	3%	↓	
7 Day Readmissions		4.2%	4.3%	4%	↑	
30 Day Readmissions - PbR		8.1%	8.3%	8%	↑	
Bed Occupancy - %		89%	85%	87%	↓	
Bed Occupancy - % Medicine & IC		95%	84%	92%	↓	
Bed Occupancy - % Surgery, W&C		82%	88%	82%	↑	
Bed Occupancy - Paediatric %		57%	80%	57%	↑	
Bed Occupancy - Orthopaedic Elective %		65%	67%	76%	↑	
Bed Occupancy - Trauma and Hip %		89%	96%	91%	↑	
Number of Patient Moves between 8pm and 8am		110	111	515	↑	
Discharged by Midday		12.7%	11.8%	13%	↓	
Outpatients						
New outpatient appointment DNA rate	8%	6.8%	6.6%	7.4%	↓	
Follow-up outpatient appointment DNA rate	8%	6.3%	5.6%	7.3%	↓	
Total outpatient appointment DNA rate	8%	6.5%	6.0%	36.8%	↓	
Clinic Utilisation		76.8%	78.8%	77.5%	↑	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	2.4	2.68	2.09	2.4	↓	
Average Length of Stay - Non-Elective	3.4	5.5	5.5	5.4	↑	

Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment



RTT 18 Week Performance - February 2019

Validated Position

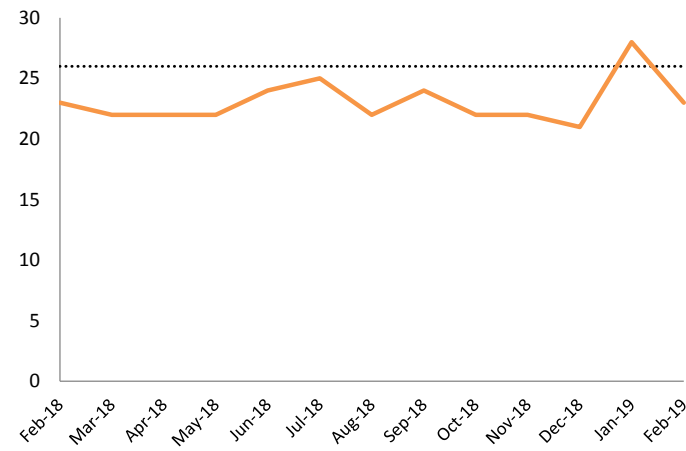
Specialty	Incompletes - Target 92%			
	<18	>18	Total	%
100 - General Surgery	855	111	966	88.5%
101 - Urology	1123	95	1218	92.2%
110 - Trauma & Orthopaedics	1941	144	2085	93.1%
120 - ENT	1197	17	1214	98.6%
130 - Ophthalmology	1955	362	2317	84.4%
140 - Oral Surgery	814	7	821	99.1%
160 - Plastic Surgery	643	59	702	91.6%
300 - General Medicine	2	0	2	100.0%
301 - Gastroenterology	1090	44	1134	96.1%
320 - Cardiology	471	21	492	95.7%
330 - Dermatology	709	47	756	93.8%
340 - Respiratory Medicine	289	5	294	98.3%
400 - Neurology	491	29	520	94.4%
410 - Rheumatology	509	11	520	97.9%
430 - Geriatric Medicine	109	0	109	100.0%
502 - Gynaecology	1116	46	1162	96.0%
Other	3641	151	3792	96.0%
Total	16955	1149	18104	93.7%

Comments

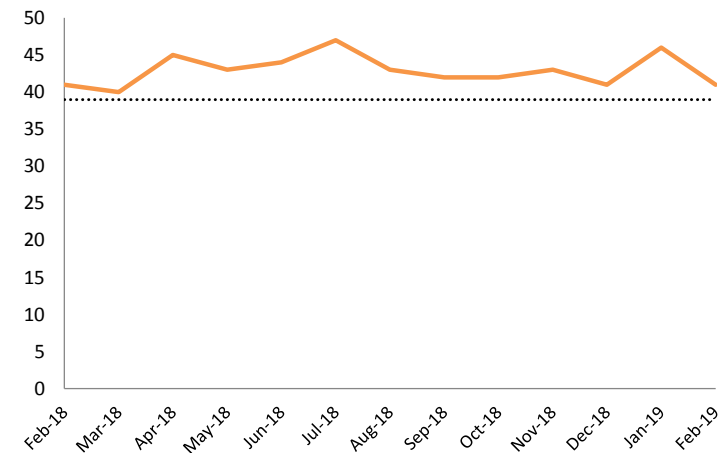
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment

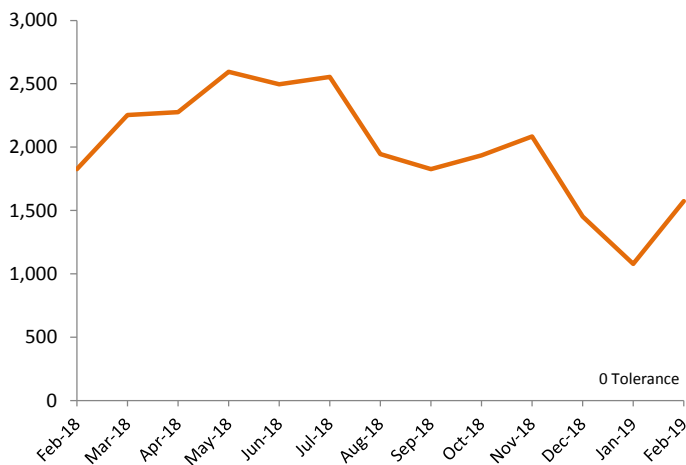
Wait in days from referral to 1st OPD



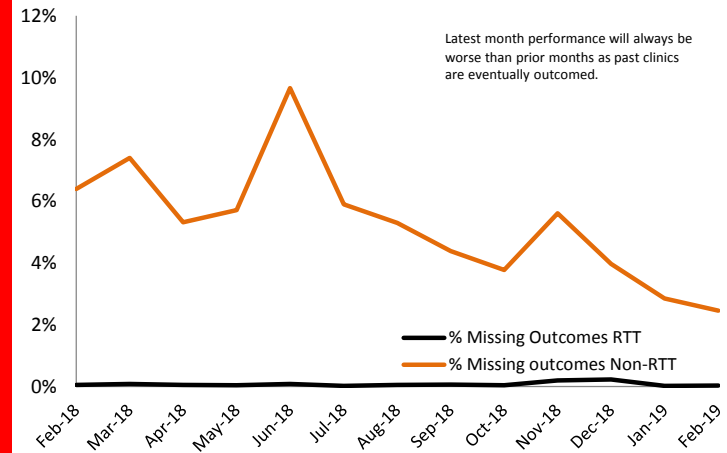
Wait in days from Add to Waiting List to Treatment or Removal



Number of unavailable slots at end of month (Appointment Slot Issues)

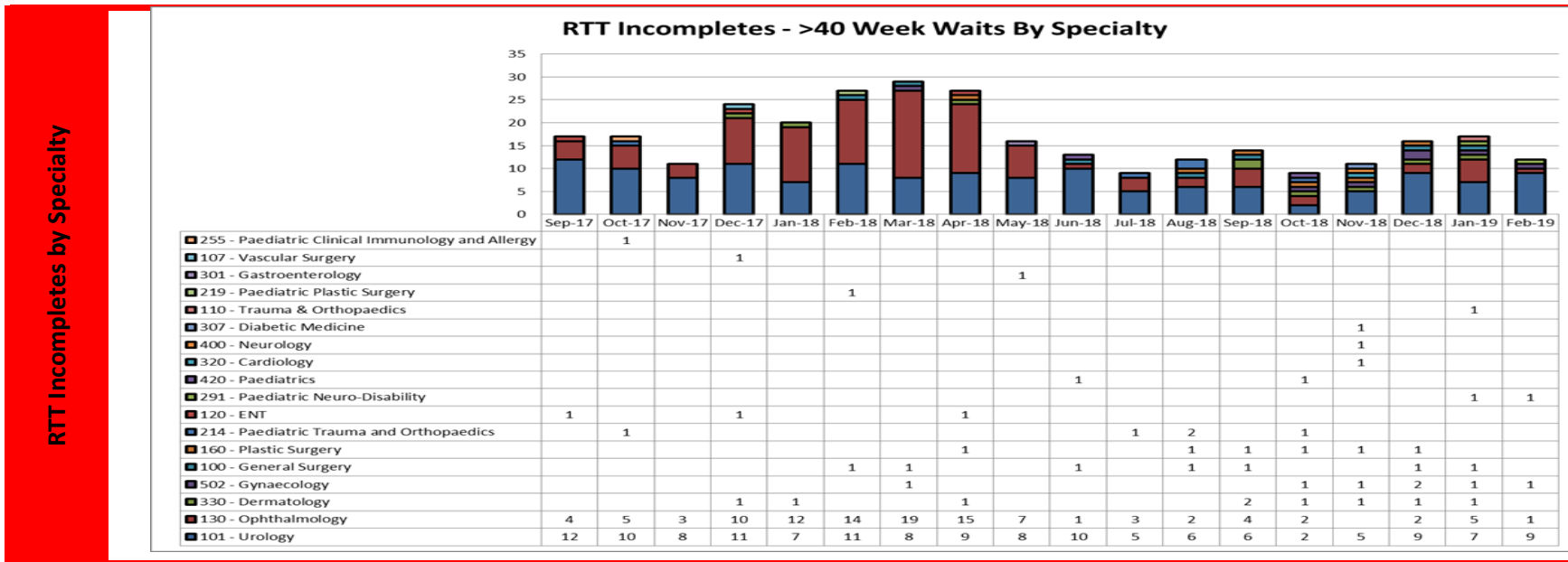


% Missing Outcomes



Performance Matters (KPIs)

Regulatory Performance - RTT Incompletes



There are '0' over 52 weeks

Financial Performance - "At a glance"

Executive Lead: Tom Jackson



Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	444	461	3.8%	-15	1,469	1,378	-6.2%	-91
Day Cases	4,102	4,071	-0.8%	611	12,158	13,838	13.8%	1,680
Non-elective inpatients	3,306	3,341	1.1%	-483	12,236	10,749	-12.2%	-1,487
Outpatients	37,418	39,895	6.6%	1,067	115,593	114,578	-0.9%	-1,015
A&E	9,134	8,277	-9.4%	305	25,595	26,316	2.8%	721
Total activity	54,404	56,045	3.0%	1,485	167,051	166,859	-0.1%	-192
CIP								
	£'000	£'000		£'000	£'000	£'000		£'000
Income	576	814	41.2%	237	6,758	6,915	2.3%	157
Pay	345	167	-51.5%	-178	3,344	2,682	-19.8%	-661
Non-Pay	390	665	70.6%	275	3,995	8,411	110.5%	4,416
Total CIP	1,311	1,646	25.5%	335	14,097	18,009	27.7%	3,912
INCOME								
	£'000	£'000		£'000	£'000	£'000		£'000
NHS Clinical	26,325	26,495	0.6%	170	304,698	305,013	0.1%	315
Other Clinical	552	312	-43.5%	-240	6,131	7,227	17.9%	1,096
STF Funding	1,055	0	-100.0%	-1,055	7,988	4,115	-48.5%	-3,873
Other	1,993	2,377	19.3%	384	21,931	21,760	-0.8%	-171
Total income	29,924	29,184	-2.5%	-741	340,748	338,115	-0.8%	-2,632
OPERATING COSTS								
	£'000	£'000		£'000	£'000	£'000		£'000
Pay	-18,141	-19,073	5.1%	-932	-203,570	-208,397	2.4%	-4,827
Drugs	-2,615	-2,770	5.9%	-155	-30,572	-32,139	5.1%	-1,567
Non-Pay	-7,287	-8,354	14.6%	-1,067	-79,409	-82,084	3.4%	-2,675
Total Costs	-28,042	-30,196	7.7%	-2,154	-313,552	-322,620	2.9%	-9,068

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	£'000		£'000	£'000	£'000		£'000
EBITDA	1,876	-990	-152.8%	-2,866	27,112	15,675	-42.2%	-11,437
Depreciation	-878	-563	-35.9%	315	-9,244	-6,292	-31.9%	2,952
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,195	-1,047	-12.4%	148	-11,535	-12,158	-5.4%	-623
SURPLUS/(DEFICIT)	-197	-2,600	1219.8%	-2,403	6,333	-2,775	-143.8%	-9,108
SOFP								
	£'000	£'000		£'000	£'000	£'000		£'000
Capital Spend	-396	-492	24.2%	-96	-10,874	-9,344	-14.1%	1,530
Inventory					3,197	3,639	13.8%	442
Receivables & Prepayments					22,673	17,097	-24.6%	-5,576
Payables					-22,114	-26,041	17.8%	-3,927
Accruals							n/a	0
Deferred Income					-2,534	-2,612	3.1%	-78
Cash & Loan Funding								
	£'000	£'000		£'000	£'000	£'000		£'000
Cash					6,368	5,533	-13.1%	-835
Loan Funding							n/a	0
KPIs								
EBITDA %	6.5%	-3.4%	-9.9%		10.1%	6.0%	-4.1%	
Deficit %	-0.7%	-9.0%	-8.3%		2.4%	-1.1%	-3.4%	
Receivable Days					0.0	0.0	n/a	
Payable (excluding accruals) Days					0.0	0.0	n/a	
Payable (including accruals) Days					0.0	0.0	n/a	
Use of Resource metric					1	3		



Workforce - "At a glance"

Executive Lead: Andrew McMenemy

	People					
	Target			Actual		Month
	18/19	Jan-19	Feb-19	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.50%	5.70%	5.48%	5.28%	↓	
Staff Turnover	8.5%	9.38%	8.78%	9.30%	↓	
Mandatory Training	90.0%	88.9%	88.6%	88.7%	↓	
Appraisal Rates - Total	90.0%	95.6%	95.6%	95.6%	↔	

Quality Indicators

Heat Map - February 2019

KPI																																
Environmental Cleaning																																
Hand hygiene																																
MRSA Screening - elective																																
MRSA Screening - emergency																																
HCAI CDIFF - due to lapses in care																																
Saving Lives - 02b peripheral lines																																
Saving Lives - 06b urinary catheter																																
Datix incidents reported																																
Falls, Injuries or Accidents																																
Pressure Ulcers - Grade 3/4																																
Serious Incidents																																
Never Events																																
Nutrition Audit																																
Pain Score																																
Medicines Management Audit																																
% of Deaths with Priorities of Care																																
Deteriorating Patient Trolley Check (1 needs to be added)																																
Fluid Balance Management Audit																																
VTE Assessment Indicator (CON01)																																
NOA - Skin Bundle																																
FFT - Response Rate																																
FFT - Recommended %																																
Complaints																																
Compliments																																
Appraisals																																
Mandatory Training																																
RN Average Fill Rate (day shifts)																																
Sickness Rate																																
Ward	Patient Safety & Quality																Clinical Indicators			Patient Experience				Workforce & Safer Staffing					Ward RAG Trend			
AMU2 (A2)			NA	90.0%				42	6		1					No Data					No Data	No Data	3	0						↓-1	↓-1	↑7
B1			100%	Audit Not Done				7	2							No Data							0	0						↑2	↑3	↓-4
B2 Hip			100%	100%				20	1		1					NA							0	10						↓-1	↑2	↓-1
B2 Trauma			67%	100%				13	2														1	8						↑2	↑2	↓-3
B3			100%	94.5%				30	2								Audit Not Done						2	1						→0	↑1	→0
B4			100%	100%				17	5														1	0						↑1	↑4	↓-5
B5			100%	100%				12	1														2	2						↓-3	↑4	↓-1
C1		Audit Not Done	NA	80%				21	7														3	37						↓-2	↓-1	↑4
C2			NA	NA			NA	26	0											NA			0	2						↑2	↑2	→0
C3			NA	50.0%				42	5														2	58						↑2	→0	↓-2
C4			100%	82.6%				25	3														1	104						→0	→0	↑1
C5			100%	78.9%				30	6														2	0						↑1	→0	↑1
C6			85.7%	67%				10	0									No Data					3	0						↑2	↑3	↓-4
C7			NA	55.6%				19	5														0	1						→0	→0	↑2
C8			NA	88.1%				28	11														1	9						↑1	↑2	↑3
CCU & PCCU			NA	88.2%				15	4														0	3						↓-1	↑1	↑2
Critical Care			100%	Audit Not Done				22	2														0	10						↑2	→0	→0
Maternity			NA	NA				109	0		2						NA				NA		0	39						↓-2	↓-1	↑6
MHDU			NA	95.2%				22	0														0	4						↑2	↓-3	↑2
Neonatal			NA	Audit Not Done			NA	10	0								NA			NA	NA		0	0						↑2	↑1	↓-3
Trust Total		99.8%			1	95%	99%	1375	85	1	4	0				29.2%						95.0%	95.0%	36.2%	94.8%	48	522	95.6%	88.7%	83.1%	88.1%	5.5%
RAG Rating	R: <85% A: 85%-95% G: ≥95%	R: <100% G: 100%	No RAG rating for this indicator	No RAG rating for this indicator	R: <0 G: 0	R: <75% A: 75%-95% G: ≥95%	R: <75% A: 75%-95% G: ≥95%	No RAG rating for this indicator	No RAG rating for this indicator	R: <0 G: 0	R: <0 G: 0	R: <0 G: 0	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: ≤30% A: 30%-60% G: ≥60%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <26% A: 26%-35.1% G: ≥35.1%	R: <96.3% A: 96.3%-97.4% G: ≥97.4%	No RAG rating for this indicator	No RAG rating for this indicator	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: >4% A: 3.5%-4% G: ≤3.5%			

Performance Dashboard

Performance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
A&E - 4 Hour A&E Dept Only % (Type 1)	78.38%	77.09%	76.50%	78.66%	76.73%	80.59%	77.23%	80.91%	73.02%	68.74%	67.16%	67.62%	-	74.89%	%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.38%	99.44%	99.46%	99.82%	99.43%	99.49%	100%	100%	99.89%	99.98%	99.88%	99.73%	-	99.74%	%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	86.56%	86.29%	85.38%	86.93%	85.29%	87.64%	85.21%	88.15%	83.21%	81.42%	80.15%	80.09%	-	84.48%	95%
A&E - Patients who Left Without Being Seen %	2.6%	1.7%	2.1%	1.8%	2.5%	1.6%	1.7%	1.2%	1.5%	2%	1.80%	1.90%	-	1.8%	5%
A&E - Time to Initial Assessment (95th Percentile)	9	4	8	9	7	4	5	7	8	4	4	7	-	7	15
A&E - Time to Treatment Median Wait (Minutes)	70	49	65	61	73	49	64	55	66	66	73	69	-	69	60
A&E - Total Time in A&E (95th Percentile)	731	593	587	504	524	463	511	462	605	645	799	730	-	730	240
A&E - Unplanned Re-Attendance Rate %	1.5%	1.3%	1.1%	1.5%	1.6%	1.3%	1.3%	1%	1.3%	1.1%	1.3%	1.2%	-	1.3%	5%
Activity - A&E Attendances	103,426	8,292	9,097	8,920	9,569	8,336	8,847	8,924	9,152	9,013	9,528	8,249	-	97,927	95,918
Activity - Cancer MDT	5,131	492	443	520	378	511	508	596	561	481	543	457	-	5,490	4,783
Activity - Community Attendances	376,548	33,662	36,319	36,299	38,817	34,833	35,291	38,326	37,353	31,083	37,057	34,143	-	393,183	371,969
Activity - Critical Care Bed Days	7,612	579	702	731	770	582	679	792	663	593	598	685	-	7,374	7,373
Activity - Diagnostic Imaging whilst Out-Patient	52,692	4,222	4,505	4,451	4,434	4,445	4,163	4,759	4,782	4,101	4,972	4,523	-	49,357	54,283
Activity - Direct Access Pathology	1,970,646	173,406	172,671	173,017	174,399	173,882	165,564	187,986	176,971	130,778	204,630	165,564	-	1,898,868	1,904,223
Activity - Direct Access Radiology	75,450	6,221	6,883	6,389	6,475	6,235	5,930	7,014	6,844	5,271	6,673	6,160	-	70,095	73,667
Activity - Elective Day Case Spells	48,682	4,184	4,366	4,058	4,159	4,400	3,891	4,472	4,418	3,676	4,383	3,978	-	45,985	45,887
Activity - Elective Inpatients Spells	5,828	433	464	451	467	492	441	497	466	410	421	461	-	5,003	5,351
Activity - Emergency Inpatient Spells	50,160	3,247	3,626	3,635	3,776	3,712	3,453	3,850	3,796	3,773	3,808	3,311	-	39,987	44,611
Activity - Excess Bed Days	11,066	707	823	922	841	580	664	778	724	603	818	397	-	7,857	13,661
Activity - Maternity Pathway	7,636	578	668	621	642	652	579	584	630	529	659	530	-	6,672	6,960
Activity - Neo Natal Bed Days	7,111	628	661	604	611	643	542	625	557	641	632	561	-	6,705	6,688
Activity - Outpatient First Attendances	146,246	12,902	13,932	13,928	14,880	13,468	12,962	15,216	14,902	13,045	16,874	14,499	-	156,608	143,828
Activity - Outpatient Follow Up Attendances	295,301	25,716	27,624	26,429	28,601	26,743	26,342	30,178	28,475	23,610	28,751	25,482	-	297,951	284,333
Activity - Outpatient Procedure Attendances	71,502	5,235	6,107	6,121	6,064	5,715	5,873	6,511	6,343	5,827	6,838	6,430	-	67,064	69,755
Activity - Rehab Bed Days	20,079	1,528	1,571	1,720	1,618	1,908	1,732	2,017	1,987	2,492	2,669	1,856	-	21,098	17,728
Activity - Renal Dialysis	52,070	4,233	4,431	4,225	4,121	4,180	3,885	4,158	4,018	4,129	4,122	3,727	-	45,229	47,280
Ambulance Handover - 30 min – breaches (DGH view)	4,608	180	437	437	542	267	441	428	488	422	503	473	-	4,618	0
Ambulance Handover - 30 min – breaches (WMAS view)	5,803	240	603	563	685	395	548	554	637	545	649	583	-	6,002	0
Ambulance Handover - 60 min – breaches (DGH view)	716	8	67	53	119	43	120	88	66	86	101	93	-	844	0
Ambulance Handover - 60 min – breaches (WMAS view)	876	9	73	66	144	52	138	106	80	98	120	105	-	991	0

Performance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	94.7%	88.2%	95.9%	94.5%	95.3%	95.0%	94.6%	94.6%	95.5%	96.6%	96.8%	98.5%	-	95%	93%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	97.3%	91.8%	96.0%	95.3%	96.3%	96.9%	92.5%	96.3%	97.2%	94.7%	94.7%	98%	-	95.6%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.8%	98.7%	100.0%	99.4%	97.1%	98.7%	96.0%	98.9%	97.7%	99%	97.5%	99.3%	-	98.4%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	100%	100%	100.0%	100%	100.0%	100%	100%	100.0%	100%	-	100%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	98.9%	100%	100%	100%	100%	100%	100%	100.0%	100%	100%	100.0%	100%	-	100%	94%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	99.4%	100%	100%	100%	100%	100%	100%	100.0%	100%	100%	100.0%	100%	-	100%	96%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	93.3%	86.6%	86.1%	91.5%	88.1%	95%	90%	95.2%	90.7%	95.1%	92%	96%	-	91.6%	85%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.4%	96.4%	96.1%	100%	100%	100%	100%	93.3%	100%	94.1%	100%	100%	-	98%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85.3%	80.8%	84%	79.8%	85.3%	79.8%	80.4%	86.6%	75.3%	85.5%	78.2%	90.3%	-	82.5%	85%
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	19	3	7	2	3	2	7	0	3	1	4	-	-	32	
Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre)	29	2	2	1	4	5	9	4	6	4	4	-	-	41	
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	48	5	9	3	7	7	16	4	9	5	8	-	-	73	
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	100%	0%
Number of Births Within the Trust	4,435	351	384	363	356	385	356	368	374	354	359	325	-	3,975	
RTT - Admitted Pathways within 18 weeks %	87.9%	84.6%	87.1%	86.6%	88.2%	89.3%	85.80%	85.6%	85.5%	85.2%	86.4%	84.6%	-	86.3%	90%
RTT - Incomplete Waits within 18 weeks %	94%	93.4%	94.7%	94.4%	94%	93.6%	93.10%	93.2%	93.30%	93.2%	93.1%	93.6%	-	93.6%	92%
RTT - Non-Admitted Pathways within 18 weeks %	93.1%	94.4%	94.6%	95.8%	95.8%	94.9%	93.80%	92.8%	94%	93.4%	94.8%	94.7%	-	94.4%	95%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	97.85%	99.31%	99.38%	99.30%	99.23%	97.7%	98.69%	99.18%	99.1%	99%	96.6%	99.18%	-	98.79%	99%

Staff/HR Finance Dashboard

Finance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Agency spend	£11,613k	£860k	£1,111k	£981k	£974k	£1,157k	£1,172k	£1,119k	£1,079k	£1,146k	£1,250k	£1,337k	-	£12,185k	k
Bank spend	£16,404k	£1,481k	£1,475k	£1,611k	£1,608k	£1,393k	£1,883k	£1,735k	£1,651k	£1,674k	£1,812k	£1,636k	-	£17,958k	k
Budgetary Performance	(£20,622)k	(£640)k	(£451)k	£646k	(£445)k	(£134)k	(£1,833)k	£121k	£254k	£562k	(£4,991)k	(£2,428)k	-	(£9,340)k	£0k
Capital v Forecast	106.6%	59.8%	51.9%	69%	67.7%	68.3%	76.9%	72.8%	76.5%	88.0%	84.5%	85.9%	-	85.9%	95%
Cash Balance	£8,617k	£13,899k	£9,420k	£9,717k	£8,752k	£7,143k	£3,929k	£7,367k	£6,388k	£4,797k	£4,787k	£5,533k	-	£5,533k	k
Cash v Forecast	54.6%	109.3%	98.8%	159.4%	85.20%	92.70%	87.4%	152.2%	201.8%	136.8%	69.5%	86.9%	-	86.9%	95%
Creditor Days	16.4	15.5	15.5	16.7	17	15.9	17.3	17.7	21.7	21.7	19.6	20.9	-	20.9	15
Debt Service Cover	0.79	0	0.64	0.85	1.03	1.12	1	1	1.13	1.13	1.03	0.88	-	0.88	2.5
Debtor Days	7.4	9.4	10.8	12.8	14.1	14.9	13.5	11.8	14.2	14.7	13.2	11.6	-	11.6	15
I&E (After Financing)	(£9,518)k	(£2,073)k	£179k	£116k	£733k	£554k	(£1,966)k	£2,066k	£1,671k	£4k	(£1,585)k	(£2,619)k	-	(£2,922)k	k
Liquidity	-7.63	-7.78	-8	-8.35	-7.98	-8.06	-9.8	-10.69	-9.63	-10.34	-12.45	-14.12	-	-14.12	0
SLA Performance	(£3,902)k	(£537)k	(£708)k	£196k	(£12)k	(£223)k	(£220)k	£912k	£923k	£621k	£1,069k	£403k	-	£2,424k	£0k

Staff/HR Dashboard

Staff/HR															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Appraisals	70.5%	17.4%	52.4%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	-	95.6%	90%
Mandatory Training	85.9%	87.8%	88.3%	87.6%	88.9%	89.3%	89.3%	88.6%	88.7%	88.8%	88.9%	88.6%	-	88.6%	90%
RN average fill rate (DAY shifts)	89.59%	83.40%	82.99%	80.43%	80.70%	77.1%	78.18%	82.96%	84.1%	81.11%	83.52%	83.09%	-	81.58%	95%
RN average fill rate (NIGHT shifts)	92.77%	85.94%	86.22%	84.57%	85.66%	83.86%	83.76%	88.4%	89%	85.94%	87.46%	88.09%	-	86.23%	95%
Sickness Rate	4.40%	3.79%	3.85%	4.17%	4.41%	4.33%	4.74%	4.91%	4.86%	5.46%	5.70%	5.48%	-	4.69%	3.50%
Staff In Post (Contracted WTE)	4,397.71	4,396.03	4,395.30	4,408.83	4,426.94	4,437.96	4,473.78	4,359.72	4,358.52	4,346.26	4,344.94	4,379.16	-	4,379.16	
Turnover Rate (Rolling 12 Months)	9.74%	9.95%	9.70%	9.56%	9.51%	9.59%	9.48%	9.45%	9.52%	9.38%	9.38%	8.78%	-	8.78%	%
Vacancy Rate	6.63%	10.87%	11.35%	11.27%	11.13%	10.86%	10.37%	9.37%	10.23%	10.37%	10.42%	9.78%	-	9.78%	%

Paper for submission to the Board of Directors on 4 April 2019

TITLE:	Finance and Performance Committee Exception Report		
AUTHOR:	Tom Jackson Director of Finance	PRESENTER:	Tom Jackson Director of Finance
CLINICAL STRATEGIC AIMS			
<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>			
ACTION REQUIRED OF BOARD / COMMITTEE / GROUP:			
Decision	Approval	Discussion	Other
		Y	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE BOARD:			
The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or action.			
CORPORATE OBJECTIVE:			
S05 Make the best use of what we have S06 Plan for a viable future			
SUMMARY OF KEY ISSUES:			
Summary report from the Finance and Performance Committee meeting held on 28 March 2019.			
IMPLICATIONS OF PAPER:			
RISK	Y		Risk Description: BAF592
	Risk Register: Y		Risk Score: 20
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Well Lead
	NHSI	Y	Details: Achievement of Financial Plan
	Other	N	Details:

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	28 March 2019	Jonathan Hodgkin	yes	no
			Yes	
Declarations of Interest Made				
None				
Assurances Received				
Finance and Efficiency				
<ul style="list-style-type: none">• The finance report for 2018/19 identified that we are currently on track to deliver the agreed position of an £8.8m deficit before Provider Sustainability Fund (PSF)• The 2019/20 Annual Plan approach was welcomed by the Committee and members were asked to provide any comments by Monday 1st April.• The 2019/20 up to date CIP programme identified an improvement from the previously reported figure to £9m.• The 2019/20 capital and revenue budget package was agreed as presented. The question as to whether or not the Trust should accept its offered control total was thoroughly debated. It was agreed to progress this with the Board outside of the Committee and following feedback from the planning regional escalation meeting on Friday 29th March. The Committee also discussed the requirement for the Board to consider very early in the new financial year opportunities to make savings from the total pay bill and other opportunities.• It was agreed to rollover the Financial Improvement Programme into the new year as presented with a focus on a communication strategy.				
Performance				
<ul style="list-style-type: none">• The Committee noted the performances in the areas of A & E target, Cancer, Referral to Treatment and DMO1.				
Workforce				
<ul style="list-style-type: none">• Medical and Nurse staffing reports were received and noted.				
Estates and Procurement				
<ul style="list-style-type: none">• Performance against the PFI contract was noted as being within acceptable limits.• The Committee discussed the financial position of Interserve Group Ltd and was assured that the Trust had not experienced any issues that impacted on the ability to deliver clinical services.				
Oversight and Risk				
<ul style="list-style-type: none">• It was highlighted to the Committee that the BAF was in the process of being addressed by the Board.• The Committee received the annual effectiveness review and Terms of Reference and agreed that further work was required to ensure the Terms of Reference were fit for purpose.				
Decisions Made / Items Approved				
<ul style="list-style-type: none">• Approval of the revenue and capital budgets for 2019/20.				
Actions to come back to Committee				
<ul style="list-style-type: none">• None				

Performance Issues to be referred into Executive Performance Management Process
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- | |
|--|
| <ul style="list-style-type: none">• None |
|--|

Areas of Risk to be escalated onto the Corporate or Divisional Risk Register

- | |
|--|
| <ul style="list-style-type: none">• None |
|--|

Items referred to the Board for decision or action

- | |
|--|
| <ul style="list-style-type: none">• A bid to enhance staff in ED was favourable recommended to the Board for approval, subject to additional assurances around value proposition metrics including agency spend. |
|--|



Paper for submission to the Board of Directors

TITLE:	No Deal EU Exit Preparedness		
AUTHOR:	Christopher Leach Emergency Planning Manager	PRESENTER:	Christopher Leach Emergency Planning Manager
CLINICAL STRATEGIC AIMS			
Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.			
CORPORATE OBJECTIVE: SO1: Deliver a great patient experience SO2: Safe and Caring Services SO3: Drive service improvements, innovation and transformation			
SUMMARY OF KEY ISSUES: In developing trust response to a potential no deal EU exit we have 2 documents that cover the high level response and assessments to threats from a no deal EU exit. The Strategy covers the risk assessments for threats posed to Dudley Group The Response policy covers the proposed response to a No Deal EU Exit in support of current trust Business Continuity arrangements. This situation is still developing with the nearest date for exit from the EU being the 12 th April 2019 The document also has an appendix attached that includes the identification of 100 medicines that are at risk of shortage			
IMPLICATIONS OF PAPER:			
RISK	Y		Risk Description: COR864 A 'No Deal' EU exit may impact on the Trust's ability to deliver services adequately
	Risk Register: Y		Risk Score: Catastrophic rating
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details SAFE EFFECTIVE CARING RESPONSIVE
	NHSI	N	Details:
	Other	Y	Details: EPRR Core Standards, EPRR Framework 2015, Civil Contingencies Act 2004 and Health and Social Care Act 2012
ACTION REQUIRED OF COMMITTEE			
Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE:

To be aware of the ongoing preparations for a potential no deal EU Exit

EU EXIT RESILIENCE STRATEGY

DOCUMENT TITLE:	EU EXIT Resilience Strategy
Name of Originator/Author /Designation & Specialty:	Christopher Leach, Emergency Planning Manager
Director Lead:	Karen Kelly, Chief Operating Officer
Target Audience:	All Staff
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The electronic version of this document is the definitive version	

Version	Date	Reason
1.0	October 2018	New Document
1.1	January 2019	Update to Pharmacy sections and requested additions of breast cancer screening from CSS
1.2	16 th January 2019	Addition of Fuel Shortage Section from BCP
1.3	30 th January 2019	Addition of assurance around Breast Cancer Screening
1.4	1 st February 2019	Addition of Post exercise report for Brexit and actions required + staffing scheme update
1.5	4 th February 2019	General updates to sections
1.6	6 th February 2019	Updates to sections following update meeting
1.7	14 th March 2019	General updates to document
2.0	26 th March 2019	Updated document for Board

THIS DOCUMENT IS SUBJECT TO CHANGE

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

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THE DUDLEY GROUP NHS FOUNDATION TRUST

EU EXIT RESILIENCE STRATEGY

1. INTRODUCTION

As part of the trusts resilience strategy it is necessary for us to prepare for incidents actual and perceived. On the 29 March, 2017 the UK triggered Article 50 of the Lisbon Treaty as part of our preparations to leave the European Union, this means the UK is scheduled to leave on the **12th May 2019** following a vote to extend Article 50 whilst a deal is being negotiated on.

There is a potential risk of a `no deal` scenario, this would potentially have a massive impact on the country both economically and financially. In the event of a deal being made there would be relatively little impact envisaged on NHS providers. This strategy will therefore mainly consider a no deal scenario but the principles could be applied in elements if a risk was perceived following a full or partial deal.

The NHS procures large amounts of equipment, supplies and personnel from EU countries this therefore could impact on the trust considerably.

This document seeks to be a strategic level document indicating areas of potential risk, certain departments have already been requested by DH to generate specific preparedness for EU exit and this will be referenced within the document.

In the eventuality of a no deal EU exit the trust will respond using established business continuity arrangements and mechanisms, with the departments referenced in this document being called to a Business Continuity Incident management team to provide input and guidance.

2. STATEMENT OF INTENT/PURPOSE

This document will only be enacted in the event of a **no-deal** EU exit. Due to the rapidly developing guidance in relation to no-deal EU exit from Department of Health and Social Care this document will be updated regularly

Preparations detailed in this document are being made in readiness for the **12th May 2019** departure date

Aim

To define impacts and preparations being undertaken at a local and national level for a no deal EU exit and to indicate the response arrangements for the trust in the event of a no deal EU exit

Objectives

- To identify areas that could potentially be impacted by EU exit
- To look at potential contingency mechanisms within the UK
- To ensure guidance is implemented within relevant departments
- To indicate response arrangements for the trust in the event of a no deal EU exit

3. DEFINITIONS

Acronym	Definition
DHSC	Department of Health and Social Care
EU Exit or Brexit	The UK process of exiting the EU
EU	European Union
ISO	International Standard
MHRA	Medicines and Healthcare products Regulatory Agency
IVDR	In Vitro Diagnostic Regulations
HMr	Human Medical Regulations
MDr	Medical Devices Regulations

4. KEY CONTACTS

Key leads for no Deal EU exit will be identified in Annex E, these persons will form part of the trusts arrangements for planning for this eventuality, meetings will be held regularly to explore the risks posed by No Deal EU Exit, as a minimum they will be attended by:

- Emergency Planning Manager (Chair)
- Representative from Pharmacy
- Representative from Medical Devices
- Representative from Trust IT
- Representative from Trust Estates
- Representative from Procurement
- Representative from Workforce
- Representative from Radiology
- Representative from Research and Development
- Representative from Finance

By invite and optional attendees will include:

- Chief Operating Officer (SRO for No Deal EU Exit)
- Interserve
- Summit
- Terrafirma
- And others as are identified by Risk Assessment

5. NO DEAL EU EXIT BUSINESS IMPACT ANALYSIS

Risk	Impact Definition	Service Delivery	Financial	Reputation	Wellbeing, Health & safety	Information Security	Statutory/ Regulatory	Business/ Work plan objectives
Reciprocal healthcare	Provision of care to EU nationals			X	X			X
Procurement	Supply of non-clinical and clinical consumables, goods and services	X	X		X			X
Pharmacy	Supply of medicines and vaccines	X	X	X	X		X	X
Medical devices	Supply and maintenance of medical devices	X	X	X	X		X	X
Interserve and support services	Estates and Soft FM	X	X	X	X		X	X
Blood Services	Blood, blood components, organs, tissues and cells	X	X	X	X			X
Workforce	Staffing	X	X	X	X		X	X
IT- Terraforma	Data sharing, processing and access	X	X	X	X	X	X	X
Fuel supplies	National supplies of fuel	X			X			X
Research and Clinical trials	Investigational medicine products and clinical research	X		X	X	X	X	X
Potential increases in demand	Capacity Increases	X		X	X		X	X

Note: All departments are expected to have in place individual Business Continuity and Impact Assessments that identify risks to their areas

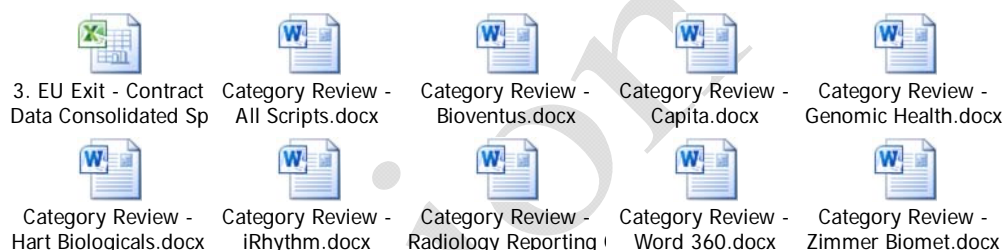
6. AREA INDIVIDUAL IMPACTS AND RESILIENCE

6.1 Procurement

The Procurement lead is working directly with Department of Health and Social Care (DHSC) to undertake internal reviews of purchased goods and services and to understand risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously. NHS Supply Chain which provides the majority of supplies to the trust are being managed and assessed nationally by DHSC assurance will be provided to trusts of resilience and processes required in a no deal EU exit in due course.

The trust has also undergone a process to assess a range of suppliers not covered at a national level (a list of identified suppliers are available in (Annex A) and conversations are taking place with these suppliers to ensure resilience of the supply chain, all suppliers identified by Procurement have been sent a questionnaire regarding Brexit

Procurement have a full list of impact assessments against companies providing supplies directly to DGH outside of NHS Supply Chain.



It has been identified nationally that there may be a need for trusts to establish a process to receive good outside of normal operating hours (Night, Weekend, Bank Holidays) Procurement have developed a process for this which can be activated if required by the Assistant Director of Procurement.

6.2 Pharmacy

Summary

The Hospital pharmacy team is leading on the preparation and planning for a potential no-deal Brexit scenario and it's impact on the supply of medicines. Pharmacy must also feed into the work of other departments across the organisation on Brexit, such as the EPRR team, research and development and procurement.

Key issues

- Matt Hancock wrote to the NHS in August 2018 to assure that a Government scheme would ensure six weeks supply of medicines were available in the UK in the event of a 'no deal' Brexit. Hospitals, GPs and pharmacies were advised to continue to manage stocks as normal, and that local stock piling should NOT be undertaken. Patients should not seek to store additional medicines at home.

- 21/12/18: DHSC published “EU Exit Operational Readiness Guidance
- Actions the health and care system in England should take to prepare for a 'no deal' scenario.” This summarised the contingency plan to ensure the flow of medicines following 27th March 2019. Wholesalers have been granted extra storage space to increase stockholding of medicines and manufacturers who import medicines across the short straits crossing have been reviewed in line with Government plans. It was reiterated that stock piling should not be undertaken by hospitals, pharmacies or patients themselves.
- Medicines legislation is being altered to allow the establishment of “Serious Shortage Protocols” that allow flexibility in dispensing of available medicines.
- PHE is leading a programme to ensure continuity of supply of centrally-procured vaccines
- Organisations running clinical trials are encouraged to consider the supply chain of IMPs following 29th March
- Action cards have been issued to providers and commissioners to supplement EPRR plans. This includes risk assessment and business continuity planning and communications and escalation. Specific actions around medicines include:
 - No stockpiling
 - No clinicians to write usual than longer prescriptions
 - Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.
 - Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

Actions for pharmacy to prepare for ‘no deal Brexit’

- Identify Senior Responsible Officer for EU exit preparation in the Trust and ensure Chief Pharmacist or representative is part of the SRO’s team response
- Ensure Executive team are cited on risks of continuing supply of medicines and the actions taken to mitigate these
- Continue to update risk register as new information is available
- Undertake local risk assessment of impact of Brexit and feed into Trust’s response
- Medicines supply chain:
 - Follow guidance not to stock pile but ensure critical and high turnover items are consistent with average stockholding. Identify “fragile lines” where historically small amount of stock is retained or product requires several days for delivery.
 - Direct staff to reassure patients regarding plans for continuity of supply and discourage patients from stockpiling
 - Continue to report shortages through usual regional routes
 - Maintain Shortages Log with details of the shortage and interim advice for pharmacy staff
 - Establish process for implementing Serious Shortages Protocol
- Identify any key consumables critical to medicines administration and link in with procurement department
- Clinical Trials
 - Identify if Trust is lead sponsor for any trials and follow MHRA advice

- Liaise with trial Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs which come from, or via, the EU are guaranteed in the event of any possible border delays.
- Find out if there are any data flows to and from the EU e.g. Early Access Schemes, that may impact on patient care. Review information assets linked to the EU e.g. clozapine database and plan for contingency if unavailable.
- Update local Pharmacy business continuity plans.
- Workforce: Identify EU nationals working in the department. Ensure aware of EU Settlement Scheme. Include service impact in risk assessments if shortfall of EU nationals identified as a potential issue. Reassure staff regarding professional registration of existing staff.
- Set up pharmacy Brexit steering group to manage actions.
- Maintain record of costs incurred to comply with guidance

Pharmacy may be impacted severely by a no deal EU exit from supply to provision to production.

Locally we have been instructed by national guidance not to stockpile medicines.

“Even though the planning assumption has been revised, the Department will continue to develop the UK-wide contingency plan with pharmaceutical companies. May I therefore take this opportunity to restate my message from August: UK health and social care providers – including hospitals, care homes, GPs and community pharmacies – should not stockpile additional medicines beyond their business as usual stock levels, there is also no need for clinicians to write longer NHS prescriptions” (DoH letter from Matthew Hancock 07/12/2018)

In addition to this NHS England is working closely with the DoH on the planning for EU Exit, this included the below preparations:

“Under the DHSC Medicines Supply Contingency Planning Programme, pharmaceutical companies should ensure they have an additional six weeks supply of medicines in the UK on top of their normal stock levels.

Medical staff should do all they can to make patients aware that they do not need to store additional NHS medicines at home” (DoH letter from Matthew Hancock 23/08/2018)

As a trust we are undertaking an assessment of critical medicines and consumables related to medicines administration to ensure that we have stocks are in line with historic usage and details of alternatives are identified in the event of a no deal EU exit. Regional discussions are also taking place with regards to accessing rarely used medications.

Pharmacy are conducting a separate piece of work on difficult to access drugs this will cover the impact analysis for a no deal EU exit also.

Pharmacy are expected to ensure continued reporting on shortage issues and to ensure escalation of queries for medicine supply issues unrelated to current shortages through existing regional communication channels. The trust ensures reporting to the regional procurement lead. This is a two way process with regional and national supply issues being reported back into the Trust.

Pharmacy have also recently strengthened governance around drug shortages, and tabled a paper at CQSPE to detail formalisation of the process.

The Chief Pharmacist has robust communication channels with the regional chief pharmacists and the regional chair. They currently meet bi-monthly with daily communication if necessary via email. The Chief Pharmacist will be fully briefed regarding any contingency and collaboration arrangements determined by the CPhO

6.3 Drug Regulation

If the event of a no deal UK participation in the European regulatory network would cease, the Medicines and Healthcare products Regulatory Agency (MHRA) would take on the functions currently undertaken by the EU for medicines on the UK market. This would require changes to UK law, via the Human Medicines Regulations 2012 (HMRs). The MHRA is planning a public consultation in early autumn on some of the key proposed legislative changes, this document will be updated as more information is received [More information](#).

6.4 Blood and Healthcare Products

Department of Health is working closely with NHS Blood and Transplant to coordinate 'no deal' planning for blood, blood components, organs, tissues and cells (as detailed in the two technical notices on blood and organs, tissues and cells and the recent letter to the health and care system sent by the Secretary of State for Health and Social Care on 7 December 2018)

The Blood Safety and Quality Regulations 2005 would be retained in UK law under the EU (Withdrawal) Act powers. The new regulation would maintain the current standard of blood quality and safety on exit day and enable updates to be made to the blood safety and quality standards to respond to emerging threats and changing safety, quality standards and technological advances.

NHSBT have indicated the following preparations for a No Deal EU exit http://hospital.blood.co.uk/business-continuity/EU_exit/

MHRA (Medicines and Healthcare products Regulatory Agency) have indicated the following preparations for No Deal EU exit <https://www.gov.uk/government/news/medicines-and-healthcare-products-regulatory-agency-statement-on-the-outcome-of-the-eu-referendum>

Local suppliers for Transfusion

Bio Rad	Supplier of automation / principle technology in use in the lab with principle distribution points for all of Europe in France and Germany. Bio-Rad have provided verbal assurances to customers around continuity of supply. The region (RHH, New Cross, Walsall and Shrewsbury) have requested a formal statement of assurance from them with a request that they will increase stock holding in the UK (Watford) The blood bank team have managed to develop a buffer with
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	partner trusts of reagents
Greiner	Suppliers of blood tubes manufactured outside of the UK. They have provided verbal assurance of their continuity A plan is being formulated to ensure a buffer stock of these are also available
Other suppliers – Pipette tips etc.	We have supply agreements within the contracts for these products, but an extra assurance statement has been requested from the suppliers As a contingency alternate suppliers have been identified within the UK

Blood Product Storage – Items in use are UK supplied and manufactured. There is not an anticipated issue around these supplies

In the eventuality of a requirement to ration supplies there is a plan in place for this already-

http://thehub/c/documents/policies/_layouts/DocIdRedirect.aspx?ID=R3W3QJMQ2MSC-3-1898

The emergency blood and platelet management plan (also on the hub), due for review in January 2020, describes how we would 'demand manage' in a RAG rated blood supply interruption.

Escalation of supply interruptions would be through our normal routes (director manager/clinical lead) where if there is an unexpected peak in demand or reduction in supply. This would then be managed through 'demand management' for blood use (see policy) or rationing use of essential items with more frequent stock checks / situation reports.

6.5 Medical Devices

Dudley Group uses a variety of medical equipment devices from a range of suppliers, including Siemens, GE, Toshiba and Phillips.

Medical Equipment Regulation: The UK will recognise medical devices approved for the EU market and CE-marked. Should this change in future adequate time will be provided for businesses to implement any changed new requirements. The UK will comply with all key elements of the Medical Devices Regulation (MDR) and the in vitro diagnostic Regulations (IVDR), which will apply in the EU from May 2020 and 2022 respectively. Formal UK presence at EU committees in respect of devices will cease.

Medical Engineering will liaise with Procurement and review EU exit planning document to assess any suppliers that have been highlighted as a risk.

Any suppliers identified that will induce delays in provision of spare parts will be assessed by medical engineering and sufficient critical spare parts will be procured in advance.

Summit/Interserve have been asked to request and then provide assurance to the trust around the resilience of Siemens as they control this contract.

6.6 Radiology

Radiological Isotopes are identified as having the potential risk to be impacted on by a no-deal EU exit, Dudley Group hold a contract with Sandwell and City to provide isotopes to the trust for radiological use.

There has been a lot of discussion nationally regarding security of supply of medicines generally, and of radiopharmaceuticals in particular. Sandwell and West Birmingham Trust have been closely engaged with these

The government is therefore fully aware of the potential issues, and has asked all companies to put in place plans to minimise disruption. As a result, companies are stock-piling 6-months' supply of medicines. Whilst this helps with the non-radioactive starting materials we use, for the radioactive component, we can't stock-pile it, as it decays away too quickly. In the event of a no-deal EU exit, there is a risk of delay in delivery of our radioactive generators which we use to manufacture most of the radiopharmaceuticals we make, and other radioactive products which we order in as finished products, such as DaTSCAN, which is a key product for diagnosis of Parkinsons Disease.

This risk has been placed on the Sandwell trusts risk register, and they have undertaken an internal risk assessment process and rated this as Amber

Kits themselves should be unaffected by Brexit.

However, radioactive starting materials such as our generators, and radioactive finished products, such as DaTSCAN may be affected.

If we have a deal, supply should remain as it is now – i.e. no affected by Brexit

In the event of no-deal, there is a potential risk of delays:

Generators:

Generators will no longer be available for delivery any day of the week as they are now but Sandwell have amended their delivery schedule to ensure the activities available are sufficient for our usual workload.

There will however be difficulties if the delivery is delayed, and once we know if there is a deal or not, Sandwell may revisit their delivery schedule so that they are not delivered before manufacturing starts. Initially there may be a need to keep bookings light at first so that older generators can be utilised. We do this now when there is a delay to the generator delivery. They are suggesting that they will assume there will be a delay and plan accordingly.

Other radioactive finished products, such as DaTSCAN, I-123 MIBG, Tl-201 and Ga-67:

GE have closed their UK manufacturing plant, which is where they made their generators and other products such as 51-Cr EDTA and 51-Cr Sodium Chromate. GE have set up an arrangement with Curium whereby GE continue to source the Moly but the generators themselves are made up in the Curium facility.

Concerns are that there is now no UK manufacturing of generators, and in the event of a no-deal Brexit, there is potentially further delay to generator deliveries

One of the mitigating strategies has been to mandate all companies to move to air freight, and possibly sea freight rather than roads. Another has been to ask companies to stock pile medicines in the UK

6.7 Interserve and support services

Interserve through contract with Summit provide assurance that they have adequate and suitable business continuity plans in place for any eventualities that may face them, this will include EU exit, as detailed below

EU Exit statement Interserve to Dudley Group March 2019

“The Dudley Group NHS Foundation Trust”

In regard to the specific requirements of the “The Dudley Group NHS Foundation Trust”, Interserve does not foresee any significant impacts on its ability to deliver services for the Hospitals in regard to Brexit. This is especially true given that import and export requirements are minimal to effective service delivery by Interserve.

Interserve continues to review its operational and service delivery requirements in the light of the ongoing Brexit negotiations between the UK Government and the European Union regarding this contract.

“EU exit – Supply Chain Statement January 2019

The decision made by the UK to leave the European Union, or ‘Brexit’ as it has become known, means that we must embrace the challenges that this decision will bring. In order to ensure that our business is sustainable, we are putting into effect a number of strategies, under the governance of the Interserve Brexit Committee, which will ensure the strongest possible outcome for our company as the transition away from EU membership takes place.

The company’s Procurement and Supply Chain strategy includes identifying and mitigating potential risks to the supply of goods and services from key suppliers and subcontractors. Our approach to supplier management quantifies all relevant risks and issues to develop mitigation and action plans, providing required assurance to our business and customers. We are assessing information received from our key suppliers and seeking to share best practice on Brexit scenario planning.

We will continue to review and respond to emerging details of the Brexit plan and any associated impacts on our business and to review updated guidance from the Chartered Institute of Procurement & Supply. This statement may be revised to reflect the findings of the review and our response to it.

Additional comments following request from Summit:

- *Review of the assets and spares [particularly critical] to establish whether exiting the EU has an issue concerning timely fault repairs*
 - *A Request for Information (RFI) document has been issued to key suppliers within the health sector that are used across multiple hospitals. Clarification is being sought regarding how Brexit may impact the provision of spares; what suppliers are doing to ensure that stock is available and accessible etc.*
- *Is the consumable supply chain robust*
 - *Based upon the responses received from suppliers, the Supply Chain Development (SCD) team will work with Procurement and Operations to assess suppliers based on their risk impact and develop risk mitigation plans as required. Given the criticality of certain service lines and vendors within the health sector – these will be prioritised.*
- *Does Brexit affect the labour force here at Dudley?*
 - *A full review of the impact it may have has been initiated by the site team with the support of John Craig and his team. A meeting is planned for early January to review progress and we expect to have a full understanding soon after that.*
- *Any subcontractors that we rely on from the EU [such as Siemens]*
 - *As outlined above, work is on-going with key suppliers to determine their plans in relation to Brexit and verifying their ability of being able to continue to provide the services required within the defined SLAs and having access to spares / stock to support this.*

6.8 NHS Property Services

“NHS Property Services is working closely with the Department of Health and Social Care and NHS system leaders in relation to preparations for Brexit to ensure our plans align with the wider, national plans. We anticipate there will be minimal impact to our services. Our providers have advised that they have proactively sought to mitigate potential disruption to their service delivery and other contractors have been asked for their business continuity plans and readiness status so we can prepare for any issues that may arise.

The Government’s recently changed position on ‘Settled Status’ charges, further reinforces our view that there is unlikely to be a material change in current levels of EU citizens working for NHS Property Services. We will continue to monitor this position. For more information, please contact our Customer Service Centre on 0800 085 3015”

6.9 IT and Data Protection

The Trust completes the annual Toolkit; this year’s Data Security and Protection Toolkit (DSPT) is due for sign off by **31st March 2019**

Trust IT ‘Terrafirma’ also completes the DSPT individually also for final sign off by **31st March 2019**

The Trust is certified to ISO27001 and Cyber Essentials indicating a good level of business continuity for disruptive events

The Trust has processing agreements in place with third party organisations within and without the EEA, during the process 4 have been identified as being hosted within the EU and assurance

Company	Assurance received (as of 21/03/2019)
Medtronic	No
Biotronik	No
Boston Scientific	Yes
Abbott (formerly St Jude Medical)	No

The Trust is currently receiving guidance on whether or not the National Framework Agreements cover the assurance required for the continued flow of data from EU to UK, or whether the Trust has to do this independently with the organisations themselves

6.10 Finance

Due to the implications of a no deal EU exit there may be an increase in costs to the organisation through either stock piling or increased costs from providers. Procurement has engaged with finance through the process and the finance team are aware of the plans in place for procurement.

Finance will continue to be engaged throughout the process so that costs can be monitored and recorded appropriately as indicated below.

Each department/team will be expected to record costs (both revenue and capital) incurred in relation to a no deal EU exit. Costs with a direct financial impact will be recorded separately to opportunity costs, these then must be shared with the Finance Team to ensure a full compilation of costs to the trust. The trust will then be expected to discuss these costs with the regional NHS EU Exit support team. Further guidance will then be provided as needed.

Confirmation has been received from departments of acknowledgement of costings storage.

6.11 Staffing

As of the 1st February 2019 the £65 resettlement scheme has been scrapped therefore reducing the risk of staff leaving due to requiring registration, HR maintains a full name list of staff from within the EU so direct contact can be made should the situation change, it has been decided that should a similar scheme be introduced in the future that the organisation will provide support to those individuals if required

The Trust acknowledges that we currently have around 92 wte who will be impacted following BREXIT. Vacancies will be one of the key workforce risk should individuals leave the organisation, however, the Trust has recruitment plans which individual area and use this mechanism to support any vacant posts. The Trust also has a recruitment and retention lead who will monitor any impact as they discuss leavers and starters on a monthly basis which leads to the production of a staff in post report.

Grade-Role	Number
Senior Manager	2
Radiographer - Diagnostic	3
Sister/Charge Nurse	13
Practitioner	2
Foundation Year 2	2
Trust Grade Doctor - Specialist Registrar Level	1
Trust Grade Doctor - Speciality Registrar Level	1
Specialist Registrar	1
Specialty Registrar	5
Manager	2
Trust Grade Doctor - SHO Level	1
Pharmacist	3
Specialist Nurse Practitioner	7
Apprentice	1
Consultant	14
Health Care Support Worker	5
Occupational Therapist	2
Staff Nurse	20
Clerical Worker	2
Specialty Doctor	4
Physiotherapist	3
Student Nurse - Adult Branch	1
Midwife	1
Secretary	1
Modern Matron	1

Those that have currently been identified as no identifier (approx. 300 staff) will be contacted by workforce to determine what level of risk they pose to the organisation, this will then be updated within the document.

6.12 Surge and Escalation

There may be impacts to trust capacity as a direct or indirect result of a no deal EU exit, it is anticipated that this will be managed through standard trust surge and capacity protocols with any causality as a result of no deal EU exit being escalated through the routes indicated in section 7 and to regional EU exit leads.

During no deal EU exit the 24/7 command and control structure will be managed as per the Business Continuity plan response, with the executive on call taking strategic control of the trust and the manager on call taking tactical command.

At an appropriate time this will be re-assessed and if necessary a Business Continuity response team comprising of subject matter experts from key areas such as:

- Procurement
- Finance
- Pharmacy
- Workforce
- Emergency Planning
- Operations

6.13 Research and Clinical trials

EU research and innovation funding schemes

The trust does not currently have any EU, Horizon 2020 or Third Health programme grants

Clinical networks

In a 'no deal' scenario, UK clinicians would be required to leave European Reference Networks (ERNs) on 29 March 2019. However, the UK will seek to strengthen and build new bilateral and multilateral relationships – including with the EU – to ensure clinical expertise is maintained in the UK.

The Department and NHS England are in contact with the ERNs and no action is required at this stage. Further information will be communicated to the NHS and professional bodies in due course.

Clinical trials and clinical investigations

The trust does not currently sponsor Investigational Medical Product (IMP) trials, all of our drug trials are sponsored commercially or through University or trial centre.

Externally the Department of Health and Social Care continues to engage with the life sciences industry and relevant NHS organizations to undertake a comprehensive assessment of potential impacts on clinical trials and investigations, to gain understanding of areas affected by supply issues.

This includes examining supply chains for IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, This assessment aims to conclude in January 2019 and, if necessary, further guidance will be issued thereafter.

Clinical Trial Regulation

For EU-wide trials, the new EU Clinical Trial Regulation (CTR) will not be in force in the EU on 29 March 2019 and so will not be incorporated into UK law. However, the Government has stated the UK will align where possible with the CTR without delay

IF carrying out clinical trials the normal process for seeking regulatory approval should be followed

As a trust the Research Nurses and Clinical Trial pharmacists are liaising with sponsors regarding arrangements for future supplies, this will be fed into this document as the information is received.

6.14 Fuel Supplies

It has been identified that a potential no deal EU exit could lead to fuel shortages due to delays at Ports. Guidance advises that plans are in place at a national level to deal with fuel stocks

The trust has a Fuel Shortage annex within the Trust Business Continuity Plan that can be followed if required (this is indicated below)

Bunkered stocks

The trust has 2 tanks on site that store fuel for generators on site, the amounts stored are indicated in the below table, the quantities stored would be sufficient to fuel all four generators for approximately 12 days.

Tank Number	Tank Capacity (Litres)	Amount stored (litres)
1	180,000	0
2	83,600	68,000
3	90,000	69,200
Total Fuel	353,600	137,200

Note: Amount stored correct as of 01/2019

Tank 1: currently offline as not fit for purpose works ongoing to rectify/replace

In addition there are 4 day tanks each containing 10 hours of fuel for the generators running at full load.

In the lead up to a fuel shortage these tanks could be charged to full loading capacity as indicated in column 2.

It must be noted that these fuel stocks are also expected to cover heating systems also should there be a gas/electricity failure, under the HTM the trust is expected to provide 200 hours running time for generators on fuel and a 10 day boiler, in adverse condition's this is predicted to required 400,000 litres of fuel, this will be managed through the trusts status as a priority customer to ensure that we continue to receive fuel even in a shortage to achieve this required 400,00 litre capacity

6.15 Primary Care and Social Care

Whilst Dudley Group must ensure we are prepared for a potential no deal EU exit scenario it is also important that the Local Health Economy is also ready to respond and it assessing implications on their services as this may impact on the Acute's ability to provide care to patients.

Dudley CCG were asked to provide assurance that this has been considered, the response received is below

"No significant risks have been identified in primary care as a result of a no deal Brexit

The biggest concern as expected will be prescribing in the event of a restriction of supply of drugs. This has been discussed economy wide and agreement reached that in the event of serious supply shortages resulting in a Supply Disruption Alert (SDA) being issued by NHSE then community

pharmacies will supply alternative medicines. It has been agreed that a panel will be convened immediately consisting of a community pharmacist, hospital and community pharmacist, GP and any relevant specialists to agree and distribute a revised Standard Operating Procedure and to monitor impact. The panel will then determine frequency of meeting until normal stocks resume. This process has been tested recently with SDAs issued for EpiPen and Adrenalin Auto-injectors and also for Epanutin, and was assessed as working well

“A number of colleagues have been in touch to ask what preparations for social care have been undertaken in advance of a possible ‘no deal’ EU exit. It is also important to note that the contingency planning that has been undertaken for a ‘no deal’ EU Exit factors in the whole of the health and social care sector. So, the work that has been done on medicines supply, for example, takes into account the demand for medicines not just from the NHS but from the whole health and social care sector. Therefore the work that has been outlined on [our website](#) is also relevant to social care in terms of demand.

In line with the operational guidance that was sent to the health system in December, [DHSC also wrote out to social care providers](#) to ask that they make preparations for a ‘no deal’ EU Exit. Work has been ongoing since then to support social care providers and DHSC has been in regular contact with providers and key stakeholders in order to ensure that providers are as best prepared as possible” (NHS England Assurance 20/03/2019)

6.16 Breast Cancer Screening

Medical Devices linked to Breast Cancer Screening are covered within the Medical Devices section of this document

We have received confirmation from Breast Cancer Screening equipment’s supplier Hologic indicating that there would be no disruption to our equipment servicing or breakdowns (see Annex H)

The trust has also contacted our consumable suppliers to ascertain whether there would be any impact due to Brexit. Once confirmation is received it will be included in this document

The assessment by the Breast Cancer Screening team is that providing all equipment and supplies continue to be delivered as they currently are there would be no adverse effect on delivery of the breast screening service

6.17 Reciprocal Healthcare

In the event of a no deal EU exit there is the potential that EU healthcare cards will no longer be valid for EU nationals within the UK.

Finance follow guidance set by the Department of Health so would not be able to implement any changes until DH advise on how to proceed with reciprocal healthcare this is still being debated and guidance has not been issued

“The Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change”

The trust currently obtains costs directly from individuals that visit requiring healthcare from outside of the EU this process can be extended to EU national if required.

7. EXERCISING

On the 1st February the trust undertook an exercise to test preparedness for a No Deal EU exit this specifically identified key areas that required further development, due to the lack of national guidance or steer on this the planning group took the decision to further develop its planning in line with other trusts around the Midlands with focus on:

- Seeking potential alternate suppliers
- Stockpiling where guidance allows
- Issuing instruction to medics on the prevention of over prescribing
- Prioritization plans for services in the event of shortages ensuring care can be provided to critical areas
- Assurance from the Dudley local Health economy that they are prepared for a no deal EU exit to mitigate against surges into Dudley Group

These plans have been requested from divisions and departments by 22nd February 2019 for a further test in early March 2019 in anticipation of the withdraw date of the 29th March

Recommendations and actions identified are indicated in the Post Exercise report within Annex I

8. TRAINING/SUPPORT

No training will be specifically provided for this document as business continuity response principles will apply if an incident was to be declared.

This document only contains overarching principles in relation to a no deal EU exit

9. PROCESS FOR MONITORING COMPLIANCE













Monitoring of Compliance Chart

Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Emergency Planning Manager	EPRR Group	Quarterly	Via EPRR Group	Emergency Planning Manager	Via EPRR Group

10. EQUALITY

Dudley Group is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

11. REFERENCES

Procurement Guidance	 EU Exit - NHS Self Assessment Methodo  3. EU Exit - Contract Data Consolidated Sp  2. EU Exit - NHS Triage Contract  1. EU Exit - NHS Self Assessment Methodo  1. EU Exit - NHS Self Assessment Methodo
Matthew Hancock Letter 7 th December 2018	 18.06.12 - Letter - Frontline Final (002).
Pharmacy Storage	 Brexit Ministers launch tens of million  KR medicines-supply-upd
Interserve EU exit Statement	 Brexit - Supply Chain Statement - Oct 2018
Matthew Hancock Letter 23 rd August 2018	 Brexit - Frontline letter final_.pdf
Government Guidance	HM Government. (2018) How to prepare if the UK leave the EU with a no deal. https://www.gov.uk/government/collections/how-to-prepare-if-the-uk-leaves-the-eu-with-no-deal#overview [accessed 5th October 2018]
EU Exit Operational Readiness Guidance	 EU Exit Operational Readiness Guidance.  EU Exit operational readiness guidance cc

Annex A Department of Health and Social Care EU Exit Operational Readiness Guidance Action Card 1 – Action card for providers

This Action card is taken from the EU Exit Operational Readiness Guidance and indicates the steps required of NHS funded providers in relation to a no deal EU Exit

Role

All providers of NHS services – including NHS Trusts and Foundation Trusts, primary care organisations and independent sector organisations who provide NHS services must consider and plan for risks that may arise due to a ‘no deal’ exit.

All providers should continue with their business continuity planning, taking into account the instructions in this national guidance, incorporating local risk assessments, and escalating any points of concern on specific issues to regional NHS EU Exit or departmental mailboxes listed in this guidance. Officials monitor these mailboxes and will respond to queries.

Clinical Commissioning Groups and NHS England should agree the handling of communications with general practice in line with existing delegation arrangements.

Actions for providers

Risk assessment and business continuity planning

- Undertake an assessment of risks associated with EU Exit by the end of January 2019, covering, but not limited to:
 - The seven key areas identified nationally
 - Potential increases in demand associated with wider impacts of a ‘no deal’ exit
 - Locally specific risks resulting from EU Exit
- Continue business continuity planning in line with your legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. These organisational and system-wide plans should be completed at the latest by the end of January 2019
- Test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February to ensure these are fit for purpose

Communications and escalation

All providers to:

- Ensure your board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
- Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy.
- Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.
- Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.

NHS providers to:

- Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document.
- Note your nominated regional NHS lead for EU Exit and their contact details
- Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team.
- Confirm your organisation's Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team as soon as possible. This role should be held by a board level member and will entail providing information returns to NHS England and Improvement, reporting emerging EU Exit-related problems, and ensuring your organisation has updated its business continuity plan to factor in all potential 'no deal' exit impacts. Organisations should also identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response.

Reporting, assurance and information

NHS providers to:

- Be aware that if additional reporting is required, NHS England and Improvement will provide further guidance on requirements. However, existing reporting from NHS EU Exit Operational Readiness Guidance organisations will be used to develop a baseline assessment of the EU Exit impact on the health and care system.
- Note that regional NHS EU Exit teams will be in contact shortly to confirm your progress on these actions.
- For queries relating to specific topic areas in this guidance, please contact the relevant departmental mailboxes. Any immediate risks or concerns about provision of NHS service continuity should be escalated to the relevant regional NHS EU Exit mailbox

Supply of medicines and vaccines

All health and adult social care providers to:

- Follow the Secretary of State's message not to stockpile additional medicines beyond their business as usual stock levels. No clinician should write longer prescriptions for patients. The Department's UK-wide contingency plan for the continued supply of medicines and vaccines from the moment we leave the EU is being developed alongside pharmaceutical companies and other government departments.
- Note that there is no need to contact suppliers of medicines directly.
- Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home.
- Note that Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
- Note that the Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines.
- Be aware that UK-wide contingency plans for medicines supply are kept under review, and the Department will communicate further guidance as and when necessary.
- Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.
- Regional pharmacists and emergency planning staff to:

- Meet at a local level to discuss and agree local contingency and collaboration arrangements. The Chief Pharmaceutical Officer will hold a meeting with the chairs of regional hospital and CCG Chief Pharmacist networks (and representatives of private hospital Chief Pharmacists) in January 2019 to help inform local plans.

Supply of medical devices and clinical consumables

- Note that there is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and if the situation changes, will provide further guidance by the end of January 2019.
- Send queries about medical devices and clinical consumables provided by NHS Supply Chain to your usual contact. If you receive medical devices and clinical consumables from other suppliers, you should contact them directly with any queries as you would normally do.
- Be aware that the contingency plan is kept under review, and the Department will communicate further guidance as and when necessary.
- Send queries regarding medical devices and clinical consumables to mdcccontingencyplanning@dhsc.gov.uk.

Supply of non-clinical consumables, goods and services

All providers to:

- Be aware that NHS Trust and Foundation Trust procurement leads have been asked to undertake internal reviews of purchased goods and services to understand any risks to operations if there is disruption in supply. This excludes goods and services that are being reviewed centrally, such as food, on which the Department has written to procurement leads previously.
- Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally.
- Continue to update local business continuity plans to ensure continuity of supply in a 'no deal' scenario. Where appropriate, these plans should be developed in conjunction with your Local Health Resilience Partnership. All health organisations should be engaged in their relevant Local Health Resilience Partnership, which should inform Local Resilience Forum(s) of local EU Exit plans for health and care.
- Be aware that the Department is conducting supply chain reviews across the health and care system, and work is in progress to identify risk areas specific to primary care.
- Await further advice from the Department on what actions should be taken locally.

NHS Trusts and Foundation Trusts to:

- Submit the results of their self-assessment on non-clinical consumables, goods and services to contractreview@dhsc.gov.uk, if not done so already.
- Act upon further guidance to be issued by the Department in January 2019. This will be based on analysis of NHS Trusts and Foundation Trusts' self-assessments.

Workforce

- Assess whether your organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU.

- Publicise the EU Settlement Scheme to your health and care staff who are EU citizens. The scheme will open fully by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register. Further information can be viewed [here](#).
- Monitor the impact of EU Exit on your workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in your organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with your Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the impact that would have on your organisation.
- Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.
- Ensure your board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.
- Notify your local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.
- Escalate concerns through existing reporting mechanisms.
- Send queries on workforce to WorkforceEUExit@dhsc.gov.uk.
- Professional regulation (recognition of professional qualifications)
- Inform your staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.
- Inform your staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
- Await further information from the Government on the future arrangements for health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019.

Reciprocal healthcare

All providers to:

- Note that, in a no deal scenario, the current arrangements for reciprocal healthcare and for overseas visitors and migrant cost recovery will continue to operate until 29 March 2019, depending on the reciprocal agreements that are concluded.
- Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).
- Note that the Department will provide updates and further information on reciprocal healthcare arrangements prior to 29 March 2019.

NHS Trusts and Foundation Trusts to:

- Maintain a strong focus on correctly charging those who should be charged directly for NHS care. Information on implementing the current charging regulations can be viewed on the webpage [here](#).
- Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements. This should be undertaken by the Overseas Visitor Management team, and guidance and support materials will be made available to support this training.

- Note that the Department will provide updates and further information in due course. This information will cover migrant cost recovery charging after 29 March 2019 to enable NHS Trusts and Foundation Trusts to amend processes and train staff if reciprocal healthcare arrangements change.

Research and clinical trials

EU research and innovation funding schemes

- Note that the Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after exit, until the end of 2020.
- Provide information about your Horizon 2020 grant here. This should be actioned as soon as possible. Further guidance can be found here and all queries should be sent to EUGrantsFunding@ukri.org.
- Contact officials at EU-Health-Programme@dhsc.gov.uk with information regarding your Third Health Programme grant, and any queries that you have, as soon as possible.

Clinical trials and clinical investigations

- Follow the Government's guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario, if you sponsor or lead clinical trials or clinical investigations in the UK.
- Consider your supply chains for those IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.
- Liaise with trial and study Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs, medical devices, IVDs, advanced therapy medicinal products, radioisotopes and other clinical consumables which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays. If multiple sites are involved within the UK, then co-ordinate with the lead site or Chief Investigator in the UK, or organisation managing the clinical trial/investigation, e.g. Clinical Research Organisation, to ensure a single approach to the Sponsor.
- Respond to any enquires to support the Department's comprehensive assessment of the expected impact of a 'no deal' exit on clinical trials and investigations. The Department is working closely with the NHS to gain a greater understanding of who might be affected by supply issues.
- Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.
- Send queries concerning IMPs or medical devices to imp@dhsc.gov.uk

Data sharing, processing and access

- Investigate your organisation's reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.
- Note that many organisations tend not to disaggregate personal and non-personal data. As such, please be aware that restrictions on personal data may have knock-on effects on data more generally.
- Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a 'no deal' scenario, which can be viewed on gov.uk and on the ICO website, in particular to determine where to use and how to implement standard contractual clauses.
- Ensure that your data and digital assets are adequately protected by completing your annual Data Security and Protection Toolkit assessment. This self-audit of compliance with the 10 Data Security Standards is mandatory to complete by the end of March 2019, but completing it early will enable health and adult social care providers to more quickly identify and address any vulnerabilities.
- Await further guidance, which will be issued to health and care providers in due course. Assistance will also be available through webinars in early 2019.

Finance

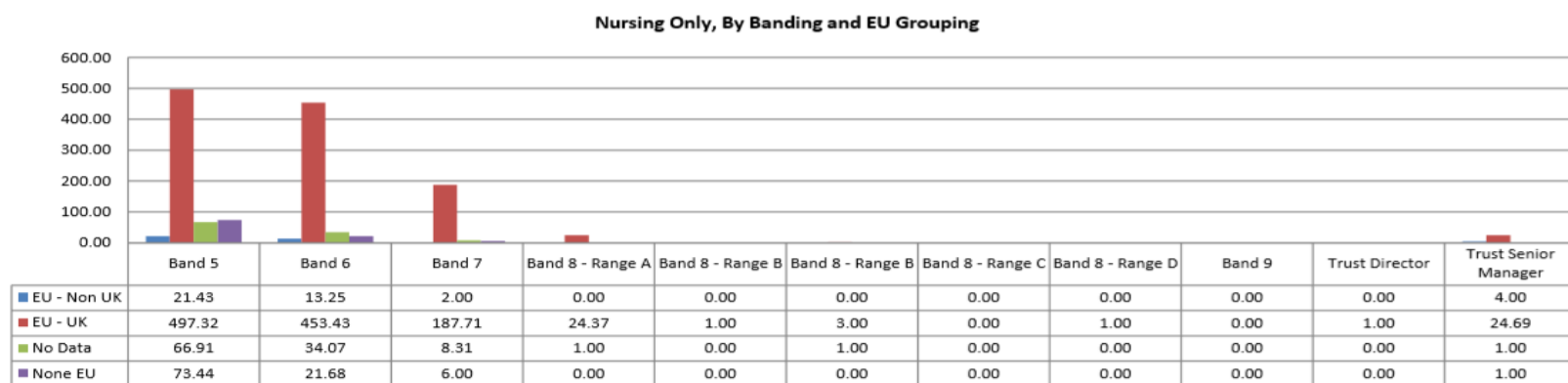
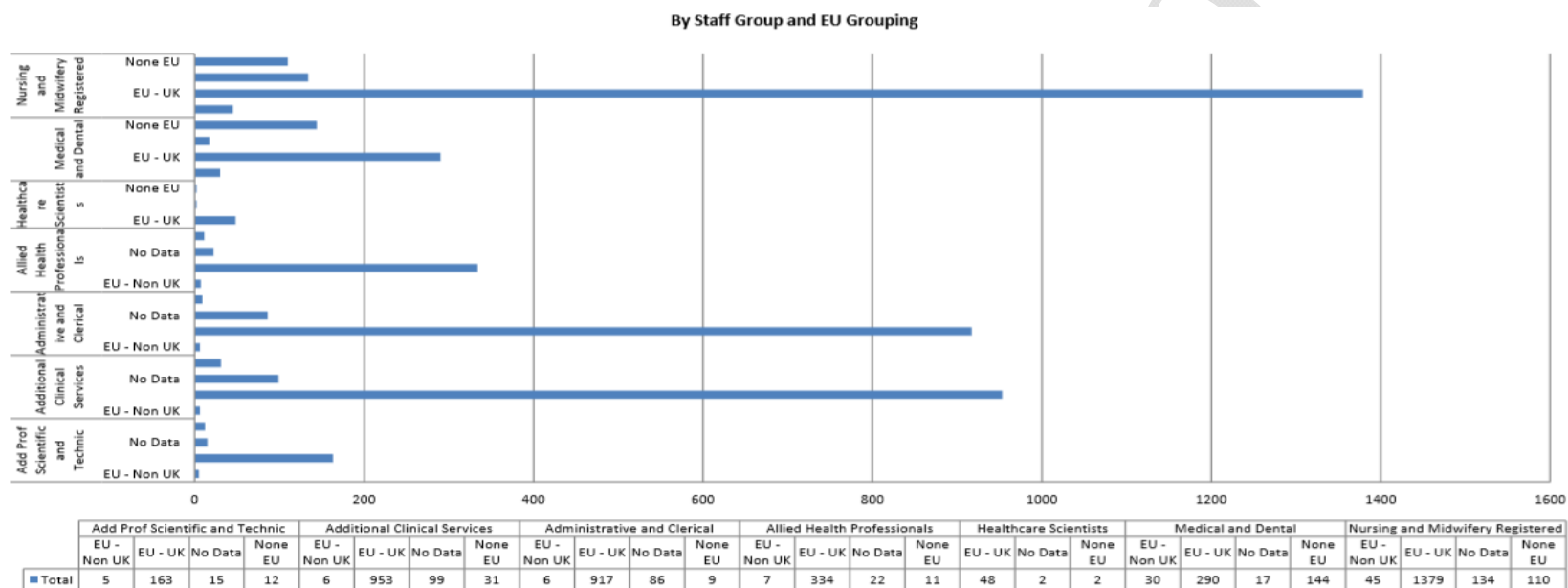
- Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Providers should discuss these costs with their regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.

Annex B Procurement identified suppliers at risk from EU exit

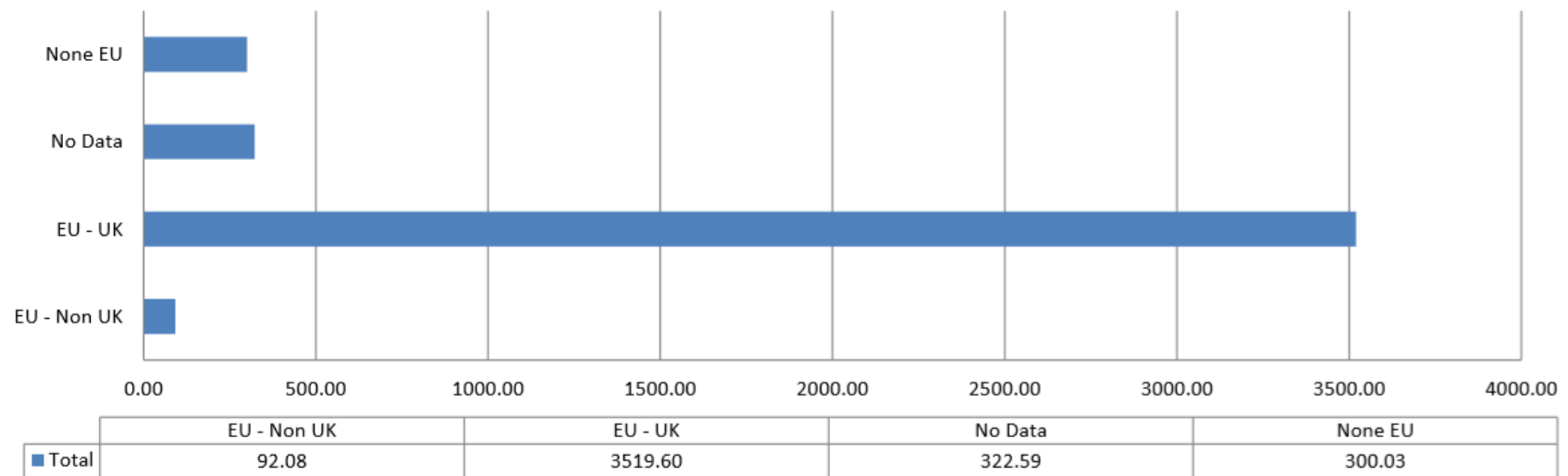
Supplier	Responses from Companies to Letter Annex F
Zimmer Biomet	<p>Q1) In the unlikely event of a No-Deal BREXIT we are in a position to divert large volumes of inventory to our local warehouse where we have the space to store 3 weeks minimum stock holding against national sales on all products that are actively sold in the UK. This will give us the capacity to allow for any delays in clearing customs.</p> <p>Q2) We supply a vast amount of products which are manufactured all over the globe including the UK.</p> <p>Q3) Zimmer Biomet distributes products directly to customers both from the European DC in Holland and a local warehouse in Bridgend, Wales. Currently we use Fed-Ex to ship parcels into the UK and clear customs. Fed-ex have a rapid customs clearance system and are themselves working on contingency plans surrounding BREXIT. They will be sharing those plans with us imminently and when they do we will likewise share with our customers.</p> <p>We are however confident at this time that there will be a positive resolution to BREXIT and if any issues or constraints are to materialise then, alongside the contingency measure detailed above, Fed-Ex are a significantly large enough company to be able to work around those constraints quickly and efficiently. This means we are not expecting any supply issues on any key product ranges due to BREXIT.</p> <p>Q4) No or minimal change</p> <p>Q5) No or minimal change</p> <p>Q6) No or minimal change</p> <p>Q7) No or minimal change</p>
Word 360	<p>Q1) It has been hard for us to speculate as to the effect of any deal as most of our interpreters are also uncertain. However, we noticed that less people are going into the interpreting profession meaning that the network of interpreters appears to be shrinking.</p> <p>Q2) N/A</p> <p>Q3) N/A</p> <p>Q4) N/A</p> <p>Q5) Yes – the cost of translations will be affected.</p> <p>Q6) No – our data is stored in the UK</p> <p>Q7) Yes – most definitely</p>
Hart Biologicals	<p>While the current uncertainty exists because of the lack of an agreement between the UK and the EU or the availability of formal information from any part of government as to what the likely outcome will be, we like many other companies are taking adequate steps to ensure that our supply chains are uninterrupted by the exit process and our ability to supply product to our customers is not compromised.</p>
Bioventus	<p>Q1) Minimal impact expected – we are familiar with shipping into and out of EU. We are also in the process of setting up a satellite warehouse in UK to facilitate local shipping.</p> <p>Q2) Exogen is made in USA & Durolane in made in Sweden. Both currently sent to centralized warehouse in south Netherlands. We are also in the process of setting up a satellite warehouse in UK to facilitate local shipping.</p> <p>Q3) Minimal impact expected – we are familiar with shipping into and</p>

	<p>out of EU. We are also in the process of setting up a satellite warehouse in UK to facilitate local shipping.</p> <p>Q4) It is possible – we would need to see the tariffs in place before making a decision on any changes needed.</p> <p>Some customers are ordering 4-10 units as buffer stock as a precautionary measure.</p> <p>Q5) It is possible – however until any impact on the exchange rate is seen, we are unable to make a firm commitment. The Trust will be notified in advance of any changes which may be necessary.</p> <p>Some customers are ordering 4-10 units as buffer stock as a precautionary measure.</p> <p>Q6) We could also store in USA</p> <p>Q7) No</p>
Genomic Health	<p>Q1) While much remains unknown about the conditions of Brexit, Genomic Health does not now foresee any direct effect on the performance of the Oncotype DX® test. The test is performed in a centralised laboratory located in California, and thus involves no flow of product across the future UK-EU border. We understand moreover that government are working to replace EU-based international aviation agreements with the US by bilateral UK-US arrangements before Brexit. Because the test does require sending a tumour block to the US via FedEx, however, a generalised air transport disruption following a 'no deal' Brexit could affect turnaround times for test results. We will of course monitor technical notices issued by government and do everything we can to avoid or minimise any effect on patients.</p> <p>Q2) United States of America.</p> <p>Q3) Government's technical notices do not mention any change in conditions of trade between the UK and the United States as a result of Brexit, and we are not otherwise aware of any. We thus do not now foresee any direct effect. Spillover effects from a general disruption of air transport and customs following a 'no deal' withdrawal could, however, affect test turnaround times.</p> <p>Q4) No</p> <p>Q5) Genomic Health does not currently plan to raise its prices for the devaluation of sterling.</p> <p>Q6) Yes, the service would theoretically be affected, as GH UK's ordering portal is hosted in France by a service provider accredited by the French health information security agency specifically for the secure hosting of health data. Current guidance from Government states, however, that 'in recognition of the unprecedented degree of alignment between the UK and EU's data protection regimes, the UK would at the point of exit continue to allow the free flow of personal data from the UK to the EU.' On this basis, we do not see an effect on our services from our data-hosting location. Genomic Health will monitor the situation and expects to be able to work around difficulties posed by any announcement from the ICO that transfer of UK personal data to the EU is no longer permitted.</p> <p>Q7) No, we do not expect any effect from EU citizens' loss of free movement rights to the UK, or British citizens' loss of the reciprocal rights.</p>

Annex C Staffing numbers affected by no deal EU exit



Trust – By EU Grouping



Annex D Key Contacts

Trust

Area	Primary Contact	Secondary Contact
Senior Responsible officer	Karen.kelly11@nhs.net	christopherleach@nhs.net
Procurement	paul.mellor1@nhs.net	
Pharmacy	emma.suggett@nhs.net	jane.elvidge@nhs.net
Medical devices	neal.shaw@nhs.net	
Interserve and support services	Darren.lowe2@nhs.net	alan.walker@summithealthcare.co.uk
Blood Services	gregorybarber@nhs.net	craig.taylor@nhs.net
Workforce	dawn.porter1@nhs.net	
IT (Terraforma)	sarah.ellis9@nhs.net	adam.thomas1@nhs.net
Fuel supplies	christopherleach@nhs.net Darren.lowe2@nhs.net	
Research and Clinical trials	claire.phillips8@nhs.net	
Potential increases in demand	gerry.fogarty@nhs.net	
Finance	chris.walker1@nhs.net	
Information Governance	Sharonwilliams2@nhs.net	

Regional and National

Contact Type	Details
Midlands region EU Exit lead	England.mids-euexit@nhs.net
Medical devices and clinical consumables	mdcccontingencyplanning@dhsc.gov.uk
Self-assessment on non-clinical consumables, goods and services	contractreview@dhsc.gov.uk
Workforce issues	WorkforceEUExit@dhsc.gov.uk
Third Health Programme grants	EU-Health-Programme@dhsc.gov.uk
Horizon 2020 grants	EUGrantsFunding@ukri.org
IMPs or clinical devices	imp@dhsc.gov.uk

Dear Sir/Madam,

As your company is a key supplier to the Trust, we would welcome your input into the effect of a No-Deal EU Exit on the continued supply of goods and services, in order that we can collectively develop mitigation plans where appropriate.

To clarify, the definition of a No-Deal Brexit is defined at Annex A.

This request is intended to gather some outline information on the areas that may be affected. A detailed response is not required at this time and therefore I would appreciate your support in getting a response back by Friday **23rd November**.

Not all questions will be relevant to your organisation but please complete those that are.

Q1) Do you feel that a no-deal Brexit would have a significant impact on your organisations ability to deliver the current goods / services to the Trust? Please explain below.

Q2) What is the Country of Origin of the products or services delivered to the Trust?

Q3) Would the service offered by your company be affected by a change in customs arrangements for delivery through UK ports?

Q4) Notwithstanding existing pricing arrangements, could the pricing offered to the Trust be affected by a change in customs tariffs between the UK and EU countries?

Q5) Notwithstanding existing pricing arrangements, would the pricing offered to the Trust be affected by a fluctuation in the value of sterling?

Q6) Would your organisations service be affected by the inability to store data in the EU?

Q7) Would the service provided be affected by a more restrictive immigration regime with the EU?

Your support in identifying risks related to a No-Deal EU Exit would be greatly appreciated and I am happy to discuss these points further by request.

Yours sincerely



Paul Mellor
Assistant Director of Procurement

Annex A

'No Deal' EU Exit Scenario

This is a 'scenario' developed at a point in time. It does not represent the actual scenario which is unknown.

The UK leaves the EU on 29 March 2019 with no withdrawal and transition agreement, and no deal on the future relationship. This would have the following impacts:

Borders

- The EU would be likely to apply third country physical checks and border procedures to items entering the EU from the UK
- This would lead to delays at borders that could disrupt and reduce the normal flow of items in and out of the UK from the EU

Regulation

- It is anticipated that **regulatory changes** could ensue under the 'No Deal' scenario
- Some regulations are expected to be transferred into English law, thereby minimising the potential impacts as far as possible

Supplier preparedness

- Suppliers will face the impacts of additional customs requirements and potential broader economic factors under this scenario
 - Supplier financial stability and resilience will depend upon their preparedness for new customs checks and their willingness to withstand short-term disruption
- Smaller / SME providers may be most vulnerable to these impacts, and could withdraw from the market

Broader Economic environment

- Fluctuations may be seen in £ values, affecting pricing and affordability of products
- Additional financial factors may be seen in the application of customs tariffs and VAT implications

Annex F Email to staff re. Pharmacy actions

FAO All Clinical Staff:

Following national and regional advice from DHSC and NHSI we would be grateful if in the coming weeks you would follow the advice below to avoid medicines shortages and ensure equity of access to medicines for all our patients at Dudley Group of Hospitals:

- Please **do NOT stockpile** additional medicines above usual stock levels. Local stockpiling is unnecessary and could cause shortages in other areas, which may put patient care at risk.
- There is no need for clinicians to write longer prescriptions.
- If asked, clinicians should reassure patients and advise that there is no need to store additional medicines at home (the Government is working with industry to ensure a continued supply of medicines from the moment we leave the EU)

Hologic customers:

Hologic deeply values our customer relationships and we strive to work in closer partnership with you. One of the immediate issues facing all European supply chains is Brexit and its impact on the ongoing supply of products, both in the U.K. and the rest of Europe. Like many other companies, in the absence of a definitive agreement between the U.K. government and the EU, Hologic has been planning for a 'Hard Brexit' outcome which could mean new tariffs and potential extra customs clearance delays between the U.K. and the rest of the EU27 countries. The Hologic team have joined several multi industry groups to ensure that our approach is both well planned and consistent to ensure ongoing supply through this potentially difficult period. Here is a summary of our preparations:

Customer Service

Hologic already has a dedicated U.K. Customer Service team based in the Manchester U.K. facility with an in depth knowledge of all U.K. customers. This team will continue to support all U.K. customers through the Brexit transition.

Manufacturing

Hologic is in the fortunate position from a Brexit standpoint that we do not manufacture any of our main product lines in EU27 countries requiring import of products from the EU27 into the U.K. Our main manufacturing locations are in the U.S. (All Divisions) , Costa Rica (Surgical products) and Manchester U.K. (Diagnostic products). The main implication of this network is that our supply chain operation can continue without fundamental changes being required for a Hard Brexit. We are taking additional steps to ensure that the supplier base for our Manchester U.K. operations have prepared for a Hard Brexit outcome.

Warehousing and Distribution

Hologic already has significant warehousing operations in Gent, Belgium and Milton Keynes, U.K. With the manufacturing base previously described this means that supply chain operations can be effectively segregated between the U.K. and the EU27 in the event of a Hard Brexit. U. K. customers will continue to receive products manufactured in the U.S., Costa Rica or Manchester which have been stored and distributed from Milton Keynes. EU27 customers will continue to be supplied products from Gent.

There are two main areas where Hologic is making extra preparations to minimize the impact of a Hard Brexit:

1. Diagnostic products manufactured in Manchester and supplied to EU27 countries. Twelve weeks forward stock will be built in Gent ahead of March 29th 2019 to mitigate the risk of delays shipping products between the U.K and the EU27 countries after a Hard Brexit until ongoing trading relationships are established and stabilized.
2. Spare parts to repair critical instrument breakdowns. At present some parts are sourced from Gent to repair machines in the U.K. We will change this so that all critical parts will be held in the U.K. to repair critical instrument breakdowns ahead of March 29th 2019 so that the current repair service offered by Hologic is uninterrupted.

Hologic will continue to work closely with you to ensure that there are no supply chain interruptions associated with a Hard Brexit.

Please feel free to contact me directly with any further questions that you have:

Best regards

Mark Ewing
Supply Chain Director – International
Hologic

Annex H on call rota

Mar-19			Apr-19			May-19		
Date	Manager on call	Director on call	Date	Manager on call	Director on call	Date	Manager on call	Director on call
Fri 1	Mitchell Fernandez	Tom Jackson	Mon 1	Jenny Bree	Andrew McMenemy	Wed 1	Karen Anderson	
Sat 2	Mitchell Fernandez	Julian Hobbs	Tue 2	Jenny Bree	Andrew McMenemy	Thu 2	Karen Anderson	
Sun 3	Mitchell Fernandez	Tom Jackson	Wed 3	Chris Darby	Andrew McMenemy	Fri 3	Manjinder Palak	
Mon 4	Gerry Fogarty	Karen Kelly	Thu 4	Chris Darby	Andrew McMenemy	Sat 4	Manjinder Palak	
Tue 5	Gerry Fogarty	Karen Kelly	Fri 5	Julie Pain	Andrew McMenemy	Sun 5	Manjinder Palak	
Wed 6	Karen Hanson	Karen Kelly	Sat 6	Julie Pain	Andrew McMenemy	Mon 6	Mitchell Fernandez	
Thu 7	Jenny Bree	Karen Kelly	Sun 7	Julie Pain	Andrew McMenemy	Tues 7	Mitchell Fernandez	
Fri 8	Ned Hobbs	Karen Kelly	Mon 8	Lesley Leddington		Wed 8	Ned Hobbs	
Sat 9	Ned Hobbs	Karen Kelly	Tues 9	Lesley Leddington		Thu 9	Ned Hobbs	
Sun 10	Lesley Leddington/Ned Hobbs	Karen Kelly	Wed 10	Anita Cupper		Fri 10	Greg Marson	
Mon 11	Greg Marson	Karen Kelly	Thu 11	Chris Darby		Sat 11	Greg Marson	
Tues 12	Greg Marson	Natalie Younes	Fri 12	Jo Wakeman		Sun 12	Greg Marson	
Wed 13	Chris Leach	Natalie Younes	Sat 13	Jo Wakeman		Mon 13	Chris Leach	
Thu 14	Chris Leach	Karen Kelly	Sun 14	Jo Wakeman		Tue 14	Chris Leach	
Fri 15	Karen Hanson	Karen Kelly	Mon 15	Julie Pain		Wed 15	Karen Hanson	
Sat 16	Karen Hanson	Karen Kelly	Tue 16	Karen Anderson		Thu 16	Karen Hanson	
Sun 17	Karen Hanson	Karen Kelly	Wed 17	Chris Darby		Fri 17	Gerry Fogarty	
Mon 18	Chris Darby	Julian Hobbs	Thu 18	Jill Faulkner		Sat 18	Gerry Fogarty	
Tue 19	Chris Darby	Julian Hobbs	Fri 19	EGreg Marson		Sun 19	Gerry Fogarty	
Wed 20	Gerry Fogarty	Julian Hobbs	Sat 20	AGreg Marson		Mon 20	Carol Love-Mecrow	
Thu 21	Gerry Fogarty	Julian Hobbs	Sun 21	SJo Wakeman		Tue 21	Carol Love-Mecrow	
Fri 22	Carol Love-Mecrow	Julian Hobbs	Mon 22	T		Wed 22	Anne-Marie Williams	
Sat 23	Carol Love-Mecrow	Julian Hobbs	Tue 23	ECarol Love-Mecrow		Thu 23	Anne-Marie Williams	
Sun 24	Carol Love-Mecrow	Julian Hobbs	Wed 24	RChris Leach		Fri 24	Jill Faulkner	
Mon 25	Jill Faulkner	Natalie Younes	Thu 25	Anne-Marie Williams		Sat 25	Jill Faulkner	
Tue 26	Jill Faulkner	Natalie Younes	Fri 26	Jenny Bree		Sun 26	Jill Faulkner	
Wed 27	Jill Faulkner	Natalie Younes	Sat 27			Mon 27	Jenny Bree	
Thu 28	Jill Faulkner	Natalie Younes	Sun 28	Ned Hobbs		Tues 28	Jenny Bree	
Fri 29	Anne-Marie Williams	Natalie Younes	Mon 29	Johanne Newens		Wed 29	Anita Cupper	
Sat 30	Anne-Marie Williams	Natalie Younes	Tues 30	Johanne Newens		Thu 30	Chris Darby	
Sun 31	Anne-Marie Williams	Natalie Younes				Fri 31	Lesley Leddington	

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

During the development or review of the Strategy, consideration must be given to the actual or potential impact on equality. Due care is given to ensure that they do not contravene the article of the Human Rights Act or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, disability, sex, race, religion or belief, gender reassignment, marriage or civil partnership, pregnancy or maternity.

[illegible]

Check List

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Prior to submission of the Strategy please ensure you can answer yes to all of the questions below.

	Yes/No
1. Title	
Is the title clear and unambiguous?	Y
2. Front Sheet Completion	
Is the colour banding strip purple?	Y
Is the Author identified (name and designation)?	Y
Is the Director Lead identified?	Y
Is the target audience identified?	Y
Is the document version controlled?	Y
Have the people contributing to the document been identified on the Front cover Sheet as per designation and not individual names?	Y
Have the CQC registration requirement outcomes been recorded?	Y
Have relevant documents/legislation standards been recorded if applicable?	Y
Have the identified contributors been documented?	Y
Has the change history been fully completed?	Y
3. Body of the document	
Has the contents page been fully completed and the numbering reflects the document content pages?	Y
Is there a footer on each page recording; document title, date of issue, version number, page number and total number of pages?	Y
Is the document written in Arial 12pt font?	Y
Does the document contain individual designations and NOT names?	Y
Does the numbering run in sequence?	Y
Does the document follow trust format of; Introduction, Statement of Intent/Purpose, Definitions, Process, Training/Support, Monitoring, Equality and References for the main body?	Y
The meaning for any definitions or abbreviations used is clearly stated?	Y
Is there identified training or support which includes the process for follow up of non-compliance clearly cited?	Y
Are procedural documents relating/supporting this document hyperlinked?	Y
Is the table for Monitoring Compliance fully completed?	Y
Are references cited in full and comply with the Harvard referencing?	Y
Does the document require changes to clinical documentation?	Y
If yes, has the digital Trust Clinical Approvals Group been informed?	Y
4. Consultation	
Is the consultation form completed?	Y
If the document includes prescribing or administering of medicines, has pharmacy been consulted?	Y
Has the Director Lead been consulted and accepted the document?	Y

NO DEAL EU EXIT RESPONSE POLICY	DOCUMENT TITLE:	No Deal EU Exit Response Policy
	Name of Originator/Author /Designation & Specialty:	Christopher Leach, Emergency Planning Manager
	Director Lead:	Karen Kelly, Chief Operating Officer and SRO for Brexit
	Target Audience:	All Staff
	Version:	1.0
	Date of Final Ratification	
	Name of Ratifying Committee	
	Review Date:	
	Registration Requirements Outcome Number(s) (CQC)	Safe Effective Well Led
	Relevant Documents /Legislation/Standards	Dudley Group NHS FT EU EXIT Resilience Strategy Dudley Group NHS FT Business Continuity Plan Policy Individual Service Level Business Continuity Plans Trust Business Impact Analysis Civil Contingencies Act 2004 ISO 22301:2012 Government Guidance EU Exit
	Contributors: <i>Individuals involved in developing the document.</i>	Designation: Megan Higgs, Emergency Planning and Capacity Administrator Joseph Webb, Emergency Planning Apprentice
The electronic version of this document is the definitive version		

CHANGE HISTORY

Version	Date	Reason
1.0	March 2019	New Document

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

THIS DOCUMENT WILL ONLY BE ENACTED IN THE EVENT OF A NO DEAL EU EXIT AND MUST BE USED IN CONJUNCTION WITH OTHER RELEVANT PLANS I.E. BUSINESS CONTINUITY PLAN POLICY, SURGE AND ESCALATION POLICY

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THE DUDLEY GROUP NHS FOUNDATION TRUST

NO DEAL EU EXIT RESPONSE POLICY

1. INTRODUCTION

The UK is scheduled to leave the European Union at **12th May 2019**

Due to current political actions there is a risk of a No Deal Exit on this date, please refer to the No Deal EU Exit Strategy for full impact analysis

The trust has undertaken risk assessments of potential at risk areas

- Reciprocal healthcare arrangements
- Clinical and Non Clinical Consumables
- Medications Supply
- Medical devices including upkeep and spare parts
- Interserve and support services, there supply chain and staffing
- Blood, Blood components, organs, tissues and cells
- Staffing those of EU nationality potentially leaving the UK
- IT and Information Governance, flows of information to and from the EU
- Fuel supply
- Research and Clinical trials
- Surge and Escalation

This could potentially cause the following impacts on the trust:

- Disruption to supply chains and key consumables used by the organisation
- Inability to provide care/ routine appointments to patients
- Potential issues for staff accessing work (fuel)
- Potential staff shortages

As such this incident would be categorised as a Business Continuity Incident, which the trust has established processes in place for, see Business Continuity Plan Policy for full details

Due to plans already being developed and embedded within the organisation the decision would be that these would be used by staff and commanders to respond to a negative impacts as a result of No Deal EU exit, however due to the complexities of this style of incident it will be supported by a reporting and escalation process to allow the trust to pass key critical information to the National EU Exit team as indicated in this document.

2. STATEMENT OF INTENT/PURPOSE

This document will only be enacted in the event of a **no-deal** EU exit. Due to the rapidly developing guidance in relation to no-deal EU exit from Department of Health and Social Care this document will be updated regularly

Preparations detailed in this document are being made in readiness for the **12th May 2019** departure date

Aim

To define the response and reporting arrangements for the trust in the event of a no deal EU exit

Objectives

- To indicate response arrangements for the trust in the event of a no deal EU exit
- To indicate reporting arrangements for the trust in the event of a no deal EU exit

3. DEFINITIONS

Acronym	Definition
DHSC	Department of Health and Social Care
EU Exit or Brexit	The UK process of exiting the EU
EU	European Union
ISO	International Standard
MHRA	Medicines and Healthcare products Regulatory Agency
IVDR	In Vitro Diagnostic Regulations
HMr	Human Medical Regulations
MDr	Medical Devices Regulations

4. RESPONSIBILITIES

4.1 Chief Executive

Has overall responsibility for EPRR including Business Continuity

Responsible for ensuring:

- The trust has required plans and arrangements in place
- The Board receives regular updates on EPRR
- That appropriate resources are made available to facilitate these responsibilities
- That board level responsibility for EPRR is clearly defined with clear lines of accountability through the organisation leading to the Board

The Chief Executive may designate these responsibilities to a Trust Accountable Emergency Officer (AEO), for the trust this is the Chief Operating Officer (COO)

4.2 Chief Operating Officer (COO)

The Chief Operating Officer is delegated Executive responsibility for EPRR and Business Continuity, for the purpose of No Deal EU exit the COO also takes the responsibility of Senior Responsible Officer (SRO) for No Deal EU exit

4.3 Emergency Planning Manager

Responsible for ensuring:

- The trust has appropriate response and recovery plans in place for No Deal EU Exit
- Ensure a rota is in place for No Deal EU Exit for full activation of an Incident Management Team (IMT)
- Ensure the trust has a full risk assessment process in place for No Deal EU Exit (No Deal EU Exit Strategy)
- To develop a process to ensure reporting is completed for the trust
- Provide EPRR and Business Continuity specific advice as requested in relation to no deal EU Exit

4.4 Control Room Manager

Responsible for ensuring

- Daily returns are completed for NHS England
- Provide as the conduit for escalations from departments into the IMT
- Act as the daily point of contact for EU Exit related queries

They will be in place Monday-Friday only

4.5 Service Area Leads

These will be daily points of contact for the relevant departments listed below:

- Procurement
- Pharmacy
- Medical devices
- Interserve and support services
- Trust Estates
- Blood, Blood components, organs, tissues and cells
- Workforce
- IT
- Information Governance
- Research and Clinical trials
- Capacity

They will be responsible for escalations to the control room manager throughout the day as required and for attending the Incident Control Centre as requested

4.6 All Staff

Responsible for ensuring:

- Familiarisation with all relevant EPRR arrangements and plans
- Provide timely escalation through pre-approved routes for identified issues related to no deal EU exit
- Provide a response as part of a structured trust response to a no deal EU exit

5. REPORTING

The trust is expected to complete daily reporting to NHS England

This will commence on the **21st March 2019** and will run for the foreseeable future

There is currently no request for weekend or overnight reporting, however if this changes the process will be updated, there is currently no indication of reporting requirements for Bank Holiday periods

On Mondays an additional report is required, this is in relation to Workforce and Reciprocal healthcare and must be provided to the DHSC system by 1700 each Monday

Timetable for daily reporting

Time	Action
1200	Control Room Manager to send reminder to preapproved contacts for completion of sitrep for a 1630 submission to the incident mailbox dgft.incidentresponse@nhs.net
1600	Responses due from all key areas back to the Incident Response Mailbox
1600-1645	Control Room Manager as required to chase missing returns
1645	SRO or deputy, escalation of those areas that are missing and/or request for approval of daily submission
1645-1700	Submission of daily return

Note: Friday submission will require a forward 72 hour look to account for weekend

Control Room Manager (Responsible for Daily Reporting Submission)

The trust has identified key individuals to perform the daily submission; these have access to the submission system:

- Christopher Leach- Emergency Planning Manager
- Julie Gardiner- Transformation Specialist
- Megan Higgs- Emergency Planning and Capacity Administrator

5.1 Control Room Manager Rota

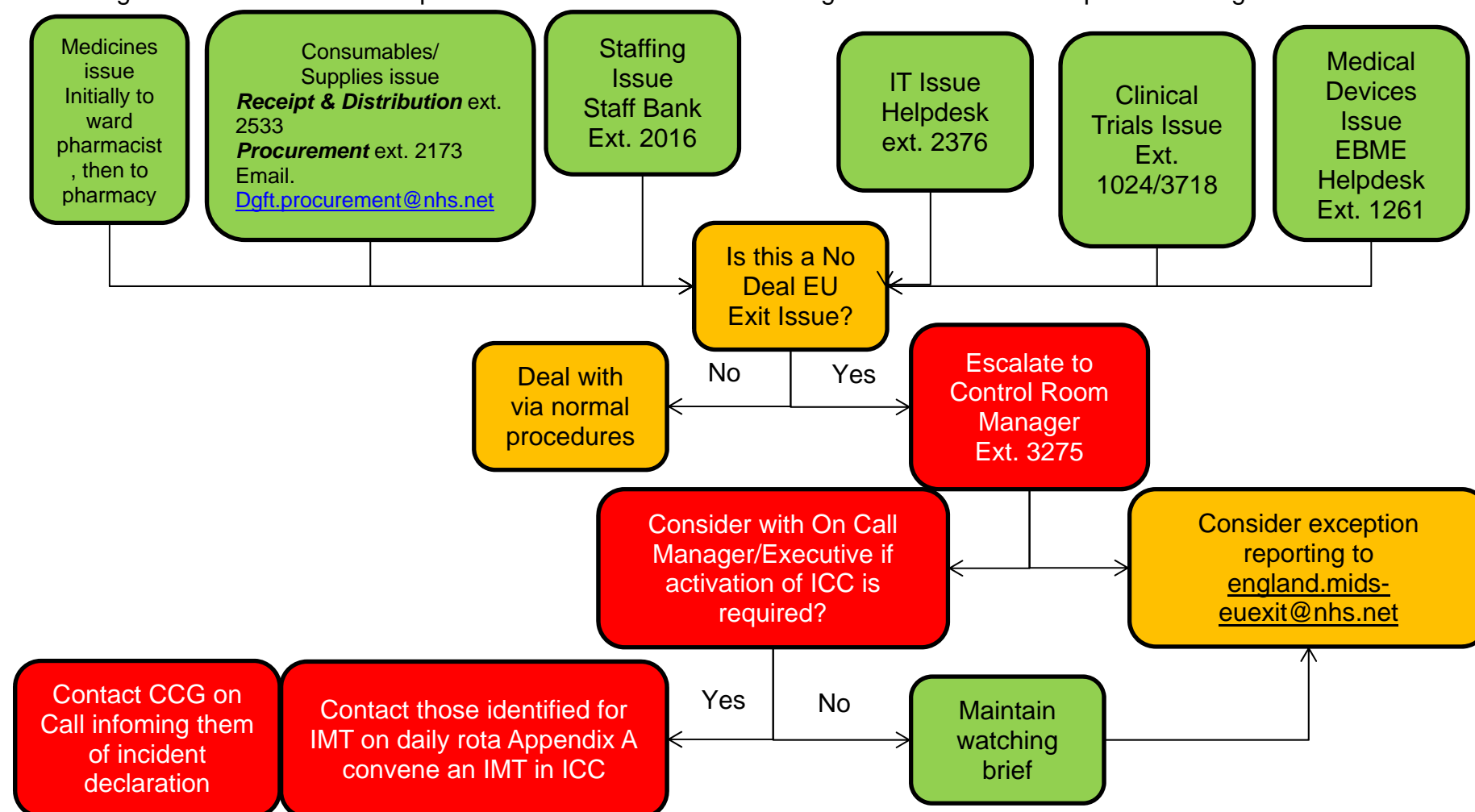
Month	Date	Day	Control Room Manager
March	25th	Monday	Chris Leach
	26th	Tuesday	Chris Leach
	27th	Wednesday	Chris Leach
	28th	Thursday	Julie Gardiner
	29th	Friday	Julie Gardiner
April	1st	Monday	Julie Gardiner
	2nd	Tuesday	Julie Gardiner
	3rd	Wednesday	Megan Higgs
	4th	Thursday	Megan Higgs
	5th	Friday	Megan Higgs
	8th	Monday	Megan Higgs
	9th	Tuesday	Megan Higgs
	10th	Wednesday	Chris Leach
	11th	Thursday	Chris Leach
	12th	Friday	Chris Leach
	15th	Monday	Julie Gardiner
	16th	Tuesday	Julie Gardiner
	17th	Wednesday	Megan Higgs
	18th	Thursday	Megan Higgs
	19th	Friday	BANK HOLIDAY REPORTING UNKNOWN
	22nd	Monday	BANK HOLIDAY REPORTING UNKNOWN
	23rd	Tuesday	Chris Leach
	24th	Wednesday	Chris Leach
	25th	Thursday	Julie Gardiner

	26th	Friday	Julie Gardiner
	29th	Monday	Megan Higgs
	30th	Tuesday	Megan Higgs
May	1st	Wednesday	Chris Leach
	2nd	Thursday	Chris Leach
	3rd	Friday	Megan Higgs
	6th	Monday	BANK HOLIDAY REPORTING UNKNOWN
	7th	Tuesday	Julie Gardiner
	8th	Wednesday	Julie Gardiner
	9th	Thursday	Megan Higgs
	10th	Friday	Megan Higgs
	13th	Monday	Julie Gardiner
	14th	Tuesday	Julie Gardiner
	15th	Wednesday	Chris Leach
	16th	Thursday	Chris Leach
	17th	Friday	Julie Gardiner
	20th	Monday	Chris Leach
	21st	Tuesday	Chris Leach
	22nd	Wednesday	Chris Leach
	23rd	Thursday	Megan Higgs
	24th	Friday	Megan Higgs
	27th	Monday	BANK HOLIDAY REPORTING UNKNOWN
	28th	Tuesday	Megan Higgs
	29th	Wednesday	Megan Higgs
	30th	Thursday	Julie Gardiner
	31st	Friday	Julie Gardiner
June	3rd	Monday	Julie Gardiner
	4th	Tuesday	Julie Gardiner
	5th	Wednesday	Julie Gardiner

	6th	Thursday	Chris Leach
	7th	Friday	Chris Leach
	10th	Monday	Chris Leach
	11th	Tuesday	Chris Leach
	12th	Wednesday	Chris Leach
	13th	Thursday	Megan Higgs
	14th	Friday	Megan Higgs
	17th	Monday	Megan Higgs
	18th	Tuesday	Megan Higgs
	19th	Wednesday	Megan Higgs
	20th	Thursday	Julie Gardiner
	21st	Friday	Julie Gardiner
	24th	Monday	Julie Gardiner
	25th	Tuesday	Julie Gardiner
	26th	Wednesday	Chris Leach
	27th	Thursday	Chris Leach
	28th	Friday	Megan Higgs

6. TRUST INCIDENT ESCALATION

The Control Room Manager will be the daily (Monday-Friday) point of contact for No Deal EU exit; information will flow through the organization as indicated in Fig 1, staff will be expected to escalate concerns into the area responsible for that service, the services will then determine if escalation is required to the Control Room manager, who will then determine with the On Call Manager/Executive if an IMT requires establishment and/or if the regional EU exit team require informing



7. INCIDENT CONTROL CENTRE

The ICC will be established in two parts

From the **12th May 2019** a point within the trust Tactical Control Room (Capacity Hub) will be established this will be where the daily Control Room Manager and Control Room Officer will be based.

They will have access to the designated incident control email address and dedicated Brexit phone line

Email: dgft.incidentresponse@nhs.net

Extension: 3275

Staff escalations will be expected to go to the department for which the impact is being felt i.e. Clinical Consumable shortage to procurement, this department will then determine if escalation is required to the Control Room Manager.

If required the Control Room Manager will contact the on call Manager/Executive and inform them of the need to fully open the ICC, performing a dynamic risk assessment determining if this is required,

If required the Control Room Manager will enact this by contacting those indicated on the EU exit rota asking them to attend immediately a meeting within the control room

Teleconference facilities

In line with the EPRR framework in the event of an Business Continuity Incident being declared we would form part of the a Health Economy Response, if teleconferences are required to discuss actions required, the trust has access to its own teleconference facilities which can be utilized

Contact Number: 020 3651 8923

Chairperson (Control Room Manager) Code: 63537665#

Participant Code: 71664425#

If the Chair person(Director On-Call) needs to confer without the participants - Press * 5 to mute/ to rejoin the conference - Press *5 again

If there are any difficulties with the conference - Press * 0 for the conference assistant who will help.

Dynamic Risk Assessment

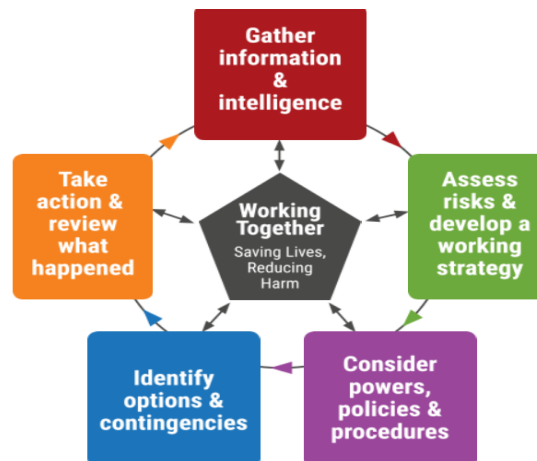
When notified the on call Manager and Executive must conduct a Dynamic Risk Assessment this is also to be used throughout the response process

Step 1	Look for Hazards, identification stage
Step 2	Decide who may be harmed and how?
Step 3	Evaluate the risk, consider any pre-existing controls or is this

	a new risk?
Step 4	Ensure your findings are logged and recorded
Step 5	Take Action and review what happened

Joint Decision Making Model (JDMM)

Commanders will then be expected to utilize the Joint Decision Making Model to ensure that they are making fully defensible decisions.



Further details available: <https://www.iesip.org.uk/joint-decision-model>

All meetings within the hub will be suspended and the Incident Control Room will be fully established as per standing arrangements

The trust will follow the designated command and control structure within the Business Continuity plan of Strategic (Gold), Tactical (Silver) and Operational (Bronze)

8. WEEKLY UPDATE MEETINGS

In order to ensure a full situational awareness is maintained in support of the Control Room Facilities being established for Monday-Friday 9-5 assistance, in addition weekly meetings will be held in the Incident Control Room to allow all departments to update on any potential impacts as well as to allow actions to be allocated, this will be chaired by the Control Room Manager and a representative from each of the areas will be expected to attend (see Appendix 6 for standing Agenda)

The meetings will be held weekly on **Mondays from 1400-1500**

This is subject to change and the Control Room Manager would communicate changes as appropriate to the SPOC for each department

9. INCIDENT MANAGEMENT TEAM

The Incident Management team will comprise of (as a minimum):

- Tactical (Silver) Commander- Manager on Call
- Loggist
- Control Room Manager for the day
- Control Room Officer
- The Department Single Point of Contact (SPOC) for areas that are affected
- Trust Communications Team
- Clinical Site Coordinator or Site Operations Team lead

If required Strategic (Gold) can be enacted also in the Chief Executive's office, this will comprise of the (as a minimum):

- Strategic (Gold) Commander- Executive on Call
- Loggist
- Trust Communications Team
- Other executives as necessary

10. PRIORITIZATION OF SERVICES

In the event of a no deal EU exit adversely affecting supply chains it may be necessary for the trust to consider prioritisation of key services and cancellation of non-critical services to protect those that are critical, as per Business Continuity planning the critical services identified are:

1. Emergency/ED& Acute care
2. EMCs
3. Cancer
4. Routine Electives
5. Outpatients

Services would be expected to be `scaled back` in line with this priority list ensuring that patients care is first and foremost in manager/clinicians decision making process.

The Trust Business Continuity Plans indicate how incidents as a result of disruptive events should be managed/run and this would need to be used by commanders, in addition the predicted surge that may result as the consequence of a no deal EU exit can be managed by utilisation of the Trusts Surge and Escalation plan

11. NATIONAL/REGIONAL RESPONSE

The NHS now has an established National Operational Response Centre. This will take overall strategic command in responding to any disruption to delivery of health and care services in England that may be caused or affected by EU exit.

The Operational Response Centre will co-ordinate EU exit related information flows and reporting across the health and care system. The Operational

Response Centre will also work with the devolved administrations to respond to UK-wide incidents.

The Operational Response Centre has been established to support the health and care system to respond to any disruption, and will not bypass existing local and regional reporting structures.

Working closely with the Operational Response Centre, NHS England and Improvement will also establish an Operational Support Structure for EU Exit. This will operate at national, regional and local levels to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required.

Contact details for the Midlands region EU Exit lead is below:

England.mids-euexit@nhs.net

NHS providers and commissioners will be supported by local NHS teams to resolve issues caused or affected by EU exit as close to the frontline as possible. These issues will be escalated to regional level, as required. Where issues are impacting across the health and care system at a national level, the Operational Response Centre will co-ordinate information flows and responses.

Escalation levels

A series of escalation levels has been determined by NHS England for the response to a No Deal EU Exit, they follow the national EPRR levels in structure.

The trust must be aware of these levels and be able to determine where they are in the escalation criteria

<ul style="list-style-type: none"> • EU Exit Level One • Limited Impact 	<ul style="list-style-type: none"> • Patients are maintained on the same care pathway • Issue is localised and has a short expected duration • Solutions are available with the same clinical indication • Solutions are available within the organisation, or within the local health and care system
<ul style="list-style-type: none"> • EU Exit Level Two • Moderate Impact 	<ul style="list-style-type: none"> • May result in impaired clinical outcome • Solution will require new skills, procedures or training to be implemented • Duration longer than short-expected • Issue is occurring at multiple sites, or across multiple geographical areas • The trajectory suggests escalation to L3 may follow • EU Exit Co-ordination Centre (Regional & National) to provide leadership with SME support
<ul style="list-style-type: none"> • EU Exit Level Three • Significant Impact 	<ul style="list-style-type: none"> • Potentially significant patient safety implications • No or limited alternatives can secure same outcome • No immediate solutions available without significant change to skills, training or procedures. • Multiple concurrent incidents occurring across multiple organisations wider geographical area. • Identified solutions cannot be sustained for likely duration of incident. • EU Exit IMT(N) established and incident declared.
<ul style="list-style-type: none"> • EU Exit Level Four • Critical Impact 	<ul style="list-style-type: none"> • Critical implications for patients and vulnerable populations. • No viable alternatives exist after exhaustion of all other escalation levels • Life-threatening or life-changing impact on patients and/or ethical implications for clinicians • Multiple concurrent incidents occurring nationally. • EU Exit Strategic Commander to provide strategic leadership, supported by NHS England Incident Response arrangements (in line with IRP(N))

12. TRAINING/SUPPORT

Relevant staff within this document receives relevant training in Business Continuity Response

13. PROCESS FOR MONITORING COMPLIANCE

Monitoring of Compliance Chart

Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
EPM	EPRR Group	Quarterly	CQPSE	EPM	EPRR group
Control Room Manager	Daily Sitrep	Daily	NHS E EU Exit	Control Room Manager	EU Exit Group

14. EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

15. REFERENCES

- NHS England advice <https://www.england.nhs.uk/eu-exit/>
- operational NHS guidance for no deal eu exit <https://www.gov.uk/government/publications/brexit-operational-readiness-guidance-for-the-health-and-social-care-system-in-england>
- medical devices and consumables advice <https://improvement.nhs.uk/resources/eu-exit-actions-medical-devices-and-clinical-consumables/>
- nhs workforce advice <https://www.nhsemployers.org/your-workforce/need-to-know/brexit-and-the-nhs-eu-workforce/frequently-asked-questions>

Appendix 1 Daily Rota

Appendix 2 Daily Return Persons Responsible

Area	Name	Email	Contact
Medicine	Anita Cupper	anita.cupper@nhs.net	3366
	Johanne Newens	johanne.newens@nhs.net	5444
	Karen Hanson	karen.hanson2@nhs.net	5444
Surgery (Paediatrics/Neonates)	Anjali Dave	anjali.dave@nhs.net	3339
	Karen Anderson	karen.anderson12@nhs.net	1278
Surgery (Critical Care)	Lesley Leddington	l.leddington@nhs.net	2165
	Lesley Smith	lisa.smith158@nhs.net	
Surgery (Maternity)	Dawn Lewis	dawnlewis@nhs.net	1513
	Claire Macdiarmid	c.macdiarmid@nhs.net	1590
Surgery (Trauma Care)	Josh Raden	joshuaraden@nhs.net	
	Lesley Leddington	l.leddington@nhs.net	2165
Surgery (Emergency Surgery)	Mandeep Chana	mandeep.chana3@nhs.net	3400
	Lesley Leddington	l.leddington@nhs.net	2165
Surgery (Service suspension)	Manjinder Palak	mpalak@nhs.net	5804
	Ned Hobbs	ned.hobbs@nhs.net	2207
Clinical Support Services	Anne- Marie Williams	anne-marie.williams1@nhs.net	2462
	Chris Darby	chris.darby2@nhs.net	
Pharmacy	Jane Elvidge	jane.elvidge@nhs.net	2008
	Danielle Stacey	danielle.stacey@nhs.net	
Information Governance	Sharon Williams	sharonwilliams2@nhs.net	1208
	Gilbert George	Gilbert.george3@nhs.net	
	Tom Jackson	tom.jackson6@nhs.net	
Procurement	Paul Mellor	paul.mellor1@nhs.net	2287
	Claire Parsons	Claire.parsons14@nhs.net	
Medical Devices	Neal Shaw	neal.shaw@nhs.net	3555
	Nick Boseley	nick.boseley@nhs.net	
Blood and Transplants	Craig Taylor	craig.taylor@nhs.net	2490
	Gregg Barber	Gregg.barber1@nhs.net	
Clinical Trials	Claire Philips	Claire.philips8@nhs.net	
	Jacqueline Smith	jacqueline.smith13@nhs.net	3707
Workforce	Marcia Hylton	marciahylton@nhs.net	
	Dawn Porter	Dawn.porter1@nhs.net	
Site Operations	Gerry Fogarty	Gerry.fogarty@nhs.net	
	Gregg Marson	g.marson@nhs.net	
	Chris Leach	Christopher.leach@nhs.net	
Communications	Jackie Dietrich	jackie.dietrich@nhs.net	1314
	Liz Abbiss	liz.abbiss@nhs.net	1013
Governance	Sharon Phillips	s.phillips6@nhs.net	1089
	Natalie Smith	natalie.smith23@nhs.net	1203
Reciprocal Healthcare (Monday only)	Heather Taylor	heather.taylor1@nhs.net	
	Lynn Hinton	lynn.hinton@nhs.net	

Appendix 3 Key Contact Information

Role	Contact Number	Email Address
Control Room Manager	Ext. 3275	Dgft.incidentresponse@nhs.net
Regional EU Exit Team	N/A	england.mids-euexit@nhs.net
SRO- Karen Kelly	Ext. 1112	Karen.kelly11@nhs.net
Emergency Planning- Chris Leach	Ext. 2614	Christopherleach@nhs.net
Procurement Escalations- Receipt and Distribution	Ext. 2533	Dgft.procurement@nhs.net
Procurement Escalations- Procurement	Ext. 2173	
Workforce Escalations – Staff Bank	Ext. 2016	
IT Escalations- Helpdesk	Ext. 2376	
Clinical Trials Escalations	Ext. 1024/3718	
Medical Device Escalations- EBME Helpdesk	Ext. 1261	
Caroline Brunt- SRO for Dudley CCG		

Appendix 4 All Staff Poster



No deal EU exit may occur on the 29th March 2019. This means that the UK may leave the EU without a structured deal. This may have a variety of impacts on the Trust including a reduced flow of supplies into the organisation, which may include medications.

The no deal EU Exit planning team for the Trust has devised this poster with a series of frequently asked questions to ensure you know who to speak to, should you identify an issue in your area.

What is Brexit?	Brexit is short for "British exit" - and is the word people use to talk about the United Kingdom's decision to leave the European Union.
What is a "no deal"?	"No deal" means the UK would have failed to agree a withdrawal agreement. That would mean there would be no transition period after the UK leaves, and EU laws would stop applying to the UK immediately.
How does that affect the Trust?	Potentially key areas a no deal could impact include: <ul style="list-style-type: none"> • Medications • Key consumables and medical supplies • Medical devices (spares and servicing) • Lack of medications could cause more patients attending the hospital leading to a surge • Staffing shortages
Who do I speak to if I have a medicines issue?	Speak to your ward pharmacist who will be able to advise you and escalate if necessary.
Who do I speak to if I am short of supplies and/or consumables?	Email drft.procurement@nhs.net Contact Receipt & Distribution Ext. 2533 or Procurement Ext. 2173
What do I do if I identify a staffing shortage/issue?	Speak to the matron dealing with staffing initially. If this is not possible, please contact the Staff Bank ext. 2016.
What if I have an IT issue?	Raise this with the IT helpdesk ext. 2376.
Who do I speak to if I have an issue with a patient on a clinical trial?	Speak to Clinical Research ext. 1024/3718 who will be able to assist you.
What if I identify a problem with a medical device?	Contact the EBME Helpdesk ext. 1261.

PLEASE NOTE THIS IS ONLY FOR ISSUES PERTAINING TO **NO DEAL** EU EXIT
PLEASE USE EXISTING ARRANGEMENTS FOR ESCALATION IF REQUIRED

Appendix 5 Action Cards

Action Card Number	Role
1	Control Room Manager
2	Single Point of Contact
3	Clinical Site Coordinator/Site Team

ACTION CARD 1

NO DEAL EU EXIT

CONTROL ROOM MANAGER

Number	Action								
1.	<p>Complete daily sitrep to NHS England</p> <ol style="list-style-type: none"> 1. Send 1200 reminder to all members via distribution list 2. Reminder at 1500 of submission time of 1600 3. 1600 chase any missing returns 4. Gain executive sign off via SRO or designated deputy 5. Submit by 1700 								
2.	Chair weekly update meetings in capacity hub on a Monday from 1400-1500 use Appendix 6 for standing Agenda								
3.	If required escalate to Manager/Executive on call the need to full establish the ICC								
4.	<p>Consider national escalation levels</p> <table border="1"> <tr> <td> <ul style="list-style-type: none"> • EU Exit Level One • Limited Impact </td><td> <ul style="list-style-type: none"> • Patients are maintained on the same care pathway • Issue is localised and has a short expected duration • Solutions are available with the same clinical indication • Solutions are available within the organisation, or within the local health and care system </td></tr> <tr> <td> <ul style="list-style-type: none"> • EU Exit Level Two • Moderate Impact </td><td> <ul style="list-style-type: none"> • May result in impaired clinical outcome • Solution will require new skills, procedures or training to be implemented • Duration longer than short-expected • Issue is occurring at multiple sites, or across multiple geographical areas • The trajectory suggests escalation to L3 may follow • EU Exit Co-ordination Centre (Regional & National) to provide leadership with SME support </td></tr> <tr> <td> <ul style="list-style-type: none"> • EU Exit Level Three • Significant Impact </td><td> <ul style="list-style-type: none"> • Potentially significant patient safety implications • No or limited alternatives can secure same outcome • No immediate solutions available without significant change to skills, training or procedures. • Multiple concurrent incidents occurring across multiple organisations wider geographical area. • Identified solutions cannot be sustained for likely duration of incident. • EU Exit IMT(N) established and incident declared. </td></tr> <tr> <td> <ul style="list-style-type: none"> • EU Exit Level Four • Critical Impact </td><td> <ul style="list-style-type: none"> • Critical implications for patients and vulnerable populations. • No viable alternatives exist after exhaustion of all other escalation levels • Life-threatening or life-changing impact on patients and/or ethical implications for clinicians • Multiple concurrent incidents occurring nationally. • EU Exit Strategic Commander to provide strategic leadership, supported by NHS England Incident Response arrangements (in line with IRP(N)) </td></tr> </table>	<ul style="list-style-type: none"> • EU Exit Level One • Limited Impact 	<ul style="list-style-type: none"> • Patients are maintained on the same care pathway • Issue is localised and has a short expected duration • Solutions are available with the same clinical indication • Solutions are available within the organisation, or within the local health and care system 	<ul style="list-style-type: none"> • EU Exit Level Two • Moderate Impact 	<ul style="list-style-type: none"> • May result in impaired clinical outcome • Solution will require new skills, procedures or training to be implemented • Duration longer than short-expected • Issue is occurring at multiple sites, or across multiple geographical areas • The trajectory suggests escalation to L3 may follow • EU Exit Co-ordination Centre (Regional & National) to provide leadership with SME support 	<ul style="list-style-type: none"> • EU Exit Level Three • Significant Impact 	<ul style="list-style-type: none"> • Potentially significant patient safety implications • No or limited alternatives can secure same outcome • No immediate solutions available without significant change to skills, training or procedures. • Multiple concurrent incidents occurring across multiple organisations wider geographical area. • Identified solutions cannot be sustained for likely duration of incident. • EU Exit IMT(N) established and incident declared. 	<ul style="list-style-type: none"> • EU Exit Level Four • Critical Impact 	<ul style="list-style-type: none"> • Critical implications for patients and vulnerable populations. • No viable alternatives exist after exhaustion of all other escalation levels • Life-threatening or life-changing impact on patients and/or ethical implications for clinicians • Multiple concurrent incidents occurring nationally. • EU Exit Strategic Commander to provide strategic leadership, supported by NHS England Incident Response arrangements (in line with IRP(N))
<ul style="list-style-type: none"> • EU Exit Level One • Limited Impact 	<ul style="list-style-type: none"> • Patients are maintained on the same care pathway • Issue is localised and has a short expected duration • Solutions are available with the same clinical indication • Solutions are available within the organisation, or within the local health and care system 								
<ul style="list-style-type: none"> • EU Exit Level Two • Moderate Impact 	<ul style="list-style-type: none"> • May result in impaired clinical outcome • Solution will require new skills, procedures or training to be implemented • Duration longer than short-expected • Issue is occurring at multiple sites, or across multiple geographical areas • The trajectory suggests escalation to L3 may follow • EU Exit Co-ordination Centre (Regional & National) to provide leadership with SME support 								
<ul style="list-style-type: none"> • EU Exit Level Three • Significant Impact 	<ul style="list-style-type: none"> • Potentially significant patient safety implications • No or limited alternatives can secure same outcome • No immediate solutions available without significant change to skills, training or procedures. • Multiple concurrent incidents occurring across multiple organisations wider geographical area. • Identified solutions cannot be sustained for likely duration of incident. • EU Exit IMT(N) established and incident declared. 								
<ul style="list-style-type: none"> • EU Exit Level Four • Critical Impact 	<ul style="list-style-type: none"> • Critical implications for patients and vulnerable populations. • No viable alternatives exist after exhaustion of all other escalation levels • Life-threatening or life-changing impact on patients and/or ethical implications for clinicians • Multiple concurrent incidents occurring nationally. • EU Exit Strategic Commander to provide strategic leadership, supported by NHS England Incident Response arrangements (in line with IRP(N)) 								
5.	<p>IF ACTIVATED:</p> <ul style="list-style-type: none"> • Activate the Business Continuity Plan and/or Surge and Escalation and/or Critical Incident Plan • Contact all Single Points of Contact identified on the EU Exit Rota • Inform them of the tactical meeting time 								
6.	Be the point of contact between the control room and NHS England EU exit team								
7.	Following stand-down attend debrief and ensure key paperwork is provided to the emergency planning manager								

ACTION CARD 2
NO DEAL EU EXIT
SINGLE POINTS OF CONTACT

Number	Action
1.	Act as escalation point for staff with No Deal EU exit issues pertaining to your service area
2.	Ensure daily return is sent to dgft.incidentresponse@nhs.net by 1630 each day
3.	Ensure a representative is sent from your area to the weekly update meeting in the Capacity hub these will be held every Monday from 1400-1500 Ensure you bring updates on areas current status in relation to EU exit, as well as any identified issues for escalation
4.	Escalate any major issues to the Control Room Manager ext. 3275
5.	If requested attend the Incident Control Centre (Site Office) at specified time, ensure you bring <ul style="list-style-type: none">• Current status of your work area• Any identified issues
6.	Act as the Operational (Bronze) commander for your service area
7.	Following stand-down attend debrief and ensure key paperwork is provided to the emergency planning manager

ACTION CARD 3
NO DEAL EU EXIT
CLINICAL SITE COORDINATOR/SITE TEAM

Number	Action
1.	Maintain awareness over weekends/nights/bank holidays of any developing issues in relation to EU exit
2.	If serious issues are identified escalate to On Call Executive/Manager making them aware that they are EU Exit related
3.	With On Call Manager/Executive decide if further response is required, if yes activate Business Continuity Plan and follow actions within your action card
4.	Ensure exception report is provided via email to england.mids-euexit@nhs.net dgft.incidentresponse@nhs.net
5.	Following stand-down attend debrief and ensure key paperwork is provided to the emergency planning manager

Appendix 6 Weekly EU Exit Response Meeting

EU Exit Response Meeting

Weekly Monday 1400-1500

Site Office, Russell's Hall Hospital

AGENDA

	Time	Item	Enc	Presented by
1.	1400	Welcome, introductions and apologies	Verbal	Control Room Manager
2.	1405	Action Log	Enclosure 1	Control Room Manager
3.	1415	National and Regional Updates	Verbal	Control Room Manager
4.	1425	Local Updates from Single Points of Contact (SPOC) 1. Procurement 2. Pharmacy 3. Blood Stocks/Pathology/Labs 4. Medical Devices 5. Radiology 6. Interserve & Support Services 7. IT 8. Information Governance 9. Finance 10. Workforce 11. Site Operations 12. Research & Clinical Trials 13. Communications	Verbal	SPOC
5.	1450	Items for escalation to Regional EU Exit Team	Verbal	All
6.	1500	Close of meeting		

Policy Consultation Form

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

During the development or review of the Policy, consideration must be given to the actual or potential impact on equality. Due care is given to ensure that they do not contravene the article of the Human Rights Act or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, disability, sex, race, religion or belief, gender reassignment, marriage or civil partnership, pregnancy or maternity.

What is the title of the procedural document:		
No Deal EU Exit Response Policy		
Date of Submission:		Author Christopher Leach
Director Lead and Date Signed off as Approved.	Name: Karen Kelly	Date Approved:
Is there a similar/same document already in existence? Please state which document this will replace. If the document has a different title or has been merged with another document, please provide details of relevant documents.		
No		
Please detail under which folder on the Procedural Documents Hub Page that the document is to be stored. Procedural documents can only be stored on the central procedural documents page. If you require the document link to be stored on another page outside of this, please contact IT and ask them to put a link on.		
Emergency Planning		
Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:		
Name	Designation	Date confirmed agreement (mm/yy)
SPECIALISTS / GROUP/S (if no Specialists Groups consultation identify the reason why)		
DIVISIONAL MANAGEMENT CONSULTATION (if no Management consultation identify the reason why)		
PHARMACY CONSULTATION (if applicable)		
OTHER		

Check List

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Prior to submission of the Policy please ensure you can answer yes to all of the questions below.

	Yes/No
1. Title	
Is the title clear and unambiguous?	Yes
2. Front Sheet Completion	
Is the colour banding strip blue?	Yes
Is the Author identified (name and designation)?	Yes
Is the Director Lead identified?	Yes
Is the target audience identified?	Yes
Is the document version controlled?	Yes
Have the people contributing to the document been identified on the Front cover Sheet as per designation and not individual names?	Yes
Have the CQC registration requirement outcomes been recorded?	Yes
Have relevant documents/legislation standards been recorded if applicable?	Yes
Has the change history been fully completed?	Yes
3. Body of the document	
Has the contents page been fully completed and the numbering reflects the document content pages?	Yes
Is there a footer on each page recording; document title, date of issue, version number, page number and total number of pages?	Yes
Is the document written in Arial 12pt font?	Yes
Does the document contain individual designations and NOT names?	Yes
Does the numbering run in sequence?	Yes
Does the document follow trust format of; Introduction, Statement of Intent/Purpose, Definitions, Process, Training/Support, Monitoring, Equality and References for the main body?	Yes
The meaning for any definitions or abbreviations used is clearly stated?	Yes
Is there identified training or support which includes the process for follow up of non-compliance clearly cited?	Yes
Are procedural documents relating/supporting this document hyperlinked?	Yes
Is the table for Monitoring Compliance fully completed?	Yes
Are references cited in full and comply with the Harvard referencing?	Yes
4. Consultation	
Is the consultation form completed?	Yes
If the document includes prescribing or administering of medicines, has pharmacy been consulted?	Yes
As the Director Lead been consulted and accepted the document?	Yes

Paper for submission to the Trust Board on 4th April 2019

TITLE:	Medicines Shortages and Supply Assurance - the impact of Brexit		
AUTHOR:	Ruckie Kahlon Chief Pharmacist	PRESENTER	Karen Kelly – Chief Operating Officer
CLINICAL STRATEGIC AIMS			
<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>			
ACTION REQUIRED OF THE TRUST BOARD			
Decision	Approval	Discussion	Other
	Y	Y	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE TRUST BOARD			
<p>To consider the actions completed by the Pharmacy in response to increasing number of medicines supply chain shortages and a “no deal” Brexit.</p> <p>To determine if these actions are sufficiently robust and comprehensive enough to mitigate the clinical risk to patients should the Trust be exposed to pressures imposed by trading restrictions as a result of the exit from the EU.</p>			
CORPORATE OBJECTIVE:			
SO2: Safe and Caring Services SO5: Make the best use of what we have			
SUMMARY OF KEY ISSUES:			
<p>The report attached provides a summary of issues in regards to medicines shortages being managed by the Trust led by the Pharmacy Procurement Team and how these will be managed with the impact of a ‘no-deal’ Brexit. Key issues highlighted:</p> <ul style="list-style-type: none"> Increasing number of medicines shortages pre- Brexit outcome Reasons for medicine shortages Impact of medicine shortages Key medicine shortage highlights Multi-disciplinary approach to shortages Impact on pharmacy service resilience <p>This paper is an update of the actions Pharmacy has taken locally to mitigate the risk of stock shortages and follows on from the paper presented to CQSPE on 29th January 2019.</p>			

IMPLICATIONS OF PAPER:			
RISK	Y		Risk Description: Inability to source affordable medicines after Brexit on 29th March 2019
	Risk Register: Y		Risk Score: 15
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Safe and Responsive
	NHSI	N	Details:
	Other	Y	Details: Advice from DHSC

Medicines Shortages and Supply Assurance

Background

Medicines are the most common intervention in the NHS and are the second largest spend (second only to staff). In 2017/18, Dudley Group spent over £32 million on in-tariff and high cost medicines. The Pharmacy department at Russells Hall Hospital procures the majority of the medicines used across Dudley Group with the exception of blood products, medical gases and radiopharmaceuticals.

How medicines are procured regionally and nationally

NHS Medicines Procurement in England is led and coordinated through a structure headed by the Commercial Medicines Unit (CMU) hosted by NHS England, and supported by the National Pharmaceutical Supply Group, The Pharmaceutical Market Support Group and the National Homecare Medicines Committee.

Operationally, medicines procurement in England is managed through 10 regional pharmacy purchasing groups and each group has a regional pharmacy procurement specialist (RPPS). Within the West Midlands the RPPS post is hosted at the West Midlands Academic Health Science network and is funded via annual contributions from each acute NHS Trust within the West Midlands.

CMU is responsible for awarding and managing frameworks for licensed medicines for the regional purchasing groups in compliance with public procurement regulations. Trusts are responsible for implementation of the contracts after award. This approach ensures the NHS obtains competitive prices for medicines whilst ensuring that the UK remains a commercially attractive marketplace for pharmaceutical companies.

Procurement of medicines at DGNHSFT

The pharmacy department lead on the procurement of medicines for the Trust, with the exception of licensed blood products (procured by Pathology), medical gases (procured by Trust procurement) and radiopharmaceuticals (procured by Imaging).

DGNHSFT holds a MHRA Wholesaler Dealers License and has a service level agreement in place to procure and distribute medicines for the Dudley and Walsall Mental Health Trust, Ramsay Healthcare, Air Alliance and Birmingham Community Healthcare Trust. The procurement team also manage contracts with medicines homecare providers; Healthcare at Home, Lloyds, Healthnet and Fresenius.

Medicines Supply Chain Concern

NHS Pharmacy teams are currently experiencing unprecedented levels of unavailability of critical medicines. In January 2018 alone, 280 individual medicines that are contracted to be supplied to NHS hospitals in England were either in limited supply or unavailable to hospitals. Many of these were critical medicines with no direct therapeutic equivalent making substitution difficult. At present there are > 100 products actively monitored by DGH Pharmacy Procurement Team. Shortages include globally and nationally unavailable products Medicines and Registered Devices. Whilst everyone plays their role in managing the shortages the Pharmacy Medicines Optimisation and Pharmacy Procurement Teams lead on this issue.

In July 2018, Medicines Management Group discussed a report on medicines shortages which describes the challenges to the supply chain and the causes of medicines shortages. Since this time, we have seen an unprecedented number of shortages and supply disruptions including some critical medicines such as intravenous fluids, adrenaline Epipen® and phenytoin oral suspension.

A medicines or drug shortage is defined as: a supply issue that affects how the pharmacy department prepares or dispenses a product or influences patient care when prescribers must choose an alternative therapy because of supply problems.

A critical medicine shortage is defined as: a formulary-approved medicine where supplies are at high risk of becoming (or have already become) exhausted and there is no direct therapeutic alternative (including unlicensed or off-label use). In addition, an interruption of supply would be considered by any one of the Clinical and Pharmacy teams to compromise therapeutic care of a patient.

There are a number of issues associated with medicines shortages including:

- Risk of patient harm through not receiving treatment, or receiving alternative treatment
- Delay of interventional procedures e.g. lack intravenous fluids or enoxaparin could affect ability to undertake surgical procedures
- Cost pressures
- Significant resource (both clinical and non-clinical) to manage drug shortages
- Patient concerns and complaints
- Media interest

What Causes Medicines Shortages?

The reasons for medicine shortages are many and complex. Also, the number of manufacturers and raw material providers used in Pharmaceutical manufacturing is often very limited. Shortages can occur as a result of:

- Active Pharmaceutical Ingredient (API) issue
- Regulatory issue with manufacturing plant.
- Globalisation of supply chain – may be only one supplier
- Globally-led manufacturing schedules & long lead times
- Incorrect tendering volumes (regionally or nationally)
- Large increases in demand over a short period – formulary changes
- Siege mentality – across a range of medicines e.g. antibiotics
- Global marketing decisions affecting UK market
- Manufacturing plant burns down!
- Low prices for generic medicines in UK which may not be treated as a priority market when global supply is tight
- Locally – change in prescribing / decision to change product when availability unknown
- Falsified Medicines Directive – EU Directive has led to financial viability challenges for smaller suppliers

As the problem grows worse, the Pharmacy department is increasingly caught in the crossfire between the consequences of problems (which they struggle to influence with national teams directly) and frustrated health care professionals who take access to regularly used medicines as a given. Pharmacy faces three key challenges in dealing with medicine shortages:

1. Inadequate information and warning about an impending medicine shortage,
2. The resources and infrastructure to deal with shortages, and
3. Poor understanding by clinical colleagues of any of the above and the important role they have to play in avoiding potential shortages and mitigating them when they arise.

How do we learn about shortages?

- Mainly – when order fails to arrive/ stock outage
- Routinely – via the NHS England Commercial Medicines Unit and Regional Procurement Lead

- Rarely - advanced notice by manufacturer

Examples of what needs to be considered when shortages are identified

- Risk assessment
- Continuation of treatment & patient safety
- Gather data manually from JAC records (no ward live stock information available – need to physically trawl wards), identifying stakeholders
- Quarantine / ring fence available stock / prioritising patients
- Find alternatives: brands, suppliers, pack sizes, forms, and strengths.
- Review licensing / therapeutic indication – Clinical procurement
- Local assessment of physical stock to mitigate against supply errors / change in storage requirements
- Changes to JAC stock management system & discharge prescribing systems
- Assess availability of suitable devices to administer sourced alternative
- Assess availability & controlled implementation of Unlicensed Alternative
- Change ward stock lists, changes to pharmacy & AMU Robotics
- Assess sustainability of alternative & internal supply management of alternatives
- Establish manpower for seamless (mainly) supply of alternatives
- Prepare communication/ memos to specialties, prescribers and other stakeholders
- Persistent constant monitoring of known issues
- Assess cost of product, manpower, impact on cost improvement targets
- Change protocols, policies / guidelines and reprinting prescriptions.

Pharmacy Supply Chain Maintenance

The Pharmacy Department Procurement team manages medicines shortages and these have been of varying criticality as outlined in Appendix 1. There are medicines shortages throughout the year when medicines are not available from the wholesaler or manufacturer. Normally the Pharmacy procurement team resolve these 'out of stock' situations by procuring from other wholesalers, other hospitals with larger stock holding or in surplus to need, or buy 'off contract' as per standard operating procurement procedures. Where alternative routes of supply cannot be achieved these are classified as medicines shortages and a clinical, technical and operations based risk assessment is commenced.

All supply issues that affect how the pharmacy department prepares or dispenses a product or alters prescribing are defined as medicines shortages and thus will follow this process. The shortage will be summarised through completion of a SBAR (Situation, Background, Assessment and Recommendation) document (Appendix 2).

Any medicines that is at high risk of becoming (or have already become) exhausted and there is no direct therapeutic alternative and would be considered to compromise therapeutic care of the patient, would be categorised as a "red" critical medicines shortage and actions may be requested of the Medicines Management Group, Chair of Drug and Therapeutics Committee or Medical Director to ration or restrict the product to key patient populations.

In addition, all "red" categorised shortages should be:

- Recorded as an incident on the Datix system
- Communicated to the appropriate clinicians/specialist teams where appropriate
- Reported to the Chief Pharmacist or Deputy to be "logged" as such.
- Reported to the West Midlands Regional Pharmacy Procurement Specialist (RPPS) in order that a regional approach may be adopted where possible

Each shortage is RAG rated according to a service impact score based on the following:

- Legal classification of the medicine e.g. controlled drug

- Impact on clinical practice
- Impact on pathways, process and policy e.g. impact on PGDs, dispensing, administration processes, need for unlicensed or off label use
- Impact on external service users e.g. SLA partners
- Financial impact

The cumulative score is rated as follows:

0-4	Inform relevant clinical areas and pharmacy dept. No SBAR required Review score if situation changes
5-9	Complete SBAR Engage relevant clinical areas and pharmacy team Inform DTC chair, Finance, CCG Medicines Management Leads and other stakeholders as dictated by the clinical pathway Review, adjust and share SBAR weekly
>10	Complete SBAR Engage relevant clinical areas and pharmacy team Inform Finance, CCG Medicines Management Leads and other stakeholders as dictated by the clinical pathway Regular face to face meetings with stakeholders to agree treatment pathway changes Keep Executive Team abreast of concern and action progress Review, adjust and share SBAR weekly

Current Medicines Shortages

During February and March to date, there are 8 new medicines shortages identified and an SBAR example for Enoxaparin is attached – appendix 3. There are 9 existing medicines shortages ongoing, each assessed and with mitigation plans. In addition to this, as of 18th March, there are 157 products being monitored weekly by the pharmacy procurement team because of disruptions in the supply chain.

During February, there were five new medicines shortages identified.

Product	Score
Baritop suspension	4
Urokinase 25000 injection	3
Metyrapone 250mg capsules	0
Enoxaparin (Clexane) 20mg injection	17
Hydrocortisone 100mg injection	3

This is in addition to the ongoing shortages:

Product	Score
Ofloxacin 0.3% eye drops	3
Tetracosactide 250mcg injection	11
Tetracosactide 1mg depot injection	11
Adrenaline 1 in 10000 injection	5
Diazepam 2.5mg enema	4
Enoxaparin (Clexane) 40mg injection	11
Diazoxide 50mg tablets	2
Gentamicin 20mg/2ml paediatric injection	6
Gastrograffin oral solution	8
Co-trimoxazole 480mg injection	2

One of the new shortages was considered critical and rated as “red”, and three of the “red” shortages” from January continue. The following medicines shortages were resolved during January 2019

- Dalteparin 2500 units injection

- Prednisolone 0.5% minims eye drops

Figure 1 summarises the number of stock shortages for 2019 that have necessitated either a change in dispensing, administration or have required a therapeutic alternative to be used. This demonstrates the lengthy duration of many shortages, which require constant management to ensure availability of alternatives, communication to staff and patients and mitigation of risk. There is also a gradual increase in the number of critical shortages observed which require more intense management.

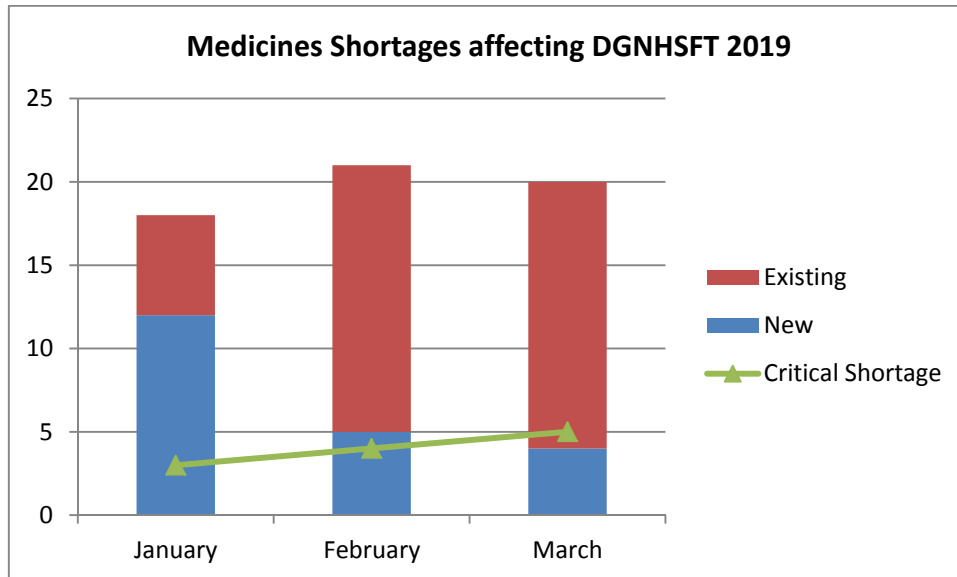


Figure 1

Brexit and Medicines Availability National Assurance

Following the national referendum the United Kingdom (UK) will leave the European Union (EU) however how the UK will leave and when exactly remains unclear.

On 21st December 2018 the Department of Health and Social Care (DHSC) wrote to all providers and commissioners of NHS Services providing guidance regarding Operational Readiness in the event of a no deal exit. The Department set up a national Operational Response Centre. This continues to lead on responding to any disruption to the delivery of health and care services in England that may be caused or affected by EU exit. NHS England and NHS Improvement have established local regional and national teams to provide rapid support on emerging issues. Several iterations of the original guidance have been received by the Trust alongside advice from the MHRA regarding the medicines supply issues.

On 18th January 2019, a Medicine Supply Update in the form of a letter from the Chief Pharmaceutical Officer summarised national guidance to all Pharmacy departments stating that they must not stockpile and that over prescribing should be discouraged. Wholesalers have been granted extra storage space to increase stockholding of medicines (6 weeks total) and manufacturers who import medicines across the short straits crossing have been reviewed in line with Government plans: <https://www.england.nhs.uk/publication/medicine-supply-update-letter-from-dr-keith-ridge-cbe/>

Local Assurance

The Hospital pharmacy team is leading on the preparation and contingency planning for a potential no-deal Brexit scenario and its impact on the supply of medicines. Pharmacy teams

feed into the work of other departments across the organisation on Brexit, such as the EPRR team, research and development and procurement. A local risk assessment has identified key risks relating to the potential delay in receiving medications and mitigation plans are in progress (as outlined in appendix 2).

In February 2019, medicines legislation was altered to allow the establishment of “Serious Shortage Protocols”. These protocols allow flexibility in dispensing of available medicines by pharmacists in event of drug shortages. The governance supporting these documents will be approved through our Drugs & Therapeutics Group by senior clinicians and pharmacists in the Trust when the protocols are released by the national teams.

The Pharmacy department is continually monitoring national advice which is available from NHSI at the following link:

<https://nhsi.kahootz.com/connect.ti/HoPMOp/view?objectid=12508912>

Communication with clinicians is key in the event of drug shortages and the Pharmacy department at Russells Hall Hospital continues to lead on communicating shortages, changes to prescribing advice or formulary. In addition the team works closely with primary care medicines management teams and supports information provision across the interface through the various medicines related forums.

Locally we have strengthened our governance procedures concerned with stock shortages and continue to collaborate with Chief Pharmacists across the West Midlands to manage stocks as a region. Procedures are in place to monitor a critical drug list on a daily basis.

In addition, NHSE has funded access to the functionality (an electronic solution known as Define®) for all hospitals to view medicines stocks in other Trusts both regionally and nationally to support equity of access to medicines for patients in the UK. The Trust already has access to this functionality.

The following advice has been shared across the Dudley Health Economy:

- Please **do NOT stockpile** additional medicines above usual stock levels. Local stockpiling is unnecessary and could cause shortages in other areas, which may put patient care at risk.
- There is no need for clinicians to write longer prescriptions.
- If asked, clinicians should reassure patients and advise that there is no need to store additional medicines at home (the Government is working with industry to ensure a continued supply of medicines from the moment we leave the EU)

The Pharmacy team have followed national guidance to not stock pile however extra vigilance is in place to ensure critical and high turnover items are consistent with average stockholding.

In addition the following actions are complete and in place (also note appendix 4 for action tracker):

- Identify Senior Responsible Officer for EU exit preparation in the Trust and ensure Chief Pharmacist or representative is part of the SRO's team response.
- Ensure Executive team are cited on risks of continuing supply of medicines and the actions taken to mitigate these (Paper presented to CQSPE 29th January 2019).
- Undertake local risk assessment of impact of Brexit and feed into Trust's response.
- Reassessed medicines stock levels and lag time to procure, ensuring awareness of which critical medicines take longer to procure and arrive on site.

- Pharmacy has identified a “Critical List” of medicines for drug omissions. These drugs are undergoing clinical mitigation planning – note that this is a ‘fluid’ process as information continues to evolve from suppliers.
- Advice issued to clinical teams not to stockpile and discourage patients from doing so.
- Medicines shortages governance procedures refined and include RAG rating, SBAR approach and decision ratification from Drugs & Therapeutics Group (plus wider relevant stakeholders) and oversight of the Medicines Management Group.
- Liaised with LPC ensure local community pharmacies are supporting patients and GPs with advice not to stockpile.
- Data flow determination to and from the EU e.g. Early Access Schemes that may impact on patient care. Assets linked to the EU e.g. clozapine database and plan for contingency if unavailable.
- Updated local Pharmacy business continuity plans

The following actions are ongoing:

- Continue to update risk register as new information is available
- Medicines supply chain:
 - Follow guidance not to stock pile but ensure critical and high turnover items are consistent with average stockholding.
 - Direct staff to reassure patients regarding plans for continuity of supply and discourage patients from stockpiling.
 - Continue to report shortages through usual regional routes.
 - Maintain Shortages Log with details of the shortage and interim advice for pharmacy staff.
 - Establish process for implementing Serious Shortages Protocol.
- Identify any key consumables critical to medicines administration and link in with procurement department.
- Clinical Trials
 - Identify if Trust is lead sponsor for any trials and follow MHRA advice
 - Liaise with trial Sponsors to understand their arrangements to ensure that clinical trials and investigations using IMPs which come from, or via, the EU are guaranteed in the event of any possible border delays.
- Liaising with Define to access guidance on viewing stock levels in other Trusts.
- Liaising with the CCG to align medicines optimisation across the whole health economy.
- Workforce: Liaising with HR to identify EU nationals working in the department. Ensure aware of EU Settlement Scheme. Include service impact in risk assessments if shortfall of EU nationals identified as a potential issue. Reassure staff regarding professional registration of existing staff.
- Maintain record of costs incurred to comply with guidance.

Impact on the Pharmacy Department

The Pharmacy Procurement and Distribution Team is under considerable pressure to meet the demand of the supply chain concern. Activity behind the scenes is significant and can go largely unnoticed due to the tireless work put in by the team to maintain often seamless provision of medicines.

Resource mitigation requires the use of additional bank staff and deployment of staff from other pharmacy teams (e.g. Dispensary and ward teams) the latter impacts negatively on dispensing waiting time and patient facing duties. These activities are closely monitored and reported via the Pharmacy Leadership Group / Pharmacy Senior Management Group to the Clinical Support Services Divisional Management, Governance and Executive led Performance Review Groups.

Patient safety is priority and the Pharmacy Teams continue to strive to source safe, quality medicines to be available for our patients and customers at the right place in the right quantity at the right time at the best value for money. This challenge is set to continue with potential changes in UK trading laws & national contracting processes. Sustaining this workload requires a long term solution to prevent detriment to other pharmacy services. The Pharmacy Senior Management Team have placed short to medium term plans to manage this issue and are progressing with a longer term solution.

Falsified Medicines Directive (FMD)

The EU Falsified Medicines Directive (2011/62/EU) (FMD) was adopted in 2011 and introduced new harmonised measures to ensure that medicines in the European Union (EU) are safe and that trade in medicines is properly controlled. Member States have until 9th February 2019 to implement the final part of the Directive, the 'safety features' Delegated Regulation. The regulation puts obligations on manufacturers to add safety features (unique identifiers and tamper evident seals) to certain medicines packaging and upload the unique identifier to a stakeholder managed EU data hub. Wholesalers and dispensers including pharmacies and hospitals, will then need to verify authenticity of products and decommission the unique identifiers through the hub.

FMD poses challenges to the supply chain overall. Manufacturers (as well as end users) also need to implement the directive and will need to have the infrastructure to barcode their products and add to the data hub. This has a large cost to manufacturers, and for some smaller companies will make them unviable. There is a risk that some smaller manufacturers of low cost generic products may suspend production and close as the cost of implementing FMD is too great for them. This could result in some medicines being unavailable or in short supply and these may be at a greater cost. This is increasing the challenge for the service as it competes with our priorities and further complicated by the expectations of our external inspectors that insist active FMD implementation plans.

Next Steps and Recommendations

The Trust Board is asked to:

- Consider this paper outlining the current challenges that exist within the medicines supply chain.
- Support the Chief Pharmacist with long term pharmacy department plans to manage the demand on medicines supply.
- Note that clinician engagement and communication is key to successfully managing these shortages and minimising any negative impact on patients and the safe use of medicines.

The Pharmacy Directorate risk register outlines any significant risks regarding medicines shortages. These will be escalated via the Clinical Support Services Divisional Governance Meeting. Any adverse incidents linked to medicines shortages will be formally noted. Pharmacy will continue to support with EPPR in the Trust regarding contingency planning around medicines shortages and Brexit.

Summary

The Trust Pharmacy team deal with medicines shortages daily and are well integrated within clinical teams to support decision making to ensure patient safety at all times. The medicines shortage procedures are thoroughly validated and successful in mitigating risk. The Pharmacy department will continue to receive and enact national advice via the EU Exit Planning meeting chaired by the Chief Operating Officer and the Medicines Management Group chaired by the Chief Executive. Both Groups provide updates and assurance to CQSPE.

Drug shortage identified

Appendix 1

Operational assessment

This is done by Procurement

1. **Validate details of shortage** e.g. manufacturer; timeline; product and dosage / form
2. **Review usage and stock holding** using JAC
3. **Estimate time to impact** on the Trust
4. **Determine distribution history and locations / stock levels held** within Pharmacy Directorate, Wards and Clinical Areas
5. **Identify clinical areas affected**
6. **Will DCSL be impacted?**
7. **Identify if medicine is wholesaled** to other organisations
8. **Identify if medicine is used in aseptic manufacture of medicines**
9. **Determine supply from pre-determined alternative sources** (e.g. wholesalers; Pharma; importer)
10. **Quarantine and / or centralise supplies if needed**
11. **Determine supply and timeline** for sourcing of alternative drug products
12. **Demand management and patient prioritisation**

Therapeutic assessment

This is done by MO pharmacists

Link with Primary Care if needed

1. **Identify primary patient population affected**
2. **Identify therapeutic alternatives** and whether these are included on the local health economy formulary
3. **Consider involvement of others in decision for alternative** e.g. aseptics, specialist pharmacist, specialist clinicians
4. **Are alternative medicines unlicensed?** (Complete ULM1 form)
5. **Review and implement any changes to clinical guidelines**
6. **Is the drug used as a PGD or PSD?** These may require review

Shortage impact analysis including Impact on Patient Care

This may be done by Pharmacy alone and / or in conjunction with clinicians and the wider MDT

1. Therapeutic differences re: licensed indications and marketing authorisation
2. Prescribing processes
3. Distribution Processes
4. Administration Processes
5. Financial ramifications including unit cost, off-contract purchases and off-contract claims
6. **Create final action plan**

Implementation

1. Information system changes e.g. JAC (consider DISP and POE); manufacturing worksheets and labelling for aseptics items, Chemocare regimens in necessary
2. Technological changes (i.e. bar coding and allocation of storage within automation)
3. Inventory system changes
4. Change control for any product made within aseptics
5. New procedures for staff to follow
6. Risk register development
7. Updating of ward stock lists

ONGOING REVIEW, ASSESSMENT AND MONITORING OF POSITION AND ANY CHANGES / IMPACT

When shortage resolves consider additional actions for communication, system and guideline changes, stock list amendments and approach to using/removing replacement product

Medicines Shortage SBAR

Medicine Affected	
S ituation	
B ackground	
A ssessment of local impact	<p>Criticality of Supply</p> <p>Impact on Patient Care</p> <p>Operational Impact</p> <p>Financial Impact</p>
R ecommendations made and action taken	

Appendix 3

Medicines Shortage SBAR

Medicine Affected	Enoxaparin (Clexane) 20mg injection
S ituation	The Trust was unable to process an order for Clexane 20mg on 22 nd February. No information could be obtained at this time on the expected date of availability. At this point the pharmacy department had 3 days worth of stock remaining. Therefore, ward areas that stocked excess boxes of Clexane were returned to pharmacy in order to supply when patients needed. Meanwhile, therapeutic alternatives were considered.
B ackground	Enoxaparin is the most used low molecular weight heparin in the organisation as it is the formulary choice for VTE prophylaxis. The 20mg strength is used less commonly than the 40mg, but is needed for individuals with low body weight or poor renal function.
A ssessment of local impact	<p>Criticality of Supply Three days supply remained in pharmacy so excess stock was returned from wards to ensure seven days of stock availability. Sanofi confirmed likely availability from 1st March would leave a shortfall of 7 days. Therapeutic alternatives were scoped and extra dalteparin 2500 and 5000 units were obtained as alternatives. Through the regional procurement network, the Trust was able to purchase a significant duration of stock holding from a neighbouring Trust. Therefore it is expected that this supply will last for the duration of the outage.</p> <p>Impact on Patient Care Patients were not impacted, as the Trust was able to obtain further supply from a neighbouring Trust. However, if this had not been possible, patients would be needed to switch to an alternative low-molecular weight heparin. This would have the same expected therapeutic effect, so would not pose harm to patients.</p> <p>Operational Impact Significant time was investing into identifying a source of supply after the manufacturers were not able to provide alternative. Clinical pharmacist time was spent identifying appropriate alternatives. If the Trust needed to change to using an alternative product as no enoxaparin could be obtained, this would require clinical engagement, and extensive education and comms.</p> <p>Financial Impact No impact felt as supply obtained from another Trust at cost price.</p>
R ecommendations made and action taken	<ul style="list-style-type: none"> • Communication to suppliers to ensure stock availability of alternative product. • Engagement of clinical teams for alternative advice • Regular product monitoring for return of stock • Continuing to monitor/ escalate as needed • Supply issue escalated to medicines management group • Preparation of "low molecular weight heparin alternatives" plan due to repeated supply issues with this class of drugs

Appendix 4


**THE DUDLEY GROUP NHS FOUNDATION TRUST
PHARMACY AND MEDICINES EU EXIT ACTION PLAN**

Source of Action Plan	Pharmacy Brexit Steering Group	Oversight Committee	Medicines Management Group
Action plan prepared and lead by	Danielle Stacey	Action plan signed off by	Ruckie Kahlon
Date presented to Div Gov Meeting		Anticipated date for completion	29/3/19

KEY	Completed and Assurance Received	Action commenced but not yet completed	Action Overdue not completed in agreed time scales or at significant risk of not achieving time scales
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Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
1	Communication	Ensure Executive team are cited on risks of continuing supply of medicines and the actions taken to mitigate these	Emma Suggett	29/1/19	Paper presented to CQSPE 29 th January 2019	
2	Communication	Issue advice to clinical teams not to stockpile and discourage patients from doing so.	Emma Suggett	10/1/19	Email correspondence highlighting national advice issued to doctors and pharmacists across Dudley Group	
3	Medicines supply chain	Identify list of "critical medicines" where shortages would compromise patient care	Gurveena Johal	29/1/19	Over 300 medicines identified as "critical".	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
4	Medicines supply chain	Send letter to all clinical trial sponsors requesting arrangements for IMPs following a no-deal Brexit scenario	Vanessa Moore	15/2/19	Letters sent to all trial sponsors. Assurance from several sponsors received. Assurance from remaining sponsors actively being chased.	
5	Operations	Identify all medicines IT assets and establish if there are any data flows to EU	Jane Elvidge	5/2/19	IT assets identified, assurance from system suppliers in progress	
6	Operations	Identify key consumables required for medicines reconstitution/Administration	Dav Manku/Gurveena Johal	29/2/19	Medicines that require special consumables for administration such as filters or PVC free containers have been identified. Consumables required for aseptic unit preparation are being identified.	
7	Medicines supply chain	Identify medicines currently supplied through early access schemes and their data flows to EU	Danielle Stacey	29/1/19	Trust is not enrolled in any early access schemes that require patient data transfer	
8	Operations	Agree additional resource required if significant shortages occur and plan to train these individuals	Colleen Lewis/Danielle Stacey	29/2/19	Additional pharmacists and pharmacy technicians can be identified for procurement activities but would require bank/locum backfill for their substantive roles. Training plan now needs to be developed and executed before 29 th March.	
9	Operations	Develop document to capture cost implications of Brexit on pharmacy and medicines	Sophie Robinson	5/2/19	All meetings and preparations related to Brexit planning are to be documented. If medicines/consumables shortages can definitely be confirmed as Brexit-related, these will also be captured. Financial impact of medicines shortages out with Brexit, to be captured on a monthly basis.	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
10	Medicines supply chain	Write SOP for identification and management of shortages	Danielle Stacey	1/3/19	SOP drafted and process is currently being piloted	
11	Medicines supply chain	Contact homecare providers (via regional procurement lead) to assure on provision of supply of homecare medicines	Danielle Stacey	11/2/19	 Copy of Suppliers Brexit FMD.xlsx Homecare providers have confirmed their adherence to DHSC advice	
12	Communications	Contact Local Pharmaceutical Committee to ensure consistent messages from community pharmacies	Emma Suggett	11/2/19	Assurance received from Dudley CCG that Dudley LPC are adhering to national advice	
13	Operations	Update pharmacy business continuity plan	Jane Elvidge	14/3/19	Current BCP contains actions for lack of digital systems, workforce, medicine dispensing capability etc. Each action identified within this plan will provide further detail / assurance on BCP.	
14	Medicines supply chain	Develop "shortages log" to retain record of supply disruptions	Danielle Stacey	15/1/19	Shortage log maintained weekly containing latest supply information and advice on alternatives. Resolved shortages are archived for future reference.	
15	Workforce	Identify EU nationals working in the department. Ensure aware of EU Settlement Scheme.	Ruckie Kahlon	15/3/19	Pharmacy HR lead to identify individuals and discuss concerns with Chief Pharmacist	
16	Operations	Liaise with procurement to assure supply chain for key consumables related to medicines	Colleen Lewis & Dav Manku	29/3/19	Provide Trust Procurement with list of consumables and triangulate any concerns with their list which is already in progress. Pharmacy Procurement to liaise with suppliers for consumables procured directly by Pharmacy	

Action Number	Recommendation / Area for Action Identified	Action Agreed	Lead	Date for Completion	Progress / Assurance	Key
17	Operations	Develop mitigation plan for preparation/administration of medicines if key consumables are unavailable	Gurveena Johal/Dav Manku	29/3/19	Identify list of consumables that cannot be sourced post Brexit and that cannot be substituted. Identify which drugs will be impacted by consumable deficiency – completed. Identify treatment pathways and clinical leads that will be impacted to assess alternative therapy types	
18	Medicines supply chain	Produce list of alternative products to critical medicines that can be mobilised if shortage occurs	Gurveena Johal/Danielle Stacey	29/3/19	List in development	
19	Operations	Discuss availability of parts for pharmacy dispensing robot with manufacturer	Ruckie Kahlon	29/3/19	Meeting with Digital Trust 15.3.19 to ascertain work in progress.	
20	Medicines supply chain	Review stockholding of medicines that are routinely obtained directly from EU and initiate ordering of these products three days earlier than usual	Colleen Lewis	29/3/19	Stock holding review in progress	
21	Nuclear Medicine	Complete risk assessment on the impact of No deal Brexit on nuclear medicines service	Julie Dunham (Radiology)	29/3/19	Chief Pharmacist to ascertain progress with this action	
22	Nuclear Medicine	Develop local contingency with SWBH to arrange different generator delivery days	Julie Dunham (Radiology)	29/3/19	Chief Pharmacist to ascertain progress with this action	

PHARMACY AND MEDICINES EU EXIT BUSINESS CONTINUITY RISKS

Business Continuity risks associated with No Deal Brexit	Actions required to mitigate risk	Contingency to maintain service provision
DHSC actions may not mitigate medicines supply chain issues	Follow medicines shortages SOP	<ul style="list-style-type: none"> Pharmacy Procurement to initiate product monitoring of medicines with limited supply or known problem Pharmacy procurement to actively monitor critical medicines Pharmacy Procurement to escalate to medicines optimisation pharmacist if supplies have or are likely to become exhausted to implement clinical alternatives Senior pharmacist to review shortages log weekly High risk medicines shortages or those impacting a significant number of patients to be escalated to Medical Director Medical Director to identify clinical staff to operate a "shortages panel" to decide how to manage critical medicines shortages Weekly email to be sent to all pharmacy staff on current shortages Detail medicines shortages on the Trust intranet utilising Hub stories where necessary and the e-BNF
Contract medicines become unavailable	Follow medicines shortages SOP	<ul style="list-style-type: none"> Purchase licensed medicines from alternative wholesaler/manufacture Undertake clinical procurement assessment to ensure safety and appropriateness of alternative product Develop communications for staff and patients in non-contract medicines has significant differences
Licensed medicines become unavailable	Follow medicines shortages SOP and unlicensed medicines policy	<ul style="list-style-type: none"> Risk assess and purchase unlicensed alternatives If concerns over product, relevant senior clinician to advise on alternatives If necessary, Medical Director to identify senior clinical support who could switch patient therapy
Supply chain issues escalate significantly so that there are insufficient numbers of trained staff to manage shortages	Move permanent staff into supporting role and backfill with bank or locum staff	<ul style="list-style-type: none"> Monitor number of shortages weekly and escalate to the division when capacity exceeding Train substantive staff to carry out some aspects of medicines procurement so that these staff can be mobilised when necessary
Homecare companies unable to supply patients with medication	Critical medicines alternative list	<ul style="list-style-type: none"> Establish "shortages panel" including relevant specialists to plan for management of supplies including switching therapy, utilising biosimilars and running additional clinics.
Patients attend ED as unable to obtain medicines from community	Communications strategy	<ul style="list-style-type: none"> Discuss action with commissioners Provide advice on Trust internet and social media pages Posters for ED and pharmacy department to show action to take by patients

		<ul style="list-style-type: none"> Mobilise “shortages panel” including CCG to agree plan for obtaining supplies of medicines
Patients and clinicians concerned about supply chain so request longer durations of prescription or additional clinic visits for supply	Medicines management policy	<ul style="list-style-type: none"> As above Send communication to prescribers to remind of national advice not to stockpile to remind to prescribe in line with Trust policy (acute issues only for one month duration) Pharmacy staff to challenge prolonged duration of prescriptions
Key pharmacy databases and electronic resources may be managed outside of the UK within the EU and access may not continue to these data sources	Business Continuity plan	<ul style="list-style-type: none"> Business continuity for lack of IT/electricity will be applied for short term issues Liaise with software providers to mitigate risk and establish alternative mechanisms for accessing information
Transport delays could occur at borders meaning that medicines supplies arrive later than usual and potentially in the evenings and overnight	Business Continuity plan	<ul style="list-style-type: none"> Utilise on-call pharmacist to handle out of hours deliveries

Paper for submission to the Board on the 4th April 2019

TITLE:	Guardian of safe working report		
AUTHOR:	Mr Babar Elahi – Guardian of safe Working Hours	PRESENTER	Mr Babar Elahi – Guardian of safe Working Hours
CORPORATE OBJECTIVES: SO2: Safe and Caring Services SO4: Be the place people choose to work SO5: Make the best use of what we have			
The report covers the following elements: <ul style="list-style-type: none"> Guardian’s quarterly report with ongoing challenges Progress to date 			
IMPLICATIONS OF PAPER:			
RISK	Y		Risk Description: Implementation of revised JD contract may adversely impact on rotas
	Risk Register: Y COR102		Risk Score: 16
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: links to safe, caring and well led domains
	Monitor	N	Details:
	Other	Y	Details: national requirement for effective guardian role
ACTION REQUIRED OF BOARD			
Decision	Approval	Discussion	Other
			Y
RECOMMENDATIONS FOR THE BOARD The Board is asked to note the actions taken by the Trust and its appointed guardian of safe working.			

Board of Directors

Guardian of Safe Working Report March 2019

Purpose

To give assurance to the Trust Board that Junior Doctors in Training (JDT) 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).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Thank you to the Chair Jenni Ord
- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)

Background and Links to Previous Papers

The role of Guardian of Safe Working Hours (GSW) is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and work schedules for JDTs
- Provide Boards with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure the fair distribution of any financial penalty income, to the benefit of JDTs.

This is the 10th GSW report and covers the period of 15th November 2018 to 28th February 2019 . The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

Thank you to the Trust Chair Jennie Ord

Guardian would like extend his sincere thanks and appreciation to our Chair Jennie Ord for all the support that she has offered to the guardian office. Her mentorship and patronage has allowed the Guardian to establish best practice in the region. She has helped raise the profile of Guardian office. Thank you.

Challenges

Engagement

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage junior doctors, which involves.

- Holding regular Guardian Junior doctor forum.
- Introduction to Guardian and his role by attending Junior Doctor Induction Day

- Attending junior doctor forum arranged by Postgraduate Clinical Tutor
- Attending junior doctors' operational forum
- Creating a dedicated Guardian email in the trust
- Creating a webpage on the Trust HUB which carries information on Guardian role as well as how to make exception reports.
- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

As part of the above mention strategy, Guardian has been engaging with junior doctors by one to one contact both formally and informally.

As mentioned in the last GSW board report, there continues to be improvement in the engagement by the Educational Supervisors (ES) and Clinical Supervisors (CS) towards exception reports.

National meeting of Regional Guardian Chairs at NHS Employers Office in Leeds

Guardian has attended National meeting of Regional Guardian Chairs at NHS Employers Office in Leeds on 17th Jan 2019. Some of the useful updates on Guardian role is shared with the board.

Exception Reporting Policy:

NHS Employers have suggested that individual trusts do not need to have their own Exception Reporting Policy. NHS Employers have very clearly suggested that Junior Doctors TCS 2016 should be treated as Exception Reporting Policy by all trusts. Some trusts have their own local guidance but it is not required to have a separate exception reporting policy. Guardian has conveyed this information to JLNC.

Bench-marking Exception Reports:

It was the joint consensus across all regions that it is very difficult to have benchmarks as all trusts have different working conditions and circumstances. One of the chairs from neighboring region has tried to gather some data on this but found out that it is difficult to benchmark.

Standardising Exception Reporting - Board Reports:

NHS Employer have created a standard board report format, which has a lot more data than we currently put in our board reports, including data on locum work by trainees and financial expenses (Bank and Agency) etc. One of the trusts in London is going to pilot it to see if the required financial and other data can be easily accumulated in one report easily.

Resilience Rep for junior doctors:

Some trusts have appointed Resilience Rep for junior doctors who need support in their job. Guardian has discussed this role with Medical Director and Director of Medical Education.

Allocate Software:

In August 2019 Allocate software is going to update which will streamline the process for adding and

removing juniors when they rotate which will help us greatly as current manual way is very time consuming. Secondly, they are working to update so that Exception Reporting outcome can be automatically conveyed to payroll when over payment is required.

Exception Reports by Department – From 15th November 2018 – 28th February 2019 total = 38 reports submitted (221 episodes).

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
0	38	35	3	28 – surgery/urology 2- O&G 5 – Gen med 3 Gen surg

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open –
FY1	0	6	24	0
FY2		3		
ST1				2
ST7				

Exception Reports and Fines.

- 38 exception reports by 8 doctors
- 3 immediate safety concerns
- 4 exception reports agreed as no further action
- 31 exception reports agreed as compensation overtime payment
- 3 pending
- 4 no further action
- No fines during this period

High level data

Number of doctors/dentists in training (total): **198** (this number includes current vacancies and MTI posts)

Number of doctors/dentists in training on 2016 TCS (total): **198**

Gaps as at Feb 2019

Speciality / Grade	FY1	FY2	ST 1-2	GPV TS	ST 3-8	Total	

Cardiology						0	
AMU			1.4		1	2.4	Level 1 and 2 posts - interviews took place 21st Jan & 7 Feb: 38 applicants shortlisted in total. 5 offers made // MTIs currently helping to cover gaps. 1 CMT post vacant till August 2019 - locum to be appointed at interviews on 7 Feb // 0.4 LTFT gap until April 19 = on-call gaps only being covered by adhoc locums // ST3 post filled LTFT 60% from 1 Feb 2019
Diabetes			0.4			0.4	1 LTFT CMT works 60%. 40% gap covered by locum for on-calls only
Dermatology						0	
Elderly Care					4	4	Trust Level 2 recruitment ongoing - 1 // 2 x ST3+ being covered by agency locums booked long term up as a contingency to ensure cover during winter pressures.
EAU		0			0	0	
Gastro			1			1	ST3 gap to Sept19 being supported by MTI. ST1 gap vacant till April 19 - on-calls only being covered by locum as MTIs supporting daytime cover.
ED			1		0.4	1.4	Discussion regarding the 11 Trust SHO's are ongoing. They were originally earmarked as being part of an Indian MTI but this was put on hold. 1 ST3 LTFT working 60% - vacant 40% being covered by ad-hoc locums
Renal				1	1	2	CMT gap until April19; adhoc locums for on-call only // no recruitment for ST3 request
General Surgery					1	1	1 Clinical Fellow appointed - possible start date of early 2019 awaiting Visa.
ENT						0	

Vascular Surgery						0	
Haematology					1	1	International Fellow (Haem) and SAS Oncology posts out for shortlisting
T & O						0	
Obs & Gynae						0	
Paeds				1		1	The GP gap is until February. No recruitment requested as being covered internally. 2 Clinical fellow posts were interviewed for currently outing outcome
Pathology						0	
Radiology						0	
Respiratory			1		1	2	1 CMT vacant until April19; no recruitment requested by department // ST3 vacancy to Nov19. department have been asked if they want to recruit locum cover.
Rheumatology			1			1	Recruitment not requested. Medical Workforce liaising with department. MW awaiting instruction from department.
Stroke		1				1	FY2 gap till August 2019
Urology						0	
Ophthalmology						0	
Oral/ Max Fax						0	.
Anaesthetics			2		1	3	currently working with department regarding recruitment

Total	0	1	7.8	2	12.4	23.2	
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Next Steps

1. To encourage wider junior doctor engagement by the Guardian.
2. To use the Trust HUB to promote the role of Guardian in the Trust.

1. Conclusion

Guardian can give assurance to the Trust Board that Junior Doctors in Training (JDT) 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).

2. Recommendation

The Board are asked to read and note this report from the Guardian of Safe Working

Author	Babar Elahi Guardian of Safe Working
Executive Lead	Chief Executive
Date	26th March 2019

Paper for submission to the Board of Directors on 4 April 2019

TITLE:	Charitable Funds Committee Summary Report		
AUTHOR:	Julian Atkins - Committee Chair	PRESENTER:	Julian Atkins – Committee Chair
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	
<i>Provide specialist services to patients from the Black Country and further afield.</i>			
ACTION REQUIRED OF BOARD:			
Decision	Approval	Discussion	Other
			Y
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input checked="checked" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery
RECOMMENDATIONS FOR THE BOARD:			
The Board is asked to note the contents of the report.			
CORPORATE OBJECTIVE:			
S01 – Deliver a great patient experience S05 – Make the best use of what we have			
SUMMARY OF KEY ISSUES:			
Summary of key issues discussed and approved at the Charitable Funds Committee on 28 February 2019.			
IMPLICATIONS OF PAPER:			
RISK	N		Risk Description:
	Risk Register: N		Risk Score:
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	N	Details:
	NHSI	N	Details:
	Other	Y	Details: Charity Commission

Meeting	Meeting Date	Chair	Quorate	
Charitable Funds Committee	28 February 2019	Julian Atkins	yes	no
			Yes	
Declarations of Interest Made				
None				
Assurances Received				
COMMUNITY EQUIPMENT FUNDING APPROVED				
Michelle Pinto and Jayne Tranter attended the meeting to provide an update on the benefits seen following the Committee's approval for the purchase of Syringe Drivers and Doppler machines for the Community team. They reported that the equipment has made a significant positive impact for patients, families and staff.				
MH DU CHAIRS FUNDING APPROVED				
Tracey Price attended the meeting and although the chairs requested had not yet been delivered, explained the benefits that the chairs will bring.				
MOUTH CARE FUNDING APPROVED				
Linzie Priestnall attended the meeting and discussed the benefits seen following the Committee's approval to assist with the quality improvement initiative for mouth care.				
The Committee were pleased to hear that this initiative is achieving not only improvements in patient experience and safety but also cost savings for the Trust.				
FUNDRAISING UPDATE				
Mrs Abbiss presented the Fundraising update. It was noted that income for the year to date is significantly ahead of plan.				
The Committee agreed to support a £100,000 charity appeal to run alongside the redevelopment of the Emergency Department.				
The Committee also approved a business case for the employment of a Charity Apprentice on the basis that it will be self-funding.				
FINANCE UPDATE				
Mr Walker presented the finance update for the period ending 31 January 2019.				
In the quarter since October 2018 income was reported as being £111,506 whilst expenditure was £143,000. The total fund balance at the end of January 2019 was £2.080m.				
Mr Walker informed the Committee that the general fund had a balance after commitments of £103,342.				
FUNDING REQUESTS				
The Committee received and approved three bids for funding:				
<ul style="list-style-type: none">- Four privacy screens for a mixed sex bay on Ward B5 (£2,138).- The replacement of two examination lights for gynaecology patients on Ward B5 (£1,002).- A portable ECG machine for the Community Heart Failure Team (£2,212).				

Decisions Made / Items Approved
<ul style="list-style-type: none">- A £100,000 Charity Appeal to run alongside the redevelopment of the Emergency Department- The recruitment of a self-funding Charity Apprentice- Three bids were approved as detailed above.
Actions to come back to Committee
None
Items referred to the Board for decision or action
None

**Paper for submission to the Board on
4TH April 2019**

TITLE:	Constitution		
AUTHOR:	Sharon Philips – Deputy Director of Governance / Helen Board - Governor Engagement Lead	PRESENTER	Gilbert George – Interim Director of Governance
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
ACTION REQUIRED OF BOARD			
Decision	Approval	Discussion	Other (Assurance)
		Y	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE EXECUTIVE TEAM			
The Board are asked to: <ul style="list-style-type: none"> Review and approve the edits and updates to the Trust Constitution 			
CORPORATE OBJECTIVES:			
SO1: Deliver a great patient experience SO2: Safe and Caring Services SO3: Drive service improvements, innovation and transformation SO4: Be the place people choose to work SO5: Make the best use of what we have SO6: Deliver a viable future			
SUMMARY OF KEY ISSUES:			

The constitution has been reviewed and updated to reflect current best practise on conflicts of interest, updates on Council of Governors duties and in addition to two new sections added:

- Annex 11 Reservation of powers and scheme of delegation [to be inserted once approved by the Board, separate board agenda item]
- Annex 12 Annual Members meeting

(All edits and updates are highlighted RED for ease, board members are also asked to note that section numbering will be further reviewed following board decision).

IMPLICATIONS OF PAPER:

RISK	Y		Risk Description: covers many risks, nut key are those related to the Trust quality priorities, deteriorating patient and patient experience
	Risk Register: Y		Risk Score: numerous across the BAF, CRR and divisional risk registers
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: links all domains
	NHSI	Y	Details: links to good governance
	Other	N	Details:

FOUNDATION TRUST CONSTITUTION

~~December~~ March 2019~~2017~~

The Dudley Group NHS Foundation Trust Constitution

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1. **Interpretation and definitions**

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006.

Words importing the singular shall import the plural and vice-versa.

The 2006 Act is the National Health Service Act 2006.

The 2012 Act is the Health and Social Care Act 2012.

Accounting Officer is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

Annual Members Meeting has the meaning given in paragraph 10 of the constitution

Care Quality Commission - CQC

Constitution means this constitution and all annexes in it

Council of Governors means the Council of Governors as constituted in this constitution, which has the same meaning as ‘Council of Governors’ in the 2006 Act.

NHS Improvement is the regulator that replaced Monitor who was previously the independent regulator-, as provided by Section 61 of the 2012 Act.

Terms of Authorisation are the terms of authorisation issued by NHS Improvement

Voluntary organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

~~The Accounting Officer is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.~~

2. Name

The name of the foundation trust is The Dudley Group NHS Foundation Trust (the Trust).

3. Principal purpose

- 3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.
- 3.2 The Trust does not fulfill its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.
- 3.3 The Trust may provide goods and services for any purposes related to –
 - 3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
 - 3.3.2 the promotion and protection of public health.
- 3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

4. Powers

- 4.1 The powers of the Trust are set out in the 2006 Act, subject to any restrictions in the Terms of Authorisation.
- 4.2 All powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.
- 4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

The Trust shall have members, each of whom shall be a member of one of the following constituencies:

- 5.1 a public constituency or
- 5.2 the staff constituency

6. Application for membership

An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7. Public Constituency

- 7.1** An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.
- 7.2** Those individuals who live in an area specified for any public constituency are referred to collectively as the Public Constituency.
- 7.3** The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

8. Staff Constituency

- 8.1** An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:
 - 8.1.1** he or she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
 - 8.1.2** he or she has been continuously employed by the Trust under a contract of employment for at least 12 months.
- 8.2** Individuals from Partner Organisations who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, and who work in The Dudley Group premises or in premises specifically serving the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. Organisations whose employees may be entitled to become Members of the staff constituency, as at the date of adoption of this constitution, by virtue of exercising functions for the Trust include those listed at Annex 2.
- 8.2** Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.
- 8.3** The Staff Constituency shall be divided into 5 descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.
- 8.4** The minimum number of Members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

- 8.5** An individual who is not from a partner organisation and who is;
 - 8.5.1** eligible to become a member of the Staff Constituency, and
 - 8.5.2** invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

9. Restriction on membership

- 9.1** An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.
- 9.2** An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.
- 9.3** Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in **Annex 9 – Further Provisions**.

10. Annual Members Meeting

- 10.1** The Trust shall hold an annual meeting of its members ('annual Members' Meeting') The annual Members Meeting shall be open to members of the public.
- 10.2** Further provision about the Annual Members Meeting are set out in **Annex 12 Annual Members Meeting**.

11. Council of Governors – composition

- 11.1** The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.
- 11.2** The composition of the Council of Governors is specified in **Annex 4**.
- 11.3** The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in **Annex 4**.

12. Council of Governors – election of Governors

- 12.1** Elections for elected Members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.
- 12.2** The Model Rules for Elections, as may be varied from time to time, form part of this constitution and are attached at **Annex 5**.

12.3 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules.

10.4 An election, if contested, shall be by secret ballot.

10.5 A vacant Governor post may be filled without an election where permitted by the Model Rules as they apply to the Trust or by paragraph 9 of **Annex 9**

13. Council of Governors - tenure

13.1 An elected governor and appointed governor may hold office for a term of up to 3 years.

13.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

13.3 An elected governor shall be eligible for re-election at the end of his or her term, subject to a maximum period of office of 9 years

13.4 An appointed Governor may hold office for a period of up to 3 years.

13.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her

13.6 An appointed governor shall be eligible for a re-appointment at the end of term (for a maximum of 6 years)

14. Council of Governors – disqualification and removal

14.1 The following may not become or continue as a member of the Council of Governors:

14.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

14.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it;

14.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him or her.

14.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

14.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in **Annex 6.**

14.4 The constitution is to make provision for the removal of Governors set out in **Annex 6**.

15. Council of Governors – meetings of Governors

15.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 20.1 or paragraph 21.1 below) or, in his or her absence, the Deputy Chairman (appointed in accordance with the provisions of paragraph 22 below), shall preside at meetings of the Council of Governors.

15.2 Meetings of the Council of Governors shall normally be open to members of the public. Members of the public may be excluded from the whole or part of a meeting for special reasons, either by resolution of the Council of Governors or at the discretion of the chair of the meeting.

16. Council of Governors – duties

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public

16.1.3 To appoint the Trust Chair

16.1.4 The Trust must take steps to secure that the governors are equipped with the skills and the knowledge they require in their capacity as such

17. Council of Governors – standing orders

17.1 The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at **Annex 7**.

18. Council of Governors – referral to the Panel

18.1. In this paragraph, the Panel means a panel of persons appointed by NHSI to which a governor of an NHS foundation trust may refer a question as to whether the Trust has failed or is failing –

18.1.1. to act in accordance with its constitution, or

18.1.2. to act in accordance with provision made by or under Chapter 5 of the 2006 Act

- 18.2.** A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

19. Council of Governors - conflicts of interest of governors

- 19.1** If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he or she becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

20. Council of Governors – expenses

- 20.1** The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

21. Council of Governors – further provisions

- 21.1** Further provisions with respect to the Council of Governors are set out in **Annex 6**.

22. Board of Directors – composition

- 22.1** The Trust is to have a Board of Directors, which shall comprise both executive and Non-executive directors.

- 22.2** Subject to paragraph 8 of **Annex 9**, the Board of Directors is to comprise:

- 22.2.1** a Non-executive chairman

- 22.2.2** Not less than 5 and no greater than 8 other ~~6 other~~ Non-executive directors; and

- 22.2.3** a Chief Executive and not less than 4 and no more than 7 executive directors

- 22.2.3** ~~-6 executive directors~~ at least half of the Board of Directors, excluding the Chair, will comprise of non-executive directors determined to be independent.

- 22.3** One of the executive directors shall be the Chief Executive.

- 22.4** The Chief Executive shall be the Accounting Officer.

- 22.5** One of the executive directors shall be the finance director, with qualifications approved by the Consultative Committee of Accountancy Bodies (CCAB).

22.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

22.7 One of the executive directors is to be a registered nurse [or a registered midwife](#).

22.8 The Board may determine that other Trust officers may attend meeting of the Board of Directors as and when required to provide operational advice and support to the Board to assist the Board in the discharge of their responsibilities. For the avoidance of doubt, such an officer attending will not be a Director of the purpose of the 2006 Act. Nor will they be able to vote and will bear no responsibility or liability for an action of decision of the Board of Directors

23. Board of Directors – general duties

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

24. Board of Directors – qualification for appointment as a non-executive Director

A person may be appointed as a voting or non-voting Non-executive director only if –

24.1 he or she is a member of the Public Constituency,

24.2 he or she is not disqualified by virtue of paragraph 25 below.

24.3 the Board will publish in its annual report, each non-executive director it considers to be independent. At least half the Board, excluding the Chair, will comprise non-executive directors determined by the Board to be independent.

25. Board of Directors – appointment and removal of chairman, deputy chairman and other non-executive directors

25.1 A nominations committee shall be established to make recommendations to the Council of Governors in respect of the appointment made under this provision. The Council of Governors only at a general meeting of the Council of Governors can they appoint or remove the chair of the trust, deputy chairman of the trust and the other voting Non-executive directors.

25.2 Removal of the chairman, deputy chairman or another voting Non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

25.3 The chairman and the voting non-executive directors are to be appointed in accordance with [paragraph 26 below](#).

26. Board of Directors – appointment of chairman, senior independent director and deputy chair and other voting Non-executive directors

- 26.1** The Council of Governors has the power to appoint the other voting non-executive directors of the Trust.
- 26.2** The Council of Governors only at a general meeting of the Council of Governors can they appoint or remove the chairman, deputy chairman of the trust and the other voting non-executive directors.
- 26.3** The criteria for qualification for appointment as a voting and non-voting non-executive director is set out in paragraph 19 above (other than disqualification by virtue of paragraph 25 below).
- 26.4** The power of the Council of Governors to re-appoint Non-executive directors is to be exercised, so far as possible, by re-appointing up to a maximum of nine years terms and for exceptional approval would be required in cases that exceed this period.
- 26.5** The Council of Governors will appoint an independent NED to be the senior independent director and one other to the position of Deputy Chair in consultation with the Trust Chair.

27. Board of Directors - appointment and removal of the Chief Executive and other executive directors

- 27.1** The voting Non-executive directors shall appoint or remove the Chief Executive.
- 27.2** The appointment of the Chief Executive shall require the approval of the Council of Governors.
- 27.3** A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.
- 27.4** A person deemed to be fit and proper as set out in the CQC Fit and Proper Persons test requirements except with the approval in writing of NHS Improvement. Removal may be triggered by a person who fails to meet the fit and proper requirements (FPPR), which includes the competence, experience and qualifications to perform the role.

28. Board of Directors – disqualification

A person may not become or continue as a member of the Board of Directors if they do not comply with the requirements of the Company Directors Disqualification Act. The following may not become or continue as a member of the Board of Directors:

- 28.1** a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

- 28.2** a person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it.
- 28.3** a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him or her.
- 28.4** person who is, or is the spouse or partner of, a member of a clinical commissioning group (for the purposes of the Health and Social Care Act 2012 established to commission NHS funded services) that commissions services from the Trust
- 28.5** Removal may be triggered by a person who fails to meet the FPPR (see 27.4).

29. Board of Directors Meetings

- 29.1** Meetings of the Board of Directors shall be open to members of the public. Members of the public will be excluded from Board of Directors private meetings.
- 29.2** Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

30. Board of Directors – standing orders

- 30.1** The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time, are attached **at Annex 8.**

31. Board of Directors - conflicts of interest of directors

- 26.1** ~~If a director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors, the director shall disclose that interest to the members of the Board of Directors as soon as he or she becomes aware of it. The Standing Orders for the Board of Directors make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.~~

- 31.1.** The duties that a director of the Trust has by virtue of being a director include in particular –

- 31.1.1.** a duty to avoid a situation in which the director has (or can have) a direct or indirect, interest that conflicts (or possibly may conflict) with the interests of the trust;

31.1.2. a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

31.2. The duty referred to in sub paragraph 31.1.1 is not infringed if –

31.2.1. the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

31.2.2. the matter has been authorised in accordance with the constitution

31.3. The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

31.4. In sub-paragraph 31.1.2 “third party” means a person other than –

31.4.1. the Trust, or

31.4.2. a person acting on its behalf

31.5. If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

31.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made

31.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement

31.8. This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

31.9. A director needs not declare an interest –

31.9.1. if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

31.9.2. if, or to the extent that, the directors are already aware of it;

31.9.3. if, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered

31.9.3.1. by a meeting of the Board of Directors, or

31.9.3.2. by a committee of the directors appointed for the purpose under the constitution

31.10 A matter shall be ‘authorised’ for the purposes of paragraph 31.2.2

31.10.1 the Board of Directors by majority disapplies the provision of the constitution

which would, otherwise prevent a director from being counted as participating in the decision making process

33.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a

conflict of interest, or

33.10.3 the director's conflict of interest arises from a permitted cause (as determined

by the 'Board of Directors') from time to time.

32. Board of Directors – remuneration and terms of office

32.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the chairman and the other voting non-executive directors in light of any recommendations made by the Council of Governors Appointments and Remuneration Committee.

32.2 The Trust shall establish a committee of voting non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

32.3 The terms of office shall be reflective of any guidance issued by NHS Improvement .

33. Registers

The Trust shall maintain:

33.1 a register of Members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

33.2 a register of members of the Council of Governors;

33.3 a register of interests of Governors;

33.4 a register of board members~~directors~~; and

33.5 a register of interests of board members~~the directors~~.

34. Admission to and removal from the registers

- 34.1** Any person entitled to be a Member who, as appropriate, applies or is invited to become a Member, shall have their name added to the register of Members. Such person's membership of the Trust shall commence from the date of their name being added to the register of Members.
- 34.2.** The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member and if:
- 34.2.1.** the Member is no longer eligible under the provisions of this constitution or is disqualified
- 34.2.2.** the Member is deceased.
- 34.3.** The register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted (which may be the Secretary).
- 34.4.** The register of interests of Governors shall contain the names of each Governor, whether he has declared any interests and, if so, the interests declared in accordance with this constitution or the standing orders for Governors.
- 34.5.** The register of Directors shall list the names of Directors, their capacity on the Board of Directors and an address through which they may be contacted (which may be the Secretary).
- 34.6.** The register of interests of Directors shall contain the names of each Director, whether he has declared any interests and, if so, the interests declared in accordance with this constitution on the standing orders for Directors.

35. Registers – inspection and copies

- 35.1** The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.
- 35.2** The Trust shall not make any part of its register of member available for inspection by members of the public, if the member so requests.
- 35.3** So far as the registers are required to be made available:
- 35.3.1** they are to be available for inspection free of charge at all reasonable times; and
- 35.3.2** a person who requests a copy of or extract from the registers is to be provided with a copy or extract.
- 35.4** If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

36. Documents available for public inspection

36.1 The Trust shall make the following documents available [at the Trust Headquarters](#) for inspection by members of the public free of charge at all reasonable times:

36.1.1 a copy of the current constitution;

36.1.2 a copy of the current authorisation;

36.1.3 a copy of the latest annual accounts and of any report of the auditor on them;

36.1.4 a copy of the latest annual report and quality accounts;

36.1.5 a copy of the latest information as to its forward planning; and

36.1.6 a copy of any notice given under section 52 of the 2006 Act.

36.2 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

36.3 If the person requesting a copy or extract is not a member of the Trust, the trust may impose a reasonable charge for doing so.

37. External Auditor

37.1 The Trust shall have an external auditor.

37.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

38. Audit committee

38.1 The Trust shall establish a committee of voting non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as is appropriate.

39. Accounts

39.1 The Trust must keep proper accounts and records in relation to the accounts

39.2 NHS Improvement may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

39.3 The accounts are to be audited by the trust's auditor.

39.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement may, with the approval of the Secretary of State direct.

39.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40. Annual report and forward plans and non-NHS work

40.1 The Trust shall prepare an Annual Report and send it to NHS Improvement.

40.2 The trust shall give information as to its forward planning in respect of each financial year to NHS Improvement.

40.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

40.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

40.5 Each forward plan must include information about –

40.5.1 the activities other than the provision of goods and services for the purposes of health service in England that the Trust proposes to carry on, and

40.5.2 the income it expects to receive from doing so.

40.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub **paragraph 34.1**, the Council of Governors must –

40.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions, and

40.6.2 notify the directors of the Trust of its determination.

34.7 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, this shall not be implemented unless more than half of the members of the Council of Governors of the Trust approve its implementation.

34.8 For a statutory transaction more than half the members of the Council of Governors must approve any application by the Trust to:

- merge with or acquire another trust
- separate the Trust into two or more new foundation trusts
- be dissolved

41. Meeting of Council of Governors to consider annual accounts and reports

41.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

41.1.1 the annual accounts

41.1.2 any report of the auditor on them

41.1.3 the annual report and quality account

41.2 The documents shall also be presented to the members of the Trust at the Annual Members Meeting by at least one member of the Board of Directors in attendance

42. **Instruments**

42.1 The Trust shall have a seal.

42.2 The seal shall not be affixed except under the authority of the Board of Directors.

43. **Amendment of the Constitution**

43.1. The Trust may make amendments of its constitution only if –

43.1.1. more than half of the members of the Council of Governors of the Trust voting approve the amendments; and

43.1.2. more than half of the members of the Board of Directors [Board of Directors needs to be defined in paragraph 1] of the Trust voting approve the amendments.

43.2. Amendments made under paragraph 43.1 take effect as soon as the conditions in that paragraph are satisfied but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

43.3. -Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)

43.3.1. at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment,

43.3.2. the Trust must give the members an opportunity to vote on whether they approve the amendment; and

43.3.3. If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

- 43.4. -Amendments by the Trust of its constitution are to be notified to NHS Improvement. For the avoidance of doubt, NHS Improvement functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006. Act.

44. Indemnity

- 44.1. Members of the Board of Directors and Council of Governors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.
- 44.2. The Trust may purchase and maintain for members of the Council of Governors and Board of Directors insurance in respect of directors' and officers' liability, including, without limitation, liability arising by reason of the Trust acting as a corporate trustee of an NHS charity.

45. Procedures and Protocols

The Board of Directors shall adopt such procedures and protocols as it shall deem to be appropriate for the good governance of the Trust from time to time.

46. Mergers etc. and Significant Transactions

- 48.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.
- 48.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction

48.3 "Significant transaction" means a transaction which meets any one of the below criteria:

48.3.1 the total of the fixed assets and current assets subject to the transaction represents more than 25% of the value of the total fixed assets and current assets of the Trust;

48.3.2 the increase or decrease in income attributable to:

48.3.2.1 the assets; or

48.3.2.2 the contract associated with the transaction represents more than 25% of the value of the Trust's income; or

48.3.2.3 the gross capital of the company or business being acquired/divested represents more than 25% of the total capital of the Trust following completion (where gross capital is the market value of

the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets).

- 48.4** "Significant Transaction" excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services.

DRAFT

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 6.1 and 6.3)

Eligibility to become a member of the Public Constitution is open to people living within the defined catchment area of the Trust. This will include residents from the following Local Authority electoral areas (as defined for the purpose of Local authority elections). The Public Constituency may also include volunteers providing support to the Trust who will be a member of the constituency in which they ordinarily reside. An individual is only eligible for membership of the public constituency if he/she lives in an area specified in the constitution for a public constituency.

Constituency	Minimum Number of Members	Number of Governors to be elected from that area
Dudley		
Brierley Hill	50	2
Central Dudley	50	2
North Dudley	50	2
Stourbridge	50	2
Halesowen	50	2
Others		
Rowley Regis and Tipton	24	1
South Staffordshire and Wyre Forest	24	1
Rest of West Midlands	12	1

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 7.1 and 7.2)

Eligibility to become a member of the Staff Constituency is defined in paragraph 8 of the Constitution. The table below details the minimum number of staff within each class.

The staff constituency will include all staff employed by the Trust who have a contract of employment which does not have a fixed term or if does have a fixed term is at least 12 months duration, or they have been employed continuously for 12 months subject to any member of staff deciding to opt out. The constituency will also include independent contractors working at DGFT Only individuals who fulfill these criteria will be eligible to be staff members, see paragraph 8.2. Staff membership will be on an opt-out basis.

Class	Minimum Number of Members	Number of Staff Governors
Medical and Dental	44	1
Nursing and Midwifery	157	3
Allied Health Professionals and Healthcare Scientists	79	2
Non-Clinical Staff	58	1
Partner Organisations' Employees from for example: Summit Healthcare (Dudley) Limited Interserve fm Siemens Healthcare Systems Commissioners– Dudley, Sandwell, Worcestershire, South Staffordshire Local Authorities – Dudley MBC, Sandwell MBC, Wyre Forest District Council, South Staffordshire District Council	10	1

Medical:

The members of the Medical staff class shall include individuals who are eligible as members of the Staff Constituency and who are persons who are included in the register of medical practitioners maintained in accordance with Section 2 of the Medical Act 1983 and who hold a licence to practice if and when this is required by legislation to enable such a person to practice.

For the avoidance of doubt, the Medical staff class shall include junior doctors who have been registered provisionally in the register of medical practitioners.

Nursing and Midwifery:

The members of the Nursing and Midwifery staff class shall include individuals who are eligible as members of the Staff Constituency who do not fall within the Medical staff class but whose regulatory body is the Nursing and Midwifery Council. For the avoidance of doubt, the Nursing and Midwifery staff class shall also include nursing auxiliaries and health care assistants.

Allied Health Professionals and Clinical Support Staff:

The members of the Allied Health Professionals and Clinical Support Staff class shall include individuals who are eligible as members of the Staff Constituency who do not fall within the Medical and Dental Practitioners staff class or the Nursing and Midwifery staff class but whose regulatory body is within the remit of the Council for Healthcare Regulatory Excellence or who are otherwise designated by the trust from time to time as eligible to be members of this class.

Management, Administrative and Support Staff (including eligible contractors):

The members of the Management, Administrative and Support Staff class shall include individuals who are eligible as members of the Staff Constituency but do not fall within any of the other staff classes mentioned above. The Management, Administrative and Support Staff class shall include individuals who are not employed by the Trust but carry out the functions of the Trust through an independent contractor.

ANNEX 3 – THE PATIENTS’ CONSTITUENCY

The Trust has no patients’ constituency.

DRAFT

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 9.2 and 9.3 and Notes 13 to 18)

The composition of the Council of Governors is as set out below, provided always that the number of Public Governors shall be more than half the total membership of the Council of Governors.

Constituency/Class	No. of Governors
Public	
Brierley Hill Ward	2
Central Dudley Ward	2
North Dudley Ward	2
Stourbridge Ward	2
Halesowen Ward	2
Rowley Regis and Tipton Ward	1
South Staffordshire and Wyre Forest Ward	1
Rest of West Midlands	1
Total Public	13
Staff	
Medical and Dental	1
Nursing and Midwifery	3
Allied Health Professionals and Healthcare Scientists	2
Non-Clinical Staff	1
Partner Organisations' staff	1
Total Staff	8
Appointed (by a statutory or partnership organisation)	
Dudley Clinical Commissioning Group	1
Dudley Metropolitan Borough Council	1
University of Birmingham Medical School	1
Governor appointed by Dudley Council for Voluntary Service, who may be a Dudley Group NHS Foundation Trust Hospital Volunteer	1
Total Appointed	4
Grand Total	25

Note: Appointed governors are appointed by a statutory or partnership organisation in accordance with the 2006 Act Schedule 7 para 9(7).

Model Rules for Elections

Reviewed ~~October 2017~~ April 2019

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PART 1 - INTERPRETATION

1.1 Interpretation

1.1 In these rules, unless the context otherwise requires –

“the Trust”	means the public benefit corporation subject to this constitution;
“election”	means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;
“the regulator”	means the Independent Regulator for NHS foundation trusts; and
“the 2006 Act”	means the National Health Service Act 2006.
“council of governors”	means the council of governors of the Trust;
“declaration of identity”	has the meaning set out in rule 21.1;
“e-voting”	means voting using either the internet, telephone or text message;
“e-voting information”	has the meaning set out in rule 24.2;
“ID declaration form”	has the meaning set out in Rule 21.1;
“internet voting record”	has the meaning set out in rule 26.4(d);
“internet voting system”	means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;
“lead governor”	means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code. “list of eligible voters” means the list referred to in rule 22.1, containing the information in rule 22.2;
“method of polling”	means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;
“numerical voting code”	has the meaning set out in rule 64.2(b)
“polling website”	has the meaning set out in rule 26.1;
“postal voting information”	has the meaning set out in rule 24.1;
“telephone short code”	means a short telephone number used for the purposes of submitting a vote by text message;
“voter ID number”	means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,
“voting information”	means postal voting information and/or e-voting information

- 1.2 Other expressions used in these rules and in Schedule 7 to the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

PART 2 – TIMETABLE FOR ELECTION

2 Timetable

- 2.1 The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

- 3.1 In computing any period of time for the purposes of the timetable –

- (a) Saturday or Sunday;
- (b) Christmas day, Good Friday, or a bank holiday, or
- (c) A day appointed for public thanksgiving or mourning, shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

- 3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3 – RETURNING OFFICER

4. Returning officer

- 4.1 Subject to rule 64, the returning officer for an election is to be appointed by the Trust.
- 4.4 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

The Trust is to pay the returning officer –

- (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
- (b) such remuneration and other expenses as the Trust may determine.

7. Duty of co-operation

The Trust is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 - STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

The returning officer is to publish a notice of the election stating –

- (a) the constituency, or class within a constituency, for which the election is being held,
- (b) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
- (c) the details of any nomination committee that has been established by the Trust,
- (d) the address and times at which nomination papers may be obtained;
- (e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
- (f) the date and time by which any notice of withdrawal must be received by the returning officer

- (g) the contact details of the returning officer, and
- (h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 The returning officer-

- (a) is to supply any member of the Trust with a nomination paper, and
- (b) is to prepare a nomination paper for signature at the request of any member of the Trust, but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's consent and particulars

The nomination paper must state the candidate's –

- (a) full name,
- (b) contact address in full (which should be a postal address), and constituency or class within a constituency, of which the candidate is a member. An e-mail address may also be provided for the purposes of electronic communication).
- (c) Constituency or class within a constituency of which the candidate is a member.

11. Declaration of interests

The nomination paper must state –

- (a) any financial interest that the candidate has in the Trust, and
 - (b) whether the candidate is a member of a political party, and if so, which party,
- and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

The nomination paper must include a declaration made by the candidate–

- (a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
- (b) for a member of the public constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination paper must be signed and dated by the candidate, indicating that –

- (a) they wish to stand as a candidate,
- (b) their declaration of interests as required under rule 11, is true and correct, and
- (c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nominations forms is an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer-

- (a) decides that the candidate is not eligible to stand,
- (b) decides that the nomination paper is invalid,
- (b) receives satisfactory proof that the candidate has died, or
- (d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds –

- (a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,
- (b) that the paper does not contain the candidate's particulars, as required by rule 10;
- (c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
- (d) that the paper does not include a declaration of eligibility as required by rule 12, or
- (e) that the paper is not signed and dated by the candidate, as required by rule 13.

14.3 The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or Invalid to the candidate at the contact address given in the candidate's nomination paper. If an email address has been given in the candidates nomination form (in addition to the candidates postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of nominated candidates –

15.1 The returning officer is to prepare and publish a statement showing the candidates who

are standing for election.

15.2 The statement must show –

- (a) the name, contact address, and constituency or class within a constituency of each candidate standing, and
- (b) the declared interests of each candidate standing, as given in their nomination paper.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the Trust as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

16.1 The Trust is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15 (4) available for inspection by members of the public free of charge at all reasonable times.

16.2 If a person requests a copy or extract of the statements of candidates or their nomination papers, the Trust is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of Members to be elected to the council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of Members to be elected to the council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of Members to be elected to be council of Governors, then –

- (a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
- (b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the Trust.

PART 5 – CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper

20.1 The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify –

- (a) the name of the Trust,
- (b) the constituency, or class within a constituency, for which the election is being held,
- (c) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
- (d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (e) instructions on how to vote,
- (f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
- (g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity public constituency

21.1 In respect of an election for a public constituency a declaration of identity must be issued with each ballot paper.

21.2 The declaration of identity is to include a declaration –

- (a) that the voter is the person to whom the ballot paper was addressed,
- (b) that the voter has not marked or returned any other voting paper in the election, and
- (c) for a member of the public constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

21.3 The declaration of identity is to include space for –

- (a) the name of the voter,
- (b) the address of the voter,
- (c) the voter's signature, and
- (d) the date that the declaration was made by the voter.

21.4 The voter must be required to return the declaration of identity together with the ballot paper.

21.5 The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be

declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The Trust is to provide the returning officer with a list of the Members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll

The returning officer is to publish a notice of the poll stating–

- (a) the name of the Trust,
- (b) the constituency, or class within a constituency, for which the election is being held,
- (c) the number of members of the council of Governors to be elected from that constituency, or class with that constituency,
- (d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
- (f) the address for return of the ballot papers, and the date and time of the close of the poll,
- (g) the address and final dates for applications for replacement ballot papers,
- (h) the date and time of the close of the poll, and
- (i) the contact details of the returning officer.

24. Issue of voting documents by returning officer

24.1 As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the Trust named in the list of eligible voters–

- (a) a ballot paper and ballot paper envelope,
- (b) a declaration of identity (if required),
- (c) information about each candidate standing for election, pursuant to rule 59 of these rules, and
- (d) a covering envelope.

24.2 The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25.1 Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

- (a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:

- (a) the completed ID declaration form if required, and
- (b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.1.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.1.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.1.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

- (i) enter his or her voter ID number; and
- (ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

- (i) the name of the corporation,
- (ii) the constituency, or class within a constituency, for which the election is being held,
- (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
- (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (v) instructions on how to vote and how to make a declaration of identity,
- (vi) the date and time of the close of the poll, and
- (vii) the contact details of the returning officer;

- (c) prevent a voter from voting for more candidates than he or she is entitled to at the election;
- (d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
 - (i) the voter's voter ID number;
 - (ii) the voter's declaration of identity (where required);
 - (iii) the candidate or candidates for whom the voter has voted; and
 - (iv) the date and time of the voter's vote,
- (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and
- (f) prevent any voter from voting after the close of poll.

26.1.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

- (a) require a voter to
 - (i) enter his or her voter ID number in order to be able to cast his or her vote; and
 - (ii) where the election is for a public or patient constituency, make a declaration of identity;
- (b) specify:
 - (i) the name of the corporation,
 - (ii) the constituency, or class within a constituency, for which the election is being held,
 - (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
 - (iv) instructions on how to vote and how to make a declaration of identity,
 - (v) the date and time of the close of the poll, and
 - (vi) the contact details of the returning officer;
- (c) prevent a voter from voting for more candidates than he or she is entitled to at the election;
- (d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
 - (i) the voter's voter ID number;
 - (ii) the voter's declaration of identity (where required);
 - (iii) the candidate or candidates for whom the voter has voted; and
 - (iv) the date and time of the voter's vote

- (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
- (f) prevent any voter from voting after the close of poll.

26.1.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

- (a) require a voter to:
 - (i) provide his or her voter ID number; and
 - (ii) where the election is for a public or patient constituency, make a declaration of identity;
 in order to be able to cast his or her vote;
- (b) prevent a voter from voting for more candidates than he or she is entitled to at the election;
- (d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
 - (i) the voter's voter ID number;
 - (ii) the voter's declaration of identity (where required);
 - (ii) the candidate or candidates for whom the voter has voted; and
 - (iii) the date and time of the voter's vote
- (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
- (f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

An individual, who becomes a member of the Trust on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

- 28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.
- 28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers

- 29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted

as a ballot paper (referred to a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.

- 29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.
- 29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she –
 - (a) is satisfied as to the voter’s identity, and
 - (b) has ensured that the declaration of identity, if required, has not been returned.
- 29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”) –
 - (a) the name of the voter, and
 - (b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
 - (c) the details of the unique identifier of the replacement ballot paper.

30. Lost voting information

- 30.1 Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement ballot paper.
- 30.2 The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she –
 - (a) is satisfied as to the voter’s identity,
 - (b) has no reason to doubt that the voter did not receive the original ballot paper, and
 - (c) has ensured that the declaration of identity if required has not been returned.
- 30.3 After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list (“the list of lost ballot papers”) –
 - (a) the name of the voter, and
 - (b) the details of the unique identifier of the replacement ballot paper.

31. Issue of replacement ballot paper

- 31.1 If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.
- 31.2 After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list (“the list of tendered ballot papers”) –
 - (a) the name of the voter, and
 - (b) the details of the unique identifier of the replacement ballot paper issued under this rule.

32. Declaration of identity for replacement ballot papers public constituency

32.1 In respect of an election for a public constituency a declaration of identity must be issued with each replacement ballot paper.

32.2 The declaration of identity is to include a declaration –
(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and
(b) of the particulars of that member's qualification to vote as a member of the public constituency, or class within a constituency, for which the election is being held.

32.3 The declaration of identity is to include space for –
(a) the name of the voter,
(b) the address of the voter,
(c) the voter's signature, and
(d) the date that the declaration was made by the voter.

32.4 The voter must be required to return the declaration of identity together with the ballot paper.

32.5 The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

33. Receipt of voting documents

33.1 Where the returning officer receives a –
(a) covering envelope, or
(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable.

33.2 The returning officer may open any ballot paper envelope, but must make arrangements to ensure that no person obtains or communicates information as to –
(a) the candidate for whom a voter has voted, or
(b) the unique identifier on a ballot paper.

33.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

34. Validity of ballot

34.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

34.2 Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to –
(a) put the declaration of identity if required in a separate packet, and
(b) put the ballot paper aside for counting after the close of the poll.

34.3 Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to –

- (a) mark the ballot paper “disqualified”,
- (b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it the ballot paper,
- (c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and
- (d) place the document or documents in a separate packet.

34.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

34.5 Where the returning officer is satisfied that rule 34.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

34.6 Where the returning officer is not satisfied that rule 34.4 has been fulfilled, he or she is to:

- (a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
- (b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
- (c) place the document or documents in a separate packet.

35. Declaration of identity but no ballot paper public constituency

Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to –

- (a) mark the declaration of identity “disqualified”,
- (b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and
- (c) place the declaration of identity in a separate packet.

36. Sealing of packets

As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing–

- (a) the disqualified documents, together with the list of disqualified documents inside it,
- (b) the declarations of identity if required,
- (c) the list of spoilt ballot papers,
- (d) the list of lost ballot papers,
- (e) the list of eligible voters, and
- (f) the list of tendered ballot papers.

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 - COUNTING THE VOTES

37. Interpretation of Part 6

In Part 6 of these rules –

“continuing candidate” means any candidate not deemed to be elected, and not excluded,

“count” means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

“deemed to be elected” means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

“mark” means a figure, an identifiable written word, or a mark such as “X”,

“non-transferable vote” means a ballot paper –

- (a) on which no second or subsequent preference is recorded for a continuing candidate, or
- (b) which is excluded by the returning officer under rule 44 (4) below,

“preference” as used in the following contexts has the meaning assigned below–

- (a) “first preference” means the figure “1” or any mark or word which clearly indicates a first (or only) preference,
- (b) “next available preference” means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
- (c) in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on,

“quota” means the number calculated in accordance with rule 41 below,

“surplus” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable papers from the candidate who has the surplus,

“stage of the count” means –

- (a) the determination of the first preference vote of each candidate,
- (b) the transfer of a surplus of a candidate deemed to be elected, or
- (c) the exclusion of one or more candidates at any given time,

“transferable paper” means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

“transferred vote” means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred, and

“transfer value” means the value of a transferred vote calculated in accordance with paragraph (4) or (7) of rule 42 below.

38. Arrangements for counting of the votes

38.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38.3 The returning officer may make arrangements for any votes to be counted using vote counting software where:

- (a) the board of directors and the council of governors of the corporation have approved:
 - (i) the use of such software for the purpose of counting votes in the relevant election, and
 - (ii) a policy governing the use of such software, and
- (b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

39. The count

39.1 The returning officer is to –

- (a) count and record the number of ballot papers that have been returned;
- (b) the number of internet voting records, telephone voting records and/or text voting records that have been created; and
- (c) count the votes according to the provisions in this Part of the rules.

39.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

39.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

40. Rejected ballot papers

40.1 Any ballot paper –

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
- (c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or

preferences.

- 40.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.
- 40.3 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).
- 40.4 Any text voting record:
- (a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate, or
 - (b) on which anything is written or marked by which the voter can be identified except the unique identifier
- 40.5 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.
- 40.6 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (b) of rule STV 40.4.

41. First stage

- 41.1 The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.
- 41.2 The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.
- 41.3 The returning officer is to also ascertain and record the number of valid ballot papers.

42. The quota

- 42.1 The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.
- 42.2 The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).
- 42.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 44 has been complied with.

43. Transfer of votes

(1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped –

- (a) according to next available preference given on those papers for any continuing candidate,

- or
- (b) where no such preference is given, as the sub-parcel of nontransferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule 44 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1) (a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall be at a value ("the transfer value") which –

- (a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
- (b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped –

- (a) according to the next available preference given on those papers for any continuing candidate, or
- (b) where no such preference is given, as the sub-parcel of nontransferable votes.

(6) The returning officer is, in accordance with this rule and rule 44 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5) (a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at –

- (a) a transfer value calculated as set out in paragraph (4) (b) above, or
- (b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are –

- (a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
- (b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

44. Supplementary provisions on transfer

(1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if –

- (a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
- (b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule 43 above –

- (a) record the total value of the votes transferred to each candidate,
- (b) add that value to the previous total of votes recorded for each candidate and record the new total,
- (c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
- (d) compare—
 - (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
 - (ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule 43 or 45 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be, all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule 43 or 45 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a nontransferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

45. Exclusion of candidates

(1) If—

- (a) all transferable papers which under the provisions of rule 43 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred, and
- (b) subject to rule 46 below, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where paragraph (12) below applies, the candidates with the then lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels so that they are grouped as—

- (a) ballot papers on which a next available preference is given, and
- (b) ballot papers on which no such preference is given (thereby including ballot papers on

which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule 44 above, transfer each sub-parcel of ballot papers referred to in paragraph (2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule 46 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule —

- (a) record —
 - (i) the total value of votes, or
 - (ii) the total transfer value of votes transferred to each candidate,
- (b) add that total to the previous total of votes recorded for each candidate and record the new total,
- (c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
- (d) compare—
 - (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
 - (ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule 43 and rule 44.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest—

- (a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

- (b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

46. Filling of last vacancies

- (1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.
- (2) Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.
- (3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

47. Order of election of candidates

- (1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 43 (10) above.
- (2) A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.
- (3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.
- (4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

Part 7 – Final proceedings in contested and uncontested elections

48. Declaration of result for contested elections

- (1) In a contested election, when the result of the poll has been ascertained, the returning officer is to—
 - (a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
 - (b) give notice of the name of each candidate who he or she has declared elected –
 - (i) where the election is held under a proposed constitution pursuant to powers conferred on the Dudley Group of Hospitals NHS Trust by section 4(4) of the 2006 Act, to the chairman of the NHS Trust, or
 - (ii) in any other case, to the chairman of the Trust, and
 - (c) give public notice of the name of each candidate who he or she has declared elected.
- (2) The returning officer is to make –
 - (a) the number of first preference votes for each candidate whether elected or not,
 - (b) any transfer of votes,
 - (c) the total number of votes for each candidate at each stage of the count at which such

- transfer took place,
- (d) the order in which the successful candidates were elected, and
- (e) the number of rejected ballot papers under each of the headings in rule 40 (1),

available on request.

49. Declaration of result for uncontested elections

In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election –

- (a) declare the candidate or candidates remaining validly nominated to be elected,
- (b) give notice of the name of each candidate who he or she has declared elected to the chairman of the Trust, and
- (c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

50. Sealing up of documents relating to the poll

(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets –

- (a) the counted ballot papers,
- (b) the ballot papers endorsed with “rejected in part”,
- (c) the rejected ballot papers, and
- (d) the statement of rejected ballot papers

(2) The returning officer must not open the sealed packets of –

- (a) the disqualified documents, with the list of disqualified documents inside it,
- (b) the declarations of identity,
- (c) the list of spoilt ballot papers,
- (d) the list of lost ballot papers,
- (e) the list of eligible voters, and
- (f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –

- (a) its contents,
- (b) the date of the publication of notice of the election,
- (c) the name of the corporation to which the election relates, and
- (d) the constituency, or class within a constituency, to which the election relates.

51. Delivery of documents

Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 50, the returning officer is to forward them to the chair of the Trust.

52. Forwarding of documents received after close of the poll

Where –

- (a) any voting documents are received by the returning officer after the close of the poll, or
- (b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
- (c) any applications for replacement ballot papers are made too late to enable new ballot

papers to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

53. Retention and public inspection of documents

(1) The Trust is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 54 (1), the documents relating to an election that are held by the Trust shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the Trust, and the Trust is to provide it, and may impose a reasonable charge for doing so.

54. Application for inspection of certain documents relating to an election

(1) The Trust may not allow the inspection of, or the opening of any sealed packet containing

- (a) any rejected ballot papers, including ballot papers rejected in part,
- (b) any disqualified documents, or the list of disqualified documents,
- (c) any counted ballot papers,
- (d) any declarations of identity, or
- (e) the list of eligible voters,

by any person without the consent of the regulator.

(2) A person may apply to the regulator to inspect any of the documents listed in (1), and the regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

- (a) persons,
- (b) time,
- (c) place and mode of inspection,
- (d) production or opening,

and the Trust must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), –

- (a) in giving its consent, the regulator, and
- (b) and making the documents available for inspection, the Trust,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

- (i) that his or her vote was given, and
- (ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

55. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to –

- (a) publish a notice stating that the candidate has died, and
- (b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
 - (i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
 - (ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 50 (1) (a).

Part 10 – Election expenses and publicity Election expenses

56. Election expenses

Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the Regulator under **Part 11** of these rules.

57 Expenses and payments by candidates

A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to –

- (a) personal expenses,
- (b) travelling expenses, and expenses incurred while living away from home, and
- (c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100 (to be reviewed after first elections).

These expenses are to be met by the candidate, not by the Trust.

58. Election expenses incurred by other persons

(1) No person may -

- (a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
- (b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments,

as it considers necessary pursuant to rules 59 and 60.

Publicity

59. Publicity about election by the Trust

(1) The Trust may –

- (a) compile and distribute such information about the candidates, and
- (b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the Trust about the candidates, including information compiled by the Trust under rule 60, must be –

- (a) objective, balanced and fair,
- (b) equivalent in size and content for all candidates (as far as the information provided by the candidates so allows),
- (c) compiled and distributed in consultation with all of the candidates standing for election, and
- (d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the Trust proposes to hold a meeting to enable the candidates to speak, the Trust must ensure that all of the candidates are invited to attend,

and in organising and holding such a meeting, the Trust must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

60. Information about candidates for inclusion with voting documents

(1) The Trust must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to **rule 24** of these rules.

(2) The information must consist of –

- (a) a statement submitted by the candidate of no more than 200 words, and
- (b) a passport type photograph of the candidate

if provided by the candidate.

61. Meaning of “for the purposes of an election”

(1) In this Part, the phrase “for the purposes of an election” means with a view to, or otherwise in connection with, promoting or procuring a candidate’s election, including the prejudicing of another candidate’s electoral prospects; and the phrase “for the purposes of a candidate’s election” is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free

of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

62. Application to question an election

- (1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.
- (2) An application may only be made once the outcome of the election has been declared by the returning officer.
- (3) An application may only be made to the regulator by -
 - (a) a person who voted at the election or who claimed to have had the right to vote, or
 - (b) a candidate, or a person claiming to have had a right to be elected at the election.
- (4) The application must –
 - (a) describe the alleged breach of the rules or electoral irregularity, and
 - (b) be in such a form as the regulator may require.
- (5) The application must be presented in writing within 21 days of the declaration of the result of the election.
- (6) If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.
 - a. The regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.
 - b. The determination by the person or persons nominated in accordance with Rule 62(7) shall be binding on and shall be given effect by the Trust, the applicant and the Members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.
 - c. The regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

63. Secrecy

- (1) The following persons –
 - (a) the returning officer,
 - (b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to –

- (i) the name of any member of the Trust who has or has not been given a ballot paper or who has or has not voted,
- (ii) the unique identifier on any ballot paper,
- (iii) the candidate(s) for whom any member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

64. Prohibition of disclosure of vote

No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

65. Disqualification

A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is –

- (a) a member of the Trust,
- (b) an employee of the Trust,
- (c) a director of the Trust, or
- (d) employed by or on behalf of a person who has been nominated for election.

66. Delay in postal service through industrial action or unforeseen event

If industrial action, or some other unforeseen event, results in a delay in –

- (a) the delivery of the documents in rule 24, or
- (b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the regulator.

67. Effect of administrative or clerical errors on election

Elections shall not be invalidated by any administrative or clerical error on the part of the Trust or any acts or omissions of the returning officer or the independent scrutineer acting in good faith on the basis of any such error.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

1. they are a Director of the Trust, or a Governor or Director of another NHS Body, or of an independent/private sector health care provider. These restrictions do not apply to Appointed Partnership Governors;
2. they are under sixteen years of age;
3. being a member of a public constituency, they were or were entitled to be a member of one of the classes of the staff constituency at any point during the preceding two years;
4. being a member of one of the public constituencies, they refuse to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;
5. they are the subject of a sex offender order;
6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, expiry of a fixed term contract, disability, ill health or age from any paid employment with a health service body. In other cases of dismissal, such as capability, an individual may be permitted to become a governor, at the discretion of the trust, and subject to full disclosure of the relevant circumstances and facts concerning that dismissal;
7. they are a person whose tenure of office as the Chairman or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for nonattendance at meetings, or for non-disclosure of a pecuniary interest;
8. they have had their name removed, by a direction under section 46 of the 1977 NHS Act from any list prepared under Part II of that Act or have otherwise been disqualified or suspended from any healthcare profession, and have not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable);
9. they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;
10. they are an elected governor and they cease to be a member of the constituency or class by which they were elected. This may include, but is not restricted to, the reasons for ceasing to be a member identified in Annex 9;
11. they are a non elected governor and they cease to be sponsored by their organisation. A person who ceases to be a governor could continue to attend the Council of Governors in an advisory capacity, if the Council of Governors so wishes, although they would not have voting rights;

12. they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;
13. they are a member of a local authority's Overview and Scrutiny Committee covering health matters;
14. they are a member of the Healthwatch relating to this Foundation Trust;
15. they fail to or indicate that they are unwilling to act in the best interests of the Trust and in accordance with The Seven Principles of Public Life laid out by the Committee on Standards in Public Life in its First Report as amended from time to time.
16. they fail to agree (or, having agreed, fail) to abide by the values of the Trust Principles set out in Annex 10.
17. Governors are required to attend mandatory training, as defined from time to time, provided by the Trust on their role and function.
18. consistently and unjustifiably fail to maintain attendance at Full Council of Governor meetings as defined within the Code of Conduct for Governors.
19. if in applying for a Staff Governor position their contract of employment is shorter than the prescribed term of office for that role.

**ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE
COUNCIL OF GOVERNORS**

(Paragraph 14)

**Standing Orders
Council of Governors**

March 2019

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1. INTRODUCTION

Statutory Framework

The Dudley Group NHS Foundation Trust is a statutory body which became a public benefit corporation following its approval as an NHS Foundation Trust by the Independent Regulator of NHS Foundation Trusts (Independent Regulator) pursuant to the National Health Service Act 2006 (the 2006 Act).

The principal places of business of the Trust are:

- Russells Hall Hospital, Pensnett Road, Dudley, West Midlands, DY1 2HQ
- Corbett Outpatients Centre, Vicarage Road, Stourbridge, West Midlands, DY8 4JB
- Guest Outpatients Centre, Tipton Road, Dudley, West Midlands, DY1 4SE

NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 [and 2012](#) Act, by their constitutions and by terms of their authorisation granted by the Independent Regulator (Regulatory Framework).

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

The Regulatory Framework requires the Council of Governors to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

2. INTERPRETATION

- 2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Trust Secretary).
- 2.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in the interpretation and in addition:

"TRUST" means The Dudley Group NHS Foundation Trust.

"COUNCIL OF GOVERNORS" means the Council of Governors of the Trust as defined in the Constitution.

"BOARD OF DIRECTORS" means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body.

"CHAIR OF THE BOARD" or "Chair of the Trust" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions "the Chair of the Board" and "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" means the Chief Executive Officer of the Trust.

"COMMITTEE" means a committee of the Council of Governors

"CONSTITUTION" means the constitution of the Foundation Trust.

"COMMITTEE MEMBERS" means the Chair and the Governors or Directors formally appointed by the Council of Governors or Board of Directors to sit on or to chair specific committees.

"DEPUTY CHAIR" means the non-executive director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

"EXECUTIVE DIRECTOR" means a Member of the Board of Directors who holds an executive office of the Trust.

"MEMBER OF THE COUNCIL" means a Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the Chair).

"NON-EXECUTIVE DIRECTOR" means a member of the Board of Directors who does not hold an executive office with the Trust. These may be referred to as voting and non-voting where appropriate.

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

“SOs” means these Standing Orders.

“SECRETARY TO THE TRUST” means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust’s compliance with the Regulatory Framework and these standing orders.

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3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council of Governors

3.1.1 In accordance with the Constitution of the Foundation Trust, the composition of the Council of Governors shall be reviewed from time to time and currently comprises:

- 13 Public Governors
- 8 Staff Governors
- 1 Primary Care Trust Governor
- 1 Local Authority Governor
- 1 University Governor
- 1 voluntary organisation Governor

3.2 Role of the Chair

3.2.1 The Chair is not a member of the Council of Governors. However under the Regulatory Framework, he or she presides at meetings of the Council of Governors and has a casting vote.

3.2.2 Where the Chair of the Trust has died or has ceased to hold office, or where he or she has been unable to perform his or her duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his or her 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 his or her duties, be taken to include references to the Deputy Chair.

3.3 Role and Responsibilities of the Council of Governors

3.3.1 The role and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust Constitution, are:

- To appoint and remove the Chair and other voting non-executive directors of the Foundation Trust at a general meeting. To approve (by a majority of members of the Council of Governors) the appointment by the non-executive directors of the Chief Executive
- To appoint or remove the auditor at a general meeting
- To be consulted by the Trust's Board of Directors on forward planning and to have the Council of Governors' views taken into account
- To be presented with, at a Members' general meeting, the Annual Report and Accounts and the report of the auditor

3.3.2 The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its Directors. The Council of Governors does not have the right to veto decisions made by the Board of Directors.

3.3.3 The Council of Governors, and individual Governors, are not empowered to speak on behalf of the Trust, and must seek the advice and views of the Chair concerning any contact from the media or any invitation to speak publicly about the Trust or their role

within it. For the avoidance of doubt, in this context the Chair acts as Chair of the Trust not as Chair of the Council of Governors and in his or her absence Governors should seek the advice and views of the Deputy Chair of the Trust or another non-executive Director of the Trust.

4. MEETINGS OF THE COUNCIL

4.1 Admission of the Public

4.1.1. The public shall be afforded facilities to attend all formal meetings of the Council of Governors except where the Council resolves:

- (a) That members of the public be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public; and/or
- (b) That in the interests of the public order the meeting adjourn for a period to be specified in such resolution to enable the Council to complete business without the presence of the public.

4.1.2 Nothing in these Standing Orders shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

4.2 Calling Meetings

4.2.1 Ordinary meetings of the Council shall be held at such times and places as the Board may determine and there shall be not less than 3 or more than 4 formal meetings in any year except in exceptional circumstances.

4.2.2 The Chair of the Trust may call a meeting of the Council at any time. 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 members of the Council, has been presented to him or her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him or her at Trust's Headquarters, such one third or more members of the Council may forthwith call a meeting.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on his or her behalf shall be delivered to every Member of the Council, or sent by post to the usual place of residence of such Member of the Council, so as to be available to him or her at least three working days before the meeting.

4.3.2 Want of service of the notice on any Member of the Council shall not affect the validity of a meeting.

- 4.3.3 In the case of a meeting called by members of the Council in default of the Chair, the notice shall be signed by those Members of the Council and no business shall be transacted at the meeting other than specified in the notice.
- 4.3.4 Agendas will be sent to Members of the Council before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.
- 4.3.5 Before each meeting of the Council a public notice of the time and place of the meeting shall be displayed at the Trust's offices at least three clear days before the meeting.

4.4 Setting the Agenda

- 4.4.1 The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.
- 4.4.2 A Member of the Council desiring a matter to be included on an agenda shall make his or her request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

4.5 Petitions

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

4.6 Chair of Meeting

- 4.6.1 At any meeting of the Council, the Chair of the Trust, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if he or she is present, shall preside. If the Chair and Deputy Chair are absent such non-executive director as the Members of the Council present shall choose shall preside. Where the Chair of the Trust, Deputy Chair and other non-executive directors are all absent or have a conflict of interest, the Council of Governors shall select one of their number to preside at the meeting. The person presiding at the meeting shall have a casting vote.
- 4.6.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive director as the Members of the Council present shall choose, shall preside. Where the Chair, Deputy Chair Lead Governor and other non-executive directors are all absent or have a conflict of interest, an appropriate representative will be appointed from amongst the Council of Governors to preside at the meeting and have a casting vote.

4.7 Notices of Motion

- 4.7.1 A Member of the Council desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the

agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

4.8 Withdrawal of Motion or Amendments

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

4.9 Motion to Rescind a Resolution

- 4.9.1 Notice of a motion to amend or 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 of the Council who gives it and also the signature of four other Council Members. When any such motion has been disposed of by the Council, it shall not be competent for any member other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if he or she considers it appropriate.

4.10 Motions

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

- 4.10.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Council to move:

- an amendment to the motion
- the adjournment of the discussion or the meeting
- that the meeting proceed to the next business (*)
- the appointment of an ad hoc committee to deal with a specific item of business
- that the motion be now put. (*)
- a motion resolving to exclude the public under SO 4.1.1.

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Member of the Council who has not previously taken part in debate and who is eligible to vote.

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

4.11 Chair's Ruling

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

4.12 Voting

- 4.12.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Members of the Council present and voting on the question and, in the case of number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.
- 4.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Council present so request.
- 4.12.3 If at least one-third of the Members of the Council present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Council present voted or abstained.
- 4.12.4 If a Member of the Council so requests, his or her vote shall be recorded by name upon any vote (other than paper ballot).
- 4.12.5 In no circumstances may an absent Member of the Council vote by proxy. Absence is defined as being absent at the time of the vote.

4.13 Minutes

- 4.13.1 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 as Chair at it.
- 4.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.
- 4.13.3 Minutes shall be circulated in accordance with the members' wishes. Minutes will be published on the Trust website within six weeks of the full Council of Governors meeting.

4.14 Suspension of Standing Orders

- 4.14.1 Except where this would contravene any statutory provision or any direction made by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, including two public Governors, and that a majority of those present vote in favour of suspension.
- 4.14.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.
- 4.14.3 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 Council.
- 4.14.4 No formal business may be transacted while Standing Orders are suspended.

4.15 Variation and Amendment of Standing Orders

- 4.15.1 These Standing Orders shall be amended only if:

- a notice of a motion under Standing Order 4.7 has been given; and
- no fewer than half the total of the Corporation's Governors vote in favour of amendment; and
- at least two-thirds of the Council Members are present; and
- the variation proposed does not contravene a statutory provision or direction made by the Independent Regulator.

4.16 Record of Attendance

4.16.1 The names of the Chair and Members of the Council present at the meeting shall be recorded in the minutes. Apologies received from Members of the Council shall also be recorded in the minutes.

4.17 Quorum

4.17.1 No business shall be transacted at a meeting unless at least eight Governors are present of which at least five are public Governors.

4.17.2 If a Member of the Council has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6, 7 or 8) he or she 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.

5. COMMITTEES

- 5.1 Subject to the Regulatory Framework and such guidance as may be issued by the Independent Regulator, the Council may, and if so required by the Independent Regulator, shall, appoint committees of the Council to assist the Council in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly of the Chair and Members of the Council of Governors.
- 5.2 A committee appointed under this regulation may, subject to such guidance as may be given by the Independent Regulator or restriction imposed by the Council, appoint sub-committees consisting wholly of members of the committee.
- 5.3 The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chair" is to be read as a reference to the Chair of the Committee as the context permits, and the term "Member of the Council" is to be read as a reference to a member of the committee also as the context permits.
- 5.4 Subject to Standing Order 5.5, each sub-committee shall have such terms of reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Independent Regulator. Such terms of reference shall have effect as if incorporated into the Standing Orders.
- 5.5 The Council may not delegate any decision-making or executive powers to any committee or sub-committee.
- 5.6 The Council shall approve the appointments to each of the committees which it has formally constituted.
- 5.7 The committees and sub-committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 The Regulatory Framework requires Council Members to declare interests which are relevant and material to the Council of which they are a Member. All existing Council Members should declare such interests. Any Council Members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as “relevant and material” are defined in the Trust’s Constitution as follows:

any pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors

6.1.3 At the time Council Members’ interests are declared, they should be recorded in the Council minutes. Any changes in interests should be declared at the next Council meeting following the change occurring.

6.1.4 Council 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.

6.1.5 There is no requirement for the interests of Council Members’ spouses or partners to be declared. However Standing Order 7, which is based on the regulations, requires that the interests of Members of the Council’s spouses, if living together, in contracts should be declared. Therefore the interests of Council Members’ spouses and cohabiting partners should also be regarded as relevant.

6.1.6 If during the course of any meeting, a conflict of interest arises as defined at para 6.1.2, it is the responsibility of the Chair to ensure the meeting is held in such a way as to ensure free and full debate, without undue or improper influence from any interested party, and that all parties present are fully aware of the interests of all other Governors of the Foundation Trust.

6.1.7 In pursuance of the above the Chair may take any or all of the following steps;

1. The Chair may remind the meeting of the role and responsibility of the Governors, as set out in the FT Constitution and these Standing Orders.
2. The Chair may require any Governor to remind the meeting of his or her interest.
3. The Chair may require any Governor that the Chair considers has a conflict to play no part during any discussion on the relevant issue.
4. The Chair may require any Governor that the Chair considers has a conflict to withdraw from the meeting room during the relevant discussion or debate.

Before taking the steps 3 or 4, the Chair shall allow representations from the Governor concerned. The decision of the Chair on these matters is final.

- 6.1.8 If any person believes that any Governor has any conflict of interest that has not been declared, or is trying to exert undue or improper influence on any other person in any way, in any matter connected with the Foundation Trust, that person may make representations to the Trust Chair. Representations may be verbal or in writing and shall detail the nature of the alleged conflict or undue influence complained of.
- 6.1.9 Upon receipt of such a representation, the Chair will communicate with the Governor concerned, and allow that Governor an opportunity to respond fully to the representation. Upon receipt of the response he or she shall make a decision about the contribution of that Governor at subsequent meetings, and shall have the range of options as detailed at para. 6.1.7 above.

6.2 Register of Interests

- 6.2.1 The Secretary to the Trust will ensure that a Register of Interests is established to record formally declarations of interests of Council Members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by Council Members, as defined in Standing Order 6.1.2.
- 6.2.2 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared will be incorporated.
- 6.2.3 The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.
- 6.2.4 In establishing, maintaining, updating and publicising the Register, the Trust shall comply with all guidance issued from time to time by the Independent Regulator.

7. DISABILITY OF CHAIR AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

- 7.1** Subject to the following provisions of this Standing Order, if the Chair or another Member of the Council 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 or she 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.
- 7.2** The Council may exclude the Chair (or Member of the Council) from a meeting of the Council while any contract, proposed contract or other matter in which he or she has pecuniary interest, is under consideration.
- 7.3** For the purpose of this Standing Order the Chair or Member of the Council shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:
- (a) he or she, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
 - (b) he or she, 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 or persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also the interest of that partner.
- 7.4** The Chair or a member of the Council shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:
- (a) of his or her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;
 - (b) of an interest in a company, body or person with which he or she is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Member of the Council in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Governor:

- (a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and
- (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 or she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him or her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his or her duty to disclose his or her interest.

7.6 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Council and applies to a Member of the Council of any such committee or sub-committee as it applies to a Member of the Council.

8. STANDARDS OF BUSINESS CONDUCT POLICY

8.1 Governors should comply with the Trust Constitution, the NHS principles of conduct, as defined by the NHS ~~Leadership Academy~~~~Appointments Commission~~, the NHS Constitution, the NHS Foundation Trust Code of Governance, published by the Independent Regulator, the requirements of the Regulatory Framework, the Trust Code of Conduct for Governors, and any guidance and directions issued by the Independent Regulator. In addition, they must adhere to the Trust Principles, given as Annex 10 to the Foundation Trust Constitution and the Trust's Policy on Business Conduct.

8.2 Interest of Governors in Contracts

8.2.1 If it comes to the knowledge of a Governor that a contract in which he or she has any pecuniary interest not being a contract to which he or she is a party, has been, or is proposed to be, entered into by the Trust he or she shall, at once, give notice in writing to the Secretary of the Trust of the fact that he or she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A Governor should also declare to the Secretary of the Trust any other employment or business or other relationship of his or hers, or of a cohabitating spouse, which might reasonably be predicted could conflict with the interests of the Trust.

8.3 Canvassing of, and Recommendations by Members of the Council in Relation to Appointments

8.3.1 Canvassing of Governors of the Trust or of any Committee of the Council of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment.

8.3.2 A Member of the Council 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 of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.4 Relatives of Members of the Council or Officers

8.4.1 Candidates for any staff appointment under the Trust, shall when making application, disclose in writing to the Trust whether they are related to any Member of the Board of Directors or Council of Governors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him or her liable to instant dismissal.

8.4.2 The Chair and every Member of the Council and officer of the Trust shall disclose to the Chief Executive any relationship between him or herself and a candidate of whose candidature that Member of the Council or Officer is aware.

- 8.4.3 On appointment, Members of the Council (and prior to acceptance of an appointment in the case of officer members) should disclose to the Council whether they are related to any other Member of the Council or holder of any office in the Trust.
- 8.4.4 Where the relationship to a Member of the Council of the Trust is disclosed, the Standing Order headed Disability of Chair and Members of the Board in proceedings on account of pecuniary interest (SO 7) shall apply.

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9. MISCELLANEOUS

9.1 Standing Orders to be given to Members of the Council

- 9.1.1 It is the duty of the Secretary to the Trust to ensure that existing Members of the Council and all new appointees are notified of and understand their responsibilities within these Standing Orders. New Members of the Council shall be informed in writing and shall receive copies where appropriate in Standing Orders.

9.2 Review of Standing Orders

- 9.2.1 Standing Orders shall be reviewed annually. The requirements for review extends to all documents having the effect as if incorporated in Standing Orders.

**ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD
OF DIRECTORS**

(Paragraph 26 and Note 26)

**Standing Orders for the Practice and Procedure of the
Board of Directors**

March 2019

FOREWORD

NHS Foundation Trusts are obliged by NHS Improvement to have Standing Orders for their Board of Directors in relation to the disclosure of interests and arrangements for exclusion of a director disclosing an interest from discussion or consideration of the matter in respect of which an interest has been disclosed. It is also suggested by NHS Improvement that Standing Orders be adopted relating to other aspects of the Board's practice and procedure.

The following revised Standing Orders and attached Scheme of Delegation, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfill the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework. All executive directors and voting and non-voting Non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

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INTRODUCTION

Statutory Framework

The Dudley Group NHS Foundation Trust (the Trust) is a body corporate which became a public benefit corporation following its approval as an NHS Foundation Trust by the Independent Regulator of NHS Foundation Trusts (Independent Regulator) pursuant to the National Health Service Act 2006 (the 2006 Act).

The principal places of business of the Trust are Russells Hall Hospital, Corbett Outpatients Centre, Guest Outpatients Centre and the Community of Dudley.

NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 [and 2012 Health Acts](#), by their constitutions and by the terms of their authorisation granted by the Independent Regulator (the Regulatory Framework).

The functions of the Corporation are conferred by the Regulatory Framework.

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

Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit. Delegated Powers are covered in a separate document (Scheme of Delegation). That document has effect as if incorporated into the Standing Orders.

1 INTERPRETATION

- 1.1 Save as permitted by law and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he or she should be advised by the Trust Secretary).
- 1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and where there is a conflict between the 2006 and 2012 Acts and another legislative provision the 2006 Act interpretation shall prevail (unless, in either case, the context otherwise requires) and in addition:

"ACCOUNTING OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. He or she shall be responsible for ensuring the proper stewardship of public funds and assets and performing the functions delegated to him or her by the Constitution in relation to the Trust's accounts. For this Trust it shall be the Chief Executive.

"TRUST" means the The Dudley Group NHS Foundation Trust.

"BOARD OF DIRECTORS" and (unless the context otherwise requires) "BOARD" shall mean the Chairman and other non-executive directors, and the executive directors appointed by the relevant committee of the Trust.

"BOARD OF GOVERNORS" means the Council of Governors of the Trust.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"CHAIRMAN" is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" shall mean the Chief Executive Officer of the Trust.

"COMMITTEE" shall mean a committee of the Board of Directors.

"COMMITTEE MEMBERS" shall be the directors formally appointed by the Trust to sit on or to chair specific committees.

"CONSTITUTION" means the constitution of the Trust.

"DEPUTY CHAIRMAN" means the non-executive director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution and includes the Chairman.

"FINANCE DIRECTOR" shall mean the chief finance officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds on trust at its date of authorisation as an NHS Foundation Trust or chooses subsequently to accept. Such funds may or may not be charitable.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

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

"OFFICER" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SOS" means Standing Orders.

"SECRETARY TO THE TRUST" means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the Regulatory Framework and these standing orders.

2. THE TRUST

- 2.1 All business shall be conducted in the name of the Trust.
- 2.2 The Trust has the functions conferred on it by the Regulatory Framework.
- 2.3 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.
- 2.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission.
- 2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. Those powers and decisions delegated by the Board are set out in the "Scheme of Delegation", which has effect as if incorporated into the Standing Orders.
- 2.6 **Composition of the Board** - In accordance with, but always subject to, the provisions of the Constitution, the composition of the Board shall be:
- The Chairman of the Trust
between 5 and 7 non-executive directors excluding the Chairperson
5 Executive directors including:
 The chief executive (and accounting officer)
 The director of finance
 A medical or dental practitioner
 A registered nurse
 The director of operations
- 2.7 **Appointment of the Chairman and other voting and Non-executive Directors** - The Chairman and the other voting and Non-executive Directors are appointed by the Council of Governors.
- 2.8 **Appointment of the Executive Directors** - The Chief Executive is appointed by the Non-executive Directors, subject to the approval of the Council of Governors. The other Executive Directors are appointed by a committee consisting of the Chairman, the other Non-executive Directors and the Chief Executive.
- 2.9 **Terms of Office of the Chairman and other Directors** - The regulations setting out the period of tenure of office of the Chairman and other Directors and for the termination or suspension of office of the Chairman and other Directors are contained in the Constitution of the Trust.
- 2.10 **Appointment of Deputy Chairman** - Subject to SO 2.11 below, the Council of Governors will appoint one of the non-executive directors to be Deputy Chairman, for such period, not exceeding the remainder of his or her term as a Director, as they may specify on appointing him or her.

- 2.11 Any Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Council of Governors may thereupon appoint another Non-executive Director as Deputy Chairman in accordance with the provisions of Standing Order 2.10
- 2.12 **Powers of Deputy Chairman** - Where the Chairman of the Trust has died or has ceased to hold office, or where he or she has been unable to perform his or her duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his or her duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his or her duties, be taken to include references to the Deputy Chairman.
- 2.13 **Appointment and Powers of Senior Independent Director** - Subject to SO 2.14 below, the Chairman (in consultation with the Non-executive Directors and the Council of Governors) may appoint any Director, who is also a Non-executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his or her term as a Director, as they may specify on appointing him or her. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Job Description", as amended from time to time by resolution of the Board.
- 2.14 Any Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman. The Chairman (in consultation with the Non-executive Directors and the Council of Governors) may thereupon appoint another Member of the Board as Senior Independent Director in accordance with the provisions of Standing Order 2.13.
- 2.15 The role of the Deputy Chairman will include deputising for the Chairman during absences. The Senior Independent Director will act as a conduit for concerns to be raised by Governors if the usual mechanisms of contact and discussion have been exhausted, and making arrangements for the annual evaluation of the performance of the Chairman. The process to achieve this evaluation and its outcome will be agreed with and reported to the Council of Governors.
- 2.16 If the Senior Independent Director is also the Deputy Chairman and he or she is acting in the capacity of the Chairman, another Non-executive director will be identified by the Board of Directors as fulfilling the role of Senior Independent Director on a temporary basis. Where there is a need for the Deputy Chairman to act in the capacity of Chairman for an extended period, the Board of Directors will agree the appointment of a different Senior Independent Director with the Council of Governors, until the Deputy Chairman is able to resume this role.

3. MEETINGS OF THE TRUST

- 3.1 **Calling Meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine.
- 3.2 The chairman may call a meeting of the Board at any time. If the chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him or her, or if, without so refusing, the chairman does not call a meeting within seven days after such requisition has been presented to him or her, at the Trust's Headquarters, such one third or more directors may forthwith call a meeting.
- 3.3 **Notice of Meetings** - Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the chairman or by an officer of the Trust authorised by the chairman to sign on his or her behalf shall be delivered to every director, so as to be available to him or her at least three clear working days before the meeting.
- 3.4 Lack of service of the notice on any director shall not affect the validity of a meeting.
- 3.5 In the case of a meeting called by directors in default of the chairman, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.
- 3.6 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.
- 3.7 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.
- 3.8 A director desiring a matter to be included on an agenda shall make his or her request in writing to the chairman at least 10 clear days before the meeting, subject to Standing Order 3.3. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the chairman.
- 3.9 **Chairman of Meeting** - At any meeting of the Board, the chairman, if present, shall preside. If the chairman is absent from the meeting the deputy chairman, if there is one and he or she is present, shall preside. If the chairman and deputy chairman are absent such non-executive director as the directors present shall choose shall preside.
- 3.10 If the chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the deputy chairman, if present, shall preside. If the chairman and deputy chairman are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.
- 3.11 **Notices of Motion** - A director of the Board desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the chairman, who shall

insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.5.

- 3.12 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the chairman.
- 3.13 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director(s) who gives it and also the signature of 3 other directors. When any such motion has been disposed of by the Board, it shall not be competent for any director other than the chairman to propose a motion to the same effect within 6 months; however the chairman may do so if he or she considers it appropriate.
- 3.14 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.
- 3.15 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:
- An amendment to the motion.
 - The adjournment of the discussion or the meeting.
 - That the meeting proceed to the next business. (*)
 - The appointment of an ad hoc committee to deal with a specific item of business.
 - That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.

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

- 3.16 **Chairman's Ruling** - Statements of directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the chairman of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.
- 3.17 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question. In the case of any equality of votes, the chairman shall have a further or casting vote.

- 3.18 All questions put to the vote shall, at the discretion of the chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.
- 3.19 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.
- 3.20 If a director so requests, his or her vote shall be recorded by name upon any vote (other than by paper ballot).
- 3.21 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.
- 3.22 **Minutes** - 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.
- 3.23 No discussion shall take place upon the minutes except upon their accuracy or where the chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
- 3.24 Minutes shall be circulated in accordance with directors' wishes.
- 3.25 **Waiver of Standing Orders** - Except where this would contravene any statutory provision or any guidance issued by the Independent Regulator, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Board are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.
- 3.26 A decision to waive Standing Orders shall be recorded in the minutes of the meeting.
- 3.27 The Audit Committee shall review every decision to waive Standing Orders.
- 3.28 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any guidance issued by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.
- 3.29 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.
- 3.30 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.
- 3.31 No formal business may be transacted while Standing Orders are suspended.
- 3.32 The Audit Committee shall review every decision to suspend Standing Orders.

- 3.33 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:
- a notice of motion under Standing Order 3.11 has been given; and
 - no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and
 - at least two-thirds of the directors are present; and
 - the variation proposed does not contravene a statutory provision or guidance issued by the Independent Regulator.
- 3.34 **Record of Attendance** - The names and titles of the directors present at the meeting shall be recorded in the minutes.
- 3.35 **Quorum** - No business shall be transacted at a meeting of the Trust unless at least one-third of the whole numbers of the directors are present including at least one executive director and one non-executive director.
- 3.36 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) he or she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration Committee).

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

- 4.1 Subject to the Regulatory Framework and such guidance as may be issued by the Independent Regulator, the Board 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 SO 5.1 or 5.2 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.
- 4.2 **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the chief executive and the chairman. The exercise of such powers by the chief executive and the chairman shall be reported to the next formal meeting of the Board for minuting.
- 4.3 **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.
- 4.4 The chief executive shall prepare a Scheme of Delegation (Annex 11) identifying his or her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The chief executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.
- 4.5 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the finance director or other executive director to provide information and advise the Board in accordance with any statutory requirements or guidance issued by the Independent Regulator.
- 4.6 The arrangements made by the Board as set out in the "Scheme of Delegation" shall have effect as if incorporated in these Standing Orders.
- 4.7 **Overriding Standing Orders** – 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 Board for action or ratification. All Members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Trust Secretary as soon as possible.

5. COMMITTEES

- 5.1 **Appointment of Committees** - Subject to the Regulatory Framework and any guidance as may be issued by the Independent Regulator, the Board may and, if so required by the Independent Regulator, shall appoint committees of the Board, consisting wholly of directors of the Board.
- 5.2 A committee appointed under SO 5.1 may, subject to any guidance issued by the Independent Regulator and to any restriction imposed by the Board, appoint sub-committees consisting wholly of one or more members of the committee.
- 5.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board.
- 5.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.
- 5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.
- 5.6 The Board shall approve the appointments to each of the committees which it has formally constituted.
- 5.7 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.
- 5.8 A director shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

- 6.1 **Declaration of Interests** - The Regulatory Framework requires directors to declare interests which are relevant and material to the board of which they are a director. All existing directors should declare such interests. Any directors appointed subsequently should do so on appointment.
- 6.2 Interests which should be regarded as "relevant and material" are to be interpreted in accordance with the Regulatory Framework:
- a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).
 - b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
 - c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
 - d) A position of trust 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) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.
 - g) Any other commercial interest in the decision before the meeting.
- 6.3 If directors have any doubt about the relevance of an interest, this should be discussed with the chairman.
- 6.4 At the time directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.
- 6.5 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.
- 6.6 During the course of a board meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.
- 6.7 There is no requirement for the interests of board directors' spouses or partners to be declared. [Note however that SO 7 requires that the interest of directors' spouses, if living together, in contracts should be declared].
- 6.8 **Register of Interests** - The trust secretary will ensure that a Register of Interests is established to record formally declarations of interests of directors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both executive and non-executive directors, as defined in SO 6.2.

- 6.9 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared during the preceding twelve month will be incorporated.
- 6.10 The Register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.
- 6.11 In establishing, maintaining, updating and publicising the Register, the Trust shall comply at all times with the Regulatory Framework and any guidance issued by the Independent Regulator. In the event of conflict between these Standing Orders and the Regulatory Framework or guidance issued by the Independent Regulator, the latter shall prevail.
- 6.12 Standing Order 6 applies to a committee or sub-committee of the Board as it applies to the Board.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

- 7.1 Subject to the following provisions of this Standing Order, if a director of the 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 or she 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.
- 7.2 The Board shall exclude a director from a meeting of the Board while any contract, proposed contract or other matter in which he or she has a pecuniary interest, is under consideration.
- 7.3 Any remuneration, compensation or allowances payable to a director by the Trust or otherwise by virtue of paragraph 9 of Schedule 2 to the NHS & CC Act 1990 shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- 7.4 For the purpose of this Standing Order a director shall be treated, subject to SO 7.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:
- (a) he or she, or a nominee of his or her, 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 or she 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 or persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also the interest of that partner.
- 7.5 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 or her membership of a company or other body, if he or she 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 or she is connected as mentioned in SO 7.4 above 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.
- 7.6 Where a director:
- (a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

- (b) all significant shareholding and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is, or might do business with the NHS
- (c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he or she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him or her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his or her duty to disclose his or her interest.

- 7.7 Standing Orders 7 apply to a committee or sub-committee of the Board as it applies to the Board.

8. STANDARDS OF BUSINESS CONDUCT

- 8.1 **Policy** - Staff must comply with the Trust's Policy on Business Conduct which embraces national guidance and requirements, and any guidance issued by the Independent Regulator. In addition, they must adhere to the Trust Principles as stated in Annex 10 of the Foundation Trust Constitution.
- 8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself or herself a party, has been, or is proposed to be, entered into by the Trust he or she shall, at once, give notice in writing to the Chief Executive of the fact that he or she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.
- 8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his or her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Chief Executive will ensure that such declarations are formally recorded.
- 8.4 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of directors or Governors of the Trust or members 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.
- 8.5 A director 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 director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.
- 8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.
- 8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him or her liable to instant dismissal.
- 8.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.
- 8.9 On appointment, directors (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 director or holder of any office within the Trust.
- 8.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed 'Disability of directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

9. TENDERING AND CONTRACT PROCEDURE

- 9.1 **Duty to comply with Standing Orders** - The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 3.26 (Waiver of SOs) is applied).
- 9.2 **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.
- 9.3 The Trust shall comply as far as is practicable with the requirements of the DH "Capital Investment Manual". In the case of management consultancy contracts the Trust shall comply as far as is practicable with DH and Treasury guidance. In all cases, the Trust shall comply with any relevant guidance issued by NHS Improvement.
- 9.4 **Formal Competitive Tendering** - The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services; for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.
- 9.5 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive, as identified in the schedule "Authorised Limits" appended to Standing Financial Instructions. This authority is subject to formal identification of the reason for such waiver, which would normally be one or more of the following reasons:-
- (a) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with; or
 - (b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
 - (c) specialist expertise or products is required and is available from only one source; or
 - (d) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
 - (e) 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; or

The limited application of the waiver rules 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.

- 9.6 Except where SO 9.5, or a requirement under SO 9.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, in most cases this will mean a minimum of four firms/individuals but this may differ when there are a limited number of firms/individuals in a specific product/service marketplace, having regard to their capacity to supply the goods or materials or to undertake the services or works required.
- 9.7 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists (see Annex Section 5). Where in the opinion of the officer responsible for procuring the supply it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see Annex).
- 9.8 Tendering procedures are set out in the Annex.
- 9.9 **Quotations** - where the intended expenditure or income is in line with the sum agreed by the Board and incorporated into the Appendix 1 ("Authorised Limits") to the Trust's Standing Financial Instructions.
- 9.10 Where quotations are required under SO 9.9 they should be obtained from at least three firms/individuals as per the Annex based on specifications or terms of reference prepared by, or on behalf of, the Board.
- 9.11 Quotations should be in writing unless the chief executive or his or her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
- 9.12 All quotations should be treated as confidential and should be retained for inspection.
- 9.13 The chief executive or his or her nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.
- 9.15 **Where tendering or competitive quotation is not required**
- Where tenders or quotations are not required, because expenditure is below the threshold referred to in 9.9 above the Trust shall procure goods and services in accordance with procurement procedures approved by the Board.
- 9.16 The chief executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering (SO 11).
- 9.17 **Private Finance** - When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

- (a) The chief executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
- (b) The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.
- (c) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

9.18 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

- (a) these Standing Orders;
- (b) the Trust's SFIs;
- (c) EU Directives and other statutory provisions;
- (d) any relevant directions issued by the Regulator;
- (e) such of the NHS Standard Contract Conditions as are applicable.

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.

9.19 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The chief executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

9.20 **Personnel and Agency or Temporary Staff Contracts** - The chief executive shall nominate officers with delegated authority to enter into contracts for the employment of and to authorise regrading of staff, and to enter into contracts for the employment of agency staff or temporary staff.

9.21 **Healthcare Services Contracts** - Unlike contracts made by an NHS Trust, contracts made between an NHS Foundation Trust and other NHS bodies do give rise to contractual rights and liabilities. This rule applies to all types of contract, including for example partnership agreements and contracts for the supply of healthcare.

9.22 The chief executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

9.23 **Other Contracts for Services Provided by the Trust** - the chief executive shall nominate officers with powers to negotiate such contracts and will ensure that contract documentation is signed by a duly authorised officer.

9.24 **Cancellation of Contracts** - Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved or adopted for use by the Trust and in accordance with Standing Orders 9.2 and 9.3, there shall be inserted in every written

contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or her or acting on his or her behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him or her or acting on his or her behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916 and other appropriate legislation.

- 9.25 **Determination of Contracts for Failure to Deliver Goods or Material** - There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.
- 9.26 **Contracts Involving Funds Held on Trust** – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

10. DISPOSALS

Competitive T~~i~~endering or Q~~u~~otation procedures shall not apply to the disposal of:

- (a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the chief executive or his or her nominated officer;
- (b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policy of the Trust;
- (c) items to be disposed of with an estimated sale value of less than £1,000.
- (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 guidance has been issued by the Independent Regulator but subject to compliance with such guidance.
- (f) Pharmaceutical and hazardous waste.

- (g) IT equipment where disposal requires the specialised removal or destruction of sensitive information stored on such devices.

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11. IN-HOUSE SERVICES

- 11.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:
- (a) Specification group, comprising the chief executive or nominated officer(s) and specialist(s).
 - (b) In-house tender group, comprising representatives of the in-house team, a nominee of the chief executive and technical support.
 - (c) Evaluation group, comprising at minimum, a specialist officer, a procurement officer and a representative of the finance director. The requirement for Trust Board representation in the evaluation group will be determined by the potential contract value and by reference to the Appendix ("Authorised Limits") to the Trust's Standing Financial Instructions.
- 11.2 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.
- 11.3 The evaluation group shall make recommendations to the Board.
- 11.4 The chief executive shall nominate an officer to oversee and manage the contract.

12. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

- 12.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.
- 12.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or otherwise under the authority of the Board through a resolution of the Board formally delegating such authorisation.
- 12.3 The seal shall be attested by at least two directors and the authorisation may specify which directors shall attest the seal on that occasion.
- 12.4 **Register of Sealing** – The Trust Secretary will ensure that an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

13. SIGNATURE OF DOCUMENTS

- 13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the chief executive, unless any enactment

otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

- 13.2 The chief executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

14. MISCELLANEOUS

- 14.1 **Standing Orders to be given to Directors and Officers** - It is the duty of the chief executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the chief executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.
- 14.2 **Documents having the standing of Standing Orders** - Standing Financial Instructions and Scheme of Delegation shall have the effect as if incorporated into SOs.
- 14.3 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

TENDERING PROCEDURE

1. Invitation to Tender

- 1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:
- (a) a plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word 'Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or
 - (b) in a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.
- 1.2 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 1.3 and 1.4 below.
- 1.3 Every tender for building and engineering works, except for maintenance work only where Estmancode guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DH.
- 1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

2. Receipt, Safe Custody and Record of Formal Tenders

- 2.1 Formal competitive tenders shall be addressed to the chief executive.
- 2.2 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.
- 2.3 The chief executive shall designate an officer or officers, not from the originating department, to receive tenders on his or her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.

3. Opening Formal Tenders

- 3.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two senior officers designated by the chief executive and not from the originating department.
- 3.2 Every tender received shall be stamped with the date of opening and initialed by two of those present at the opening.
- 3.3 A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:
 - (a) the names of firms/individuals invited;
 - (b) the names of and the number of firms/individuals from which tenders have been received;
 - (c) closing date and time;
 - (d) date and time of opening;

and the record shall be signed by the persons present at the opening.

- 3.4 Except as in Section 3.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialed by two of those present at the opening.
- 3.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure Section 3.4 unreasonable.

4. Admissibility and Acceptance of Formal Tenders

- 4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the chief executive.
- 4.2 Tenders received after the due time and date will not be considered unless it is clear that the reason for late receipt is due entirely to an internal failing within the Trust.
- 4.3 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 or her own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.
- 4.4 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his or her offer.

- 4.5 Necessary discussions with a tenderer of the contents of his or her tender, in order to elucidate technical points etc., before the award of a contract, need not disqualify the tender.
- 4.6 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.
- 4.7 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.
- 4.8 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless for good and sufficient reason the Board or a delegated officer decides otherwise and record that decision in their minutes.
- 4.9 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.
- 4.10 All Tenders should be treated as confidential and should be retained for inspection in line with the Trust's retention documents policy.

5. Lists of Approved Firms

- 5.1 The Trust shall compile and maintain, and the officers responsible for procuring the supply shall keep, lists of approved firms and individuals from whom tenders may be invited, as provided for in SO 9.7, and shall keep these under review. The lists shall be selected from all firms which have applied for permission to tender provided that:
- (a) in the case of building, engineering and maintenance works, the chief executive is satisfied on their capacity, conditions of labour, etc., and that the finance director is satisfied that their financial standing is adequate.
 - (b) in the case of the supply of goods, materials and related services, and consultancy services the chief executive or the nominated officer is satisfied as to their technical competence etc., and that the finance director is satisfied that their financial standing is adequate.
 - (c) in the case of the provision of healthcare services to the Trust by a private sector provider, the finance director is satisfied as to their financial standing and the chief executive is satisfied as to their technical/medical competence.
- 5.2 The Trust shall arrange for advertisements to be issued as may be necessary, in trade journals, OJEU Website and national newspapers inviting applications from firms for inclusion in the prescribed lists.
- 5.3 If in the opinion of the chief executive or the finance director it is impractical to use a list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), the chief executive should

ensure that appropriate checks are carried out as to the technical and financial capability of firms invited to tender or quote.

- 5.4 A permanent record should be made of the reasons for inviting a tender or quote other than from an approved list.

ANNEX 9 – FURTHER PROVISIONS

1. A person may not become a member of the Foundation Trust if within the last five years they have been involved as a perpetrator in an incident of violence or abuse at any NHS hospital or facilities; against any NHS employees or other persons who exercise functions for the purposes of the NHS; against registered volunteers; against patients or the public on NHS premises; or if they are the subject of a security alert. Also, any person may not become or remain a member of the NHS Foundation Trust if in the opinion of the Council of Governors, there are reasonable grounds to believe that they are likely to behave in a way detrimental to the interests of the Trust.
2. A member shall cease to be a member if:
 - they resign by notice to the Secretary;
 - they die;
 - they are expelled from membership under this constitution;
 - they cease to be entitled under this constitution to be a member of any of the public constituencies or of any of the classes of the staff constituency;
 - if after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a member of the Trust.
3. A member may be expelled by a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a General Meeting. The following procedure is to be adopted:
 - Any member may complain to the Trust Secretary that another member has acted in a way detrimental to the interests of the Trust.
 - The Chair of the Council of Governors, assisted by the Trust Secretary, will judge the manner in which the complaint should be managed.
 - If appropriate, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that the point of view of the members involved is heard and may either:
 - dismiss the complaint and take no further action; or
 - arrange for the complaint to be considered at the next General Meeting of the Council of Governors.
 - Details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the next General Meeting of the Council of Governors.
 - At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.
 - If the member complained of fails to attend the meeting without reasonable cause the meeting may proceed in their absence.

- The Council of Governors will take a view on the complaint and may decide to expel the member from membership of the Foundation Trust. To effect expulsion from membership, the Council of Governors will adopt a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a General Meeting.
 - A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried.
4. A member who is expelled may apply for re-admission to membership. This application is to be made in writing to the Chairman, who will arrange for the application to be considered by the next General meeting of the Council of Governors. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a General Meeting.
5. The Trust will have a Trust Secretary, who may be appointed and removed by resolution of the Board of Directors.
6. The Trust Secretary and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly and the Trust may also take out and maintain for their benefit insurance against such risks. Any costs arising in this way will be met by the Trust.
- 6.1. The Council may make amendments to this Constitution but where these can not be agreed with both the Board and Council then these will be made subject to approval of NHS Improvement, subject to paragraph 6.2 below.
- 6.2. No proposals for amendment of this Constitution will be put to NHS Improvement unless it has been approved by three quarters of those Governors present and voting at a meeting of the Council of Governors.
7. The validity of any act of the Trust is not affected by any vacancy among the directors or the Governors or by any defect in the appointment of any director or governor.
- 8.1 If:
- (a) an executive director is temporarily unable to perform his or her duties due to illness or some other reason (the "Absent Director"); and
 - (b) the board of directors agree that it is inappropriate to terminate the Absent Director's term of office and appoint a replacement director; and
 - (c) the board of directors agree that the duties of the Absent Director need to be carried out;
then the non-executive directors may appoint an acting director as an additional director to carry out the Absent Director's duties temporarily.

- 8.2. For the purposes of paragraph 8.1 of this Annex, the maximum number of directors that may be appointed under paragraph 18.2 of the Constitution shall be relaxed accordingly.
- 8.3. The acting director will vacate office as soon as the Absent Director returns to office.
- 8.4. An acting director shall be responsible for his or her own acts and defaults and he or she shall not be deemed to be the agent of the Absent Director.
9. When a vacancy arises for one or more elected Governors, the Council of Governors shall have the option to take from the list of members who stood for election at the most recent election of Governors for the class or constituency in question whichever member who was not elected as a governor at the recent election but had secured the next most votes at that time. This procedure, which shall be an uncontested election for the purposes of the Model Rules for Elections as they apply to the Trust, shall be available to the Governors on 2 occasions within 12 months of the previous election. Governors appointed in this way shall hold office for a minimum of 6 months from their appointment but, subject thereto, shall hold office until the earlier of the conclusion of the next election of Governors and (except where the vacancy arose through expiry of a term of office) the date on which would have expired the term of office of that Governor whose cessation of office gave rise to the vacancy.
10. The minimum age for membership of this Trust is 14 years old. There is no upper age limit.

ANNEX 10 – TRUST PRINCIPLES

Trust Principles of Conduct

The Seven Principles of Public Life, also known as the ‘Nolan Principles’ of selflessness, integrity, objectivity, accountability, openness, honesty and leadership should be upheld by all employees and elected and appointed Governors of the Dudley Group of Hospitals NHS Foundation Trust

The **Seven Principles of Public Life** which apply to everyone engaged in public service are:

Selflessness Holders of public office should act solely in terms of the public interest. They should not seek to gain financial or other benefits for themselves, their family or their friends.

Integrity Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit. This includes a commitment to promote racial and religious tolerance, and to be aware of community diversity and to be trained in that context.

Accountability Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office. Everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.

Openness Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands. There should be sufficient transparency about the Trust’s activities to promote confidence between the Trust and its staff, patients and the public.

Honesty Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest. There should be an absolute standard of honesty in dealing with the assets of the Trust: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of employment.

Leadership Holders of public office should promote and support these principles by leadership and example.

It is an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee corruptly to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts

Further Guidance

Employees and Governors are expected to:

- ensure that the interests of patients remain paramount at all times
- act impartially in all their work
- adhere to the regulations as set out in the prevailing legislation relating to the Bribery Act
- refuse gifts, benefits, hospitality or sponsorship of any kind (including attendance at conferences) which might reasonably be seen to compromise their personal judgment or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused
- declare and register gifts, benefits, or sponsorship of any kind, in accordance with time limits agreed locally, (provided that they are worth at least £25), whether refused or accepted. In addition gifts should be declared if several small gifts worth a total of over £100 are received from the same or closely related source in a 12-month period
- declare and record financial or personal interest (e.g. company shares, research grant) in any organisation with which they have to deal, and be prepared to withdraw from those dealings if required, thereby ensuring that their professional judgment is not influenced by such considerations
- make it a matter of policy that offers of sponsorship that could possibly breach these principles and guidance will be reported to the Board
- not misuse their official position or information acquired in the course of their official duties, to further their private interests or those of others
- ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services
- beware of bias generated through sponsorship, where this might impinge on professional judgment and impartiality
- neither agree to practice under any conditions which compromise professional independence or judgment, nor impose such conditions on other professionals.

Anyone requiring further advice should contact their line manager in the first instance, or for Governors, the Foundation Trust Secretary. If the line manager is unable to decide then the Foundation Trust Secretary should be consulted.

Failure to adhere to the Trust's rules may lead to disciplinary action up to and including dismissal, or for Governors, disqualification from becoming or continuing as a Governor.

RESERVATION OF POWERS AND SCHEME OF DELEGATION

March 2019

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CONTENTS

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Reservation of powers and scheme of delegation

1. Introduction

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the Board of Directors expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. It is consistent with the Scheme of Delegation with the NHS Code of Conduct and Accountability.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive or other Executive Directors. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

2. Purpose

The purpose of this document is to clearly identify the control framework set by the Board and identifies the powers and functions and who will perform these as in the

- Decisions Reserved for the Board
- Decisions and duties delegated by the Board to committees
- Standing Financial instructions
- Standing Orders

To add in once agreed

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ANNEX 12– ANNUAL MEMBERS’ MEETING

1. ANNUAL MEMBERS’ MEETINGS

- 1.1. The Trust shall hold a members’ meeting for all members (called the “Annual Members’ Meeting”) within six months of the end of each financial year of the Trust.
- 1.2. Annual Members’ Meetings shall be open to all members of the Trust, members of the Council of Governors and members of the Board of Directors, together with representatives of the Trust’s auditors, and open to members of the public. The Trust may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend any such meeting.
- 1.4. The Board of Directors (or at least one member thereof) shall present to the members at the Annual Members’ Meeting:
 - 1.4.1. the annual accounts;
 - 1.4.2. any report of the auditor on them;
 - 1.4.3. the annual report;
 - 1.4.4. the results of any election and appointments to the Council Governors, and any other reports or documentation it considers necessary.
 - 1.4.5. If there has been an amendment to the Trusts Constitution which relates to the powers, duties or roles of the Council of Governors, at least one Governors must attend the next Annual Members Meeting and present the amendment/s to member. Members have the right to vote on and veto these types of constitutional amendments.
- 1.5. The Chair of Governors shall give notice to all members’ of the scheduled meeting:
 - 1.5.1. by giving not less than 21 ~~days~~ day’s notice
 - 1.5.2. by notice prominently displayed at the Trust’s headquarters and at all sites operated by the Trust
 - 1.5.3. by notice on the Trust’s website; and
 - 1.5.4. to the Council of Governors, the Board of Directors, and to the Trust’s auditors, stating the meeting is an Annual Members Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least at least 21 working days before the date of the relevant meeting).
 - 1.5.5. meeting papers and any associated documentation to be made available on the Trust website not less than three working days before the meeting
- 1.6. An accidental omission to give notice of a members’ meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person

entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

- 1.7. The Chair, or in his or her absence, the Deputy Chair shall preside at all members' meetings of the Trust. If neither the Chair nor the Deputy Chair is present, the governors present shall elect one of their members to act as Chair.
- 1.8. The quorum for a members' meeting shall be 8 (eight) Council members present and entitled to vote. If a quorum is not present within thirty minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven days until such time as the Council of Governors determine.
- 1.9. The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time-to-time and from place to place or for an indefinite period.
- 1.10. A resolution put to the vote of a members' meeting shall be decided on a show of hands.
- 1.11. No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.
- 1.12. If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date and/or place.
- 1.13. In the case that a members' meeting is adjourned or postponed for 14 days or more, at least seven working days' notice shall be given specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted.
- 1.14. The Board of Directors may make any arrangement and impose any restrictions it considers appropriate to ensure the security of a members' meeting.
- 1.15. Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. Unless in the opinion of the Chair it would not be appropriate or desirable to time limit speeches on any topic to be discussed having regard to its nature, complexity or importance, no proposal, speech or any reply may exceed three minutes. In the interests of time, the Chair may, in his or her absolute discretion, and where that discretion is exercised reasonably, limit the number of replies, questions or speeches which are heard at any one members' meeting.
- 1.16. A person who has already spoken on a matter at a members' meeting may not

Speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply, or (ii) on a point of order.

- 1.17. The Board of Directors shall cause minutes to be made and kept, in writing, of all proceedings at members' meetings.

Change History

Date	Reason	Change summary	Review date	Approval
March 2013	Monitor request	To reflect changes as set out the Health and Social Care Act 2012	April 2013	2 nd May 2013 Council of Governors
April 2013	Annual review	Minor amendments to update Appointed Governor organisation names	April 2014	12 th September 2013 Annual Members Meeting
April 2014	Annual Review			
September 2015	Annual Review			
May 2016	Annual Review	To reflect changes to include electronic voting		5 th May 2016 Council of Governors
October 2017	Annual Review	To reflect change from Monitor to NHS Improvement, Elections nominations process to no longer require supporters and to allow the use of non-voting non executives. To remove references to		7 th December 2017

		<p>'initial' pre FT activity relating to appointment of execs and NEDS.</p> <p>To adjust the size of the Board from 11 to 13 (an additional ONE NED and ONE exec)</p>		
March 2019	Review	<p>To reflect current best practise, <u>notability</u> <u>conflicts of interest and</u> <u>Members meeting.</u></p>	March 2019	

**Paper for submission to the Board on
4th April 2019**

TITLE:	SCHEME OF DELEGATION inc Powers Reserved for the Board		
AUTHOR:	Sharon Philips – Deputy Director of Governance	PRESENTER	Gilbert George – Interim Director of Governance
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
ACTION REQUIRED OF BOARD			
Decision	Approval	Discussion	Other (Assurance)
		Y	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE EXECUTIVE TEAM			
The Board are asked to: <ul style="list-style-type: none"> review and approve the Scheme of Reservation and Delegation agree that the Scheme of Reservation and Delegation be reviewed annually by the board 			
CORPORATE OBJECTIVES:			
SO1: Deliver a great patient experience SO2: Safe and Caring Services SO3: Drive service improvements, innovation and transformation SO4: Be the place people choose to work SO5: Make the best use of what we have SO6: Deliver a viable future			

SUMMARY OF KEY ISSUES:

The Board remains accountable for all of its functions under the NHS Act 2006, including those it delegates.

This Scheme of Reservation and Delegation seeks to record where authority rests within the Trust for particular types of decision made in the name of or on behalf of the Board. No such Scheme can be absolutely comprehensive, but, in addition to explicitly locating the locus of authority for specific categories of decision, the Scheme also forms a frame of reference through which questions about other types of decision may be resolved.

Much of the features of a Scheme of Reservation and Delegation at the Trust were entwined in the Terms of Reference of Board Committees but did not exist as a standalone document or as annex in the Constitution. To comply with best practice it was recommended that the Scheme of Reservation and Delegation featured as both a standalone document as well as being an annex in the Constitution.

In delegating authority the Board has taken full account of the following guiding principles:

- *Everything is retained by the Board unless it is specifically delegated in accordance with the requirements a Scheme of Reservation and Delegation or Standing Financial Instructions.*
- *The Board must retain that which it is required to retain (whether by statute or as determined by the Secretary of State).*
- *Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility.*
- *The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities.*
- *The Board must take appropriate action to assure itself that all matters delegated are effectively carried out.*
- *The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes.*
- *Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory*

IMPLICATIONS OF PAPER:

RISK	Y		Risk Description: covers many risks, but key risks are those related to the Trust Quality Priorities, deteriorating patient and patient experience
	Risk Register: Y		Risk Score: numerous across the BAF, CRR and divisional risk registers
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: links all domains
	NHSI	Y	Details: links to good governance
	Other	N	Details:

ANNEX 11 – RESERVATION OF POWERS AND SCHEME OF DELEGATION

RESERVATION OF POWERS AND SCHEME OF DELEGATION

March 2019

CONTENTS

- 1 Introduction
- 2 Reservation of Powers to the Board of Directors
- 3 Delegation to Committees
- 4 Purpose of scheme of Delegation
- 5 Reservation of Power to the Board of Directors
- 6 Reservation of power Delegated by the Board to Committees
- 7 Summary of Delegated Authorities (Accountable Officer Memorandum)
- 8 Scheme of Delegation derived from the Code of Conduct and Accountability

Definitions

NHSI is the NHS improvement

CCG is the Dudley Clinical Commissioning Group

1. Introduction

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the Board of Directors expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. It is consistent with the Scheme of Delegation with the NHS Code of Conduct and Accountability. The arrangements (Scheme) is to be used in conjunction with and subject to the Standing Orders and Standard Financial Instruction in addition to the the Trust and other established policies and procedures within the Trust

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the chief executive or other executive irectors. The Scheme of Delegation identifies any functions which the chief executive shall perform personally and those delegated to other directors or officers. All powers delegated by the chief executive can be re-assumed by him/her should the need arise.

The chief executive is the accounting officer of the Trust (Paragraph 16(1) of Schedule 7 to the 2006 Act). The NHS Foundation Trust Accounting Officer Memorandum issued by the independent regulator, the Independent Regulator(17 April 2008) sets out the additional responsibilities and duties of the chief executive, in relation to discharging these functions.

2. Reservation of Powers to the Board of Directors

The Code of Accountability which has been adopted by the Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in tabular form in the “Reservation of Powers to the Board of Directors” table in Section xx.

3. Delegation to Committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors from time to time taking into account where necessary the requirements of regulators and commissioners e.g. NHSI, CCG. The Board of Directors shall determine the reporting requirements in respect of these committees, committees may not delegate executive powers to sub committees unless expressly authorised by the Board of Directors.

4. Purpose

The purpose of this document is to clearly identify the control framework set by the Board and identifies the powers and functions and who will perform

these. Delegated matters in respect of decisions which may have a far reaching effect must be reported to the chief executive.

5. RESERVATION OF POWER TO THE BOARD OF DIRECTORS

Reserved to/ Delegated to	Reserved / Delegated Matter
Trust Board	Ratify Reservation of Powers to the Board of Directors and Council of Governors, Schedule of Decisions/Duties Delegated by the Board of Directors
Trust Board	The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers
Trust Board	Approve a scheme of delegation of powers from the Board to Committees
Trust Board	Adopt the Standing Financial Instructions which set out the responsibilities of individuals
Trust Board	Approve Standing Orders, a schedule of matters reserved to the Board and Standing Financial Instructions for the Regulation of its proceedings and business
Trust Board	Annually review Standing Orders, a schedule of matters reserved to the Board and Standing Financial Instructions for the Regulation of its proceedings and business
Trust Board	Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto
Trust Board	Suspend Standing Orders
Trust Board	Vary or amend a Standing Order
Trust Board	Approve variations or amendments to the Trusts constitution in conjunction with the Council of Governors
Trust Board	Ratify any urgent decisions taken by the chair and chief executive in Public session
Trust Board	Require and receive the declaration of Board members interests that may conflict with those of the Trust and determining the extent to which that Member may remain involved in the matter under consideration
Trust Board	At the next formal meeting of the Board of Directors ratify any urgent decisions taken by the chair of the Trust and chief executive
Trust Board	Approve arrangements for dealing with complaints

Reserved to/ Delegated to	Reserved / Delegated Matter
Trust Board	Determine the independence of the non-executive directors
Trust Board	Regularly review and at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services as per the Provider Licence. (SFIs para 7.1)
Trust Board	Appoint and disband the sub-committees that are directly accountable to the Board of Directors
Trust Board	Receive reports from its sub-committees including those that the Trust is required to establish and take appropriate action
Trust Board	Confirm the recommendations of the Trust's sub-committees where they do not have the power to make such a decision
Trust Board	Ratify the terms of reference and reporting arrangements of all sub-committees that are formally established by the Board of Directors
Trust Board	Discipline members of the Board or employees who are in breach of statutory requirement of the Trusts constitution
Trust Board	Ratify a memorandum of understanding between the chair of the Trust and the chief executive setting out a division of responsibilities, review any modifications to that memorandum
Trust Board	Approve the wording of any statement of the Board of Directors pertaining to a dispute between the Council of Governors and the Board of Directors
Trust Board	Approve and monitor the Trust's risk management framework
Trust Board	Decide on whether the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority
Trust Board	Make any arrangements it considers appropriate to the provision of indemnity insurance or similar arrangements for the benefit of the Trust or directors to meet all or any liability which are properly the liability of the Trust recognising the Public Benefit Corporation status
Trust Board	Approve any recording by members of the public of any public Board of Directors' meeting
Trust Board	Resolve to exclude members of the public from any meeting or part of a meeting
Trust Board	Determine that certain matters appear on each agenda of the Board of Directors' meeting
Trust Board	Provide permission that governors, directors, officers or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting of the Board of Directors may disclose the contents of the papers or any

Reserved to/ Delegated to	Reserved / Delegated Matter
	discussion
Trust Board	Send a copy of the agenda of the meeting of the Board of Directors to the Council of Governors
Trust Board	Send a copy of the minutes of the public Board of Directors' meeting to the Council of Governors
Trust Board	Determine the times and places for the meetings of the Board of Directors
Trust Board	Approval of the Trust's banking arrangements
Trust Board	Approve arrangements relating to the discharge of the Trusts responsibilities as a corporate trustee for funds held on Trust
Trust Board	Approve arrangements relating to the discharge of the Trusts responsibilities for patients property
Trust Board	Ratify any changes to the overall number of non-executive directors and executive directors
Trust Board	Appoint one of the independent non-executive directors as the senior independent director
Trust Board	Appoint, appraise, discipline and dismiss executive directors
Trust Board	Advise a partner organisation of concerns regarding any individual that an organisation may appoint to the Council of Governors (i.e. an appointed governor)
Trust Board	Approve the appointment of any advisor to assist or advise the Council of Governors
Trust Board	Appoint and dismiss the board secretary [<i>Board to agree or disagree</i>]
Trust Board	Consider and approve proposals presented by the chief executive for setting remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee
Trust Board	Approve procedures presented by the chief executive for the determination of commencing pay rates, condition of service etc for employees
Trust Board	Approve the directors' Code of Conduct
Trust Board	Appoint and dismiss Committees (and individual members) that are directly accountable to the Board
Trust Board	Confirm appointment of members of any committee of the Trust as representatives on outside bodies
Trust Board	Approve proposals of the Remuneration Committee regarding directors and the senior employees and those of the chief executive for staff not covered by the Remuneration Committee

Reserved to/ Delegated to	Reserved / Delegated Matter
Trust Board	Define the aim, goals and strategic objectives of the Trust
Trust Board	Ratify any supporting (underpinning) strategies
Trust Board	Approve the capital programme and capital budgets annually
Trust Board	Ratify proposal for acquisition, disposal or change of use of land and/or buildings
Trust Board	Approve the annual Business Plan and Annual Business Plan
Trust Board	Approve any new capital investments / business cases of £500k or more
Trust Board	Approve annual revenue budgets as set out in the Budgetary Control Framework and any variations of £500k or more per annum and ensure these are consistent with the plans outlined in the operational plan.
Trust Board	Ratify proposals for acquisition, disposal or change of use of land and/or buildings of £1m or more
Trust Board	Approve any new Private Finance Initiative (PFI) contract and/or significant changes to PFI contracts of £500k or more (for avoidance of doubt this would include any refinancing agreements).
Trust Board	Approve proposals in individual cases for the write-off of losses or making of special payments of £10k or more and all those of a novel or contentious nature
Trust Board	Ratify the introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant where it is of a novel or contentious nature, or if it has a gross annual income in excess of £1m per annum
Trust Board	Approve orders for items of expenditure in respect of service directorate and corporate budgets where the value is for £500k or more
Trust Board	Approve individual compensation payment over £10k except where these are made in accordance with the NHS Litigation authority instruction
Trust Board	Approve the Care Quality Commission Registration Declaration
Trust Board	Ratify the Trust's Quality Report prior to submission
Trust Board	Ratify any monitoring returns prior to submission to Regulators, ensuring these are submitted at such frequency as is required
Trust Board	Ratify the Trust's forward plan prior to submission to commissioners, ensuring that it has regard to the views of the

Reserved to/ Delegated to	Reserved / Delegated Matter
	Council of Governors
Trust Board	Receipt and adoption of the Trust's Annual Report and Annual Accounts
Trust Board	Receive recommendations from the evaluation team on matters regarding in-house services that are subject to competitive tendering
Trust Board	Receive reports from the chief financial officer on financial performance against budget and plans
Trust Board	Approve annually Trusts proposed organisational development proposals
Trust Board	Review the use of NHS Litigation Authority Risk Pooling Schemes
Trust Board	Approve the annual Letter of Representation to the external auditors and agreement of proposed action, taking account of the advice, where appropriate of the Audit Committee
Trust Board	Receive from the external auditor any Public Interest Report, taking account of advice, where appropriate of the Audit Committee
Trust Board	Continuously appraise the affairs of the Trust by means of the provision to the Board reports as it may require from directors, committees, and officers of the Trust, including performance against contractual, regulatory and internal targets, standards and measures.
Trust Board	Receipt of reports as the Board sees fit from committees in respect of their exercise of powers delegated
Trust Board	To receive Trust wide annual report for example clinical governance and infection control
Trust Board	Authorise the use of the Trust seal

6. RESERVATION OF POWER DELEGATED BY THE BOARD TO COMMITTEES

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
	Audit Committee	<p>The Committee will:</p> <ul style="list-style-type: none"> • Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control (clinical and non clinical) • Advise the Board on internal and external audit services • Monitor compliance with Standing Orders and Standing Financial Instruction • Review the adequacy of underlying assurance process that indicate the degree of achievement of corporate objectives • Review the adequacy of all risk and control related disclosure statements prior to endorsement by the Board of Directors <ul style="list-style-type: none"> • annual governance statement • Head of Internal Audit Statement • External Audit Opinion • Other appropriate independent assurances • Review the adequacy of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • Will seek assurance over the effectiveness of the Trust Whistleblowing processes • Will ensure there is an effective internal audit function that meets government internal Audit Standards and provides independent assurance to the Board • Will review the work and findings of the external auditors and consider the implications and management responses • Review the findings of other significant assurance functions, both internal and external to the Trust

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
		<p>and consider the implications for the governance of the organisation</p> <ul style="list-style-type: none"> • Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work • Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance • Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board • Review the Annual Report, Quality Accounts, Clinical Audit plan and financial statements before submission to the Board
	Remuneration and Nominations Committee	<p>The Committee will:</p> <ul style="list-style-type: none"> • Advise the Board about appropriate remuneration and terms of service for chief executive and other executives including: <ul style="list-style-type: none"> • All aspects of salary • Provisions for other benefits, including pensions and care • Arrangements for the termination of employment and other contractual terms • Determine any monetary severance arrangements for the Trust's chief executive and executive directors. • Review and determine expenses payable to governors • Evaluate the balance of skills, knowledge and experience on the Board of Directors and to identify those required for appointments of the Trust chair, non-executive directors, chief executive and executive directors • For the appointment of the chief executive and executive directors, to agree a job description and

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
		<p>person specification for the role and capabilities required</p> <ul style="list-style-type: none"> To agree and manage the nominations, appointments and re-appointments processes for: <ul style="list-style-type: none"> o chief executive o executive directors To meet, without the chair, chief executive and director of human resources, to review the performance of the Chair on a regular basis To explore any reported concerns and compliance relating to the Trust's chief executive and non-executive directors in relation to Fit and Proper Person demands
	Clinical Quality Safety and Patient Experience Committee	<p>The Committee will:</p> <ul style="list-style-type: none"> Identify and advise on quality improvement priorities of service areas, receive exception reports and external reviews of provider services and ensure appropriate action is identified and monitored Ensure that the Trust fulfils its obligations with regard to the Health Act (2009) and NHSI in the production of an Annual Quality Account and Report Scrutinise Quality and Patient Safety within the organisation and provide assurance to the Board, including actions in place to drive improvements and mitigate risks Review, drive improvement and learn from patient experience and complaints across the organisation Review quarterly claims report, identifying trends and themes and lessons learned, being assured of learning and completed actions Review and monitor compliance with new and existing statutory and accreditation standards and legislative requirements Review assurances received on clinical practice and be advised of the progress of any major quality initiatives in the Trust Review the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
		<p>other patient outcomes</p> <ul style="list-style-type: none"> • Review and monitor compliance the Quality priority targets prior to reporting progress to the Trust Board • Monitor the effectiveness, investigation and learning from incidents, including Serious Incidents (SIs), Near Misses and other incidents • Review the outcomes of investigations and external inspections, triangulating information from several sources to ensure that there is sufficient detail to enable systemic failings in patient care to be identified • Review, scrutinise and challenge clinical unit compliance with national safety alerts (e.g. National Patient Safety Agency, Medical Device Alert) • Review the Trust's research and development plans ensuring there is adequate linkage and relevance to the Trust's quality priorities and evidence of developments and improvements in care • Review Clinical audit plans to ensure that programmes are progressing as planned, providing challenge as necessary for any shortfalls in compliance with the plans and receive assurance of improvements in care as a result of the identified outcomes • Review and scrutinise the Trust's compliance with medicine management, investigate variances and review and approve proposed actions to remediate any shortfalls, holding senior staff to account • Review and scrutinise where necessary the quality components of the PFI (Private Finance Initiative) estates contract compliance • Discuss key risks relating to quality and safety practices; to consider, challenge as necessary and monitor plans for mitigation to maintain the risks at their lowest realistic level and advise the Board as appropriate

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
	Workforce and Staff Engagement Committee	<p>The Committee will:</p> <ul style="list-style-type: none"> • Ensure the completion of workforce strategy and the key strategic initiatives to deliver it • Monitor and scrutinize workforce planning priorities are addressed and progressed from annual business planning process • Review the establishment and maintenance of an effective system of Human Resources and Workforce Planning • Review Human Resources, Workforce Planning and Learning and Development and staff engagement to ensure adequate evaluation and monitoring within the Trust and to ensure local and national priorities are being addressed • Review, challenge and agree progress against the workforce key performance indicators (staff appraisals and mandatory training) • Approve the annual workforce data prior to submission to the LETC/B. (Local Education Training Council/Board). • Discuss key strategic risks relating to workforce and employment practice • Review regular reports and plans, on Organisational Development including leadership capability, medical and non- medical education priorities and challenge progress as necessary • Ensure that feedback from the National and other Staff Surveys is appropriately analysed, reported and actions identified and taken • Oversee the development and implementation of a comprehensive education and training strategy to include corporate learning and development requirements

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
		<ul style="list-style-type: none"> • Oversee the development and implementation of the Equality and Diversity Strategy and Health and Wellbeing Strategy and Trusts Staff Engagement Strategy • Monitor compliance with CQC standards that relate to employment • Oversee the adequacy of arrangements for the management of and compliance with the Health and Safety at Work Act 1974 and subsequent amendments including the reporting of non-clinical workforce related incidents and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS)
	Finance and Performance Committee	<p>The Committee will:</p> <ul style="list-style-type: none"> • Undertake detailed scrutiny of processes for the preparation and the content of Strategic and Business Plans (including the local CCG (Clinical Commissioning Group) contract) and Annual Revenue and Capital Budgets • Review, discuss and challenge the Trust Annual Plan and Annual Budgets before submission to the Board of Directors. Monitoring these and investigate variances • Consider and advise on financial aspects of Business Cases for significant revenue or capital expenditure prior to submission to the Board of Directors. Undertaking PIR (post implementation review) of all Business Cases for return on investment/benefits realization • Review opportunities for increasing activity/income from market intelligence analyses • Review minutes of all performance review meetings (including financial performance) held by Directors of the Trust with Clinical Units or Directorates ensuring appropriate challenge has been made and evidence of actions to manage variances in performance detailed • Consider performance against external performance targets set by the Care Quality Commission, NHSI and as agreed in legally binding contracts. In addition review the Trust compliance with

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
		<p>relevant financial and performance CQC standards,</p> <ul style="list-style-type: none"> • Undertake detailed scrutiny of the PFI contract performance with Summit Healthcare (Dudley) Ltd • Review and challenge reports in respect of Transformation and Cost Improvement Programmes • Review and approve local delivery plans (including CQUIN) • Consider regular reports of Trust and Directorate performance in respect of contracts agreed with third party organisations and to take appropriate action • Consider and provide advice to the Board on detailed expenditure, cash flow and working capital plans and forecasts • Commission and consider various financial reports and analyse • Consider and provide advice to the Board on regular financial performance reports and forecasts, focusing particularly on risks and assumptions and provide advice on the short to medium term impact on current performance of internal and external business risks • Review NHSI's risk rating and instigate appropriate action • Undertake detailed financial assessment of the Trust's strategic risks in conjunction with the Board of Directors and monitor trends and progress in reducing financial exposure • Monitor the financial and operational performance of any subsidiary companies wholly or partly owned by the Trust

Details/ reference	Reserved to/ Delegated to	Reserved / Delegated Matter
	Digital Trust Committee	<p>The Committee will:</p> <ul style="list-style-type: none"> • Agree and recommend the Trust's IT strategy • Ensure all projects are aligned with the Trust's IT strategy • Review of any issues or dependencies that need DTPC Consideration • Review Digital Trust risks and issues rated extreme and high, agree appropriate course of action and agree items to review at Trust Board • Provide guidance on priorities relating to project deliveries

7. SUMMARY OF DELGATED AUTHORITIES (Accountable Officer Memorandum)

Reserved to/ Delegated to	Reserved / Delegated Matter	Details / Reference
Chief Executive	<ul style="list-style-type: none"> Accountable through the NHS accounting officer to parliament for stewardship of the Trust resources 	Accountable Officer Memorandum
Chief Executive and Director of Finance	<ul style="list-style-type: none"> Ensure the accounts of the Trust are prepared under principles and in a format directed by NHSI. Accounts must disclose a true and fair view of the Trust income and expenditure and its state of affairs Sign the accounts on behalf of the Board 	Accountable Officer Memorandum
Chief Executive	<ul style="list-style-type: none"> Sign a statement in the accounts outlining responsibilities as the accounting officer Sign a statement in the accounts outlining responsibilities in respect of Internal Control 	Accountable Officer Memorandum
Chief Executive	<ul style="list-style-type: none"> Ensure effective management systems that safeguard public funds and assist the Trust chairman to implement requirements of corporate governance including ensuring managers: Have a clear view of their objectives and the means to assess achievements in relation to those objectives; Be assigned well defined responsibilities for making best use of resources; and, Have the information, training and access to the expert advice they need to exercise their responsibilities effectively 	Accountable Officer Memorandum
Chair	<ul style="list-style-type: none"> Implement requirements of corporate governance. 	Accountable Officer Memorandum
Chief Executive	<ul style="list-style-type: none"> Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission, the National Audit 	Accountable Officer Memorandum

Reserved to/ Delegated to	Reserved / Delegated Matter	Details / Reference
	Office (NAO) and Regulators	
Director of Finance	<ul style="list-style-type: none"> Operational responsibility for effective and sound financial management and information 	Accountable Officer Memorandum
Chief Executive	<ul style="list-style-type: none"> Primary duty to see that director of finance discharges this function 	Accountable Officer Memorandum
Chief Executive	<ul style="list-style-type: none"> Ensuring that expenditure by the Trust complies with Parliamentary requirements 	Accountable Officer Memorandum
Chief Executive & Director of Finance	<ul style="list-style-type: none"> The chief executive, supported by director of finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness 	Accountable Officer Memorandum
Chief Executive	<ul style="list-style-type: none"> If the chief executive considers the Board or chairman is doing something that might infringe probity or regularity, he/she should set this out in writing to the chairman and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the Board. 	Accountable Officer Memorandum
Chief Executive	<ul style="list-style-type: none"> If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the chief executive's responsibility for value for money, the chief executive should draw the relevant factors to the attention of the Board. 	Accountable Officer Memorandum

8. SCHEME OF DELEGATION DERIVED FROM THE CODE OF CONDUCT AND ACCOUNTABILITY

Reserved to/ Delegated to	Reserved / Delegated Matter
Trust Board	<ul style="list-style-type: none"> • Approve procedure for declaration of hospitality and sponsorship
Trust Board	<ul style="list-style-type: none"> • Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns
All Trust Board Members	<ul style="list-style-type: none"> • Subscribe to Code of Conduct
Board	<ul style="list-style-type: none"> • Board Members share corporate responsibility for all decisions of the Board
Chairman and Non Executive / Officer Members	<ul style="list-style-type: none"> • Chairman 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
Board Member Non Executive Directors	<ul style="list-style-type: none"> • The Trust's most Senior Managers (as defined by the board) are required to meet the Fit & Proper Person requirements including completion of a Fit & Proper Persons Declaration
Trust Board	<ul style="list-style-type: none"> • The Board has six key functions for which it is held accountable: • To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; • To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;

Reserved to/ Delegated to	Reserved / Delegated Matter
	<ul style="list-style-type: none"> • To appoint, appraise and remunerate senior executives; • 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; • To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; and, • 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
Trust Board	<ul style="list-style-type: none"> • It is the Board's duty to: • Act within statutory financial and other constraints; • Be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these; • 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 Board can fully undertake its responsibilities; and, • Establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the

Reserved to/ Delegated to	Reserved / Delegated Matter
	membership of the sub-Committees, the limit to their powers, and the arrangements for reporting back to the main Board
Chairman	<ul style="list-style-type: none"> • It is the Chairman's role to: • Provide leadership to the Board; • Enable all Board Members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; • Ensure that key and appropriate issues are discussed by the Board in a timely manner; • Ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; • Lead non-executive Board Members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the chief executive and (with the latter) other executive Board Members; • Appoint non- executive Board Members to an Audit Committee of the main Board; and, • Advise the Secretary of State on the performance of non-executive Board Members
Chief Executive	<ul style="list-style-type: none"> • The chief executive is accountable to the chairman and non-executive Members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship • The chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board • The other duties of the chief executive as Accountable Officer are laid out in the Accountable Officer Memorandum

Reserved to/ Delegated to	Reserved / Delegated Matter
Non-Executive Directors	<ul style="list-style-type: none"> Non-executive directors are appointed in accordance with the Constitution to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Governors to stakeholders and to the local community
Chairman and Directors	<ul style="list-style-type: none"> Declaration of conflict of interests
Trust Board	<ul style="list-style-type: none"> NHS Boards must comply with legislation and guidance issued by Regulators, 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

**Paper for submission to the Board on
4TH April 2019**

TITLE:	Annual review of the Board Effectiveness		
AUTHOR:	Sharon Phillips – Deputy Director of Governance	PRESENTER	Jenny Ord – Trust Chair
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>	<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>	
ACTION REQUIRED OF BOARD			
Decision	Approval	Discussion	Other
	X	X	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input checked="" type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE BOARD			
<ul style="list-style-type: none"> • To review exceptions and identify the key objectives for 2019/20 • To note the detailed outcome of the Board Effectiveness review • To review and identify amendments to the Board Terms of Reference 			
CORPORATE OBJECTIVE:			
SO5: Make the best use of what we have SO6: Deliver a viable future.			

SUMMARY OF KEY ISSUES:

The Board is required to review annually its effectiveness and the effectiveness of its committees.

This is essential to identify changes required for 2019/20. The report details the following:

- 1 Section 1: Background
- 2 Section 2 - : Exceptions Overview of the Board

Board Effectiveness Review - Key Highlights

- spending more time on strategic matters
- improve the unitary of the board
- use the BAF as a board dynamic tool
- request improvement in the quality of papers being submitted to the board with a greater focus on assurance
- request improvement in the timeliness of papers and concise reporting
- ensure board committees Terms of Reference are fit for purpose

Committee Effectiveness Reviews

Reviews are being undertaken by committees and improved effectiveness plans will be reported to the May board.

Board Action:

- The Board is requested to review the exceptions highlighted from the Board Effectiveness review (see section 2 below) and discuss any changes they feel are required
- The Board is requested to review the exceptions from the Committee effectiveness reviews and identify if there are any immediate changes as to the delegation of duties to the committees

IMPLICATIONS OF PAPER:

RISK	N		Risk Description:
	Risk Register:		Risk Score:
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details:
	NHSI	Y	Details:
	Other	Y	Details:

SECTION 1:

SUMMARY OF EFFECTIVENESS REVIEW

Background

The Board is required to review annually its effectiveness and review the effectiveness of the committees of which it has delegated authority to identify changes required for 2019/20. This is essential to identify and ensure a robust meeting forum to ascertain assurances, identify risk, change practice and drive improvement.

The following report provides an overview of the outcome of the committee effectiveness for the Board and subcommittees of the Board

The Board Effectiveness reviews consisted of a total of 39 questions grouped into five themes:

- 1 - Support and Infrastructure (10 questions)
- 2 – Structure (5 questions)
- 3 – Leadership (7 questions)
- 4 – Effectiveness (4 question)
- 5 – Stakeholder Engagement (3) questions)
- 6 – Behaviours (10 questions).

The Committee effectiveness tool consisted of 22 questions grouped into five themes:

- 1 - Committee focus (5 questions)
- 2 – Committee Team Working (4 questions)
- 3 – Committee Effectiveness (9 questions)
- 4 – Committee Engagement (1 question)
- 5 – Committee Leadership

SECTION 2: BOARD EFFECTIVENESS REVIEW EXCEPTIONS OVERVIEW

The following table provides an overview of the exceptions. Full details can be found at Appendix 1. In summary the key exceptions are:

Hardly Ever / Poor	Occasionally/ Below average	Some of the time/Average	Item
1. Support and Infrastructure			
		4	Does the Board receive timely information?
	2	4	Is the information of the right quality?
1	4	1	Is the information sufficiently concise?
	2	3	Is information in the right form to enable the Board to make sound decisions?
	2	1	The number and length of meetings and access to resources is sufficient to allow the Board to fully discharge its duties?
	1		Is the agenda sufficient to allow the Board to carry out its functions?
	2	4	Does the agenda prioritise the right issues?
1	1	3	Sufficient time is spent on each agenda item?
		1	The Board receives an appropriate amount of presentations from Clinicians, Managers and others to remain informed?
	2	2	Board Committee meetings are held sufficiently far in advance of Board meetings to allow for the resolution of issues?
2. Structure			
	1	2	Does the Board have the right balance of skills, knowledge and experience to deal with current and anticipated challenges?
	1	2	Board Members are clear on the role of the Board as a whole?
	1	3	The Board is clear as to its role in relation to Governance across the Trust?
		2	The Board is the right size to ensure effective decision making?
	3	2	Is a succession plan in place?
3. Leadership			
		3	Does the Board periodically review organisational culture and plan to maintain a positive culture?
	3	1	Does the Board collectively and individually model behaviours consistent with organisational values and culture?
1	3	2	Does the time spent on strategy result in defined proposals to be incorporated into the business plan?
	1	1	Is the Board satisfied that it has identified the strategic risks facing the organisation, and that it has the controls to manage them?
	1	3	The Board focuses on the right questions and can challenge effectively?
	2	2	Does the Board keep abreast of changes in the external environment and considers their impact on the strategic direction of the Trust?
	3	3	Does the Board spend sufficient time discussing the organisation's strategic direction?

Hardly Ever / Poor	Occasionally/ Below average	Some of the time/Average	Item
4. Effectiveness			
	1	6	The Board assures itself that patient safety and quality issues are being addressed?
	1	5	Is the Board Assurance Framework effective?
		4	Communication between the Board and its Committees is adequate and effective?
	1	3	The Board has an effective working relationship with the Executive Team?
5. Stakeholder Engagement			
	2	5	Does the Board inform and involve key stakeholders in its work and check their views?
	1	4	The Board has clearly identified open channels of communication with Staff and external Stakeholders in order to improve patient care?
	2	1	Does the Chair ensure that there is sufficient challenge on each issue on the Board's agenda?
6. Behaviours			
	2	1	The Chair demonstrates good listening skills?
		1	Board meetings encourage a high quality of debate with robust and probing discussions?
		1	The Board responds positively and constructively to bad news in order to encourage future transparency?
	1	2	The Chair operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings?
	1	3	Executive and Non-Executive Board members have a frank and open relationship with each other and each Director understands his/her own personal Board level responsibilities?
	2	4	The Board has a good understanding of key people issues, particularly those regarding Transformation?
	3	2	All Board members attend and actively contribute at meetings?
	2	5	All Board members have sufficient time and commitment to fulfil their responsibilities?
1	1	5	Board members undertake ongoing personal development activities to update their skills and knowledge?
Comments <ul style="list-style-type: none"> Improve the Unitary of the board. Implement the best way to use the BAF as a dynamic board tool Encouraging a greater use of assurance reporting to board, including reports from committees Allowing sufficient time to discuss key agenda items 			

APPENDIX 1

BOARD EFFECTIVENESS REVIEW RESULTS

Total no. responses = 7

Theme 1 - Support and Infrastructure

Q1: Does the Board receive timely information?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	
3 Some of the time/Average	4
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Q2: Is the information of the right quality?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	4
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Q3: Is the information sufficiently concise?	
N/A	
1 Hardly ever/Poor	1
2 Occasionally/Below average	4
3 Some of the time/Average	1
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Q4: Is information in the right form to enable the Board to make sound decisions?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	3
4 Most of the time/Above average	2
5 All of the time/Fully satisfactory	
Grand Total	7

Q5: The number and length of meetings and access to resources is sufficient to allow the Board to fully discharge its duties?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	1
4 Most of the time/Above average	4
5 All of the time/Fully satisfactory	
Grand Total	7

Q6: Is the agenda sufficient to allow the Board to carry out its functions?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	
4 Most of the time/Above average	6
5 All of the time/Fully satisfactory	
Grand Total	7

Q7: Does the agenda prioritise the right issues?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	4
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Q8: Sufficient time is spent on each agenda item?	
N/A	
1 Hardly ever/Poor	1
2 Occasionally/Below average	1
3 Some of the time/Average	3
4 Most of the time/Above average	2
5 All of the time/Fully satisfactory	
Grand Total	7

Q9: The Board receives an appropriate amount of presentations from Clinicians, Managers and others to remain informed?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	
3 Some of the time/Average	1
4 Most of the time/Above average	6
5 All of the time/Fully satisfactory	
Grand Total	7

Q10: Board Committee meetings are held sufficiently far in advance of Board meetings to allow for the resolution of issues?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	2
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Theme 2 Structure

Q11: Does the Board have the right balance of skills, knowledge and experience to deal with current and anticipated challenges?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	2
4 Most of the time/Above average	4
5 All of the time/Fully satisfactory	
Grand Total	7

Q12: Board Members are clear on the role of the Board as a whole?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	2
4 Most of the time/Above average	4
5 All of the time/Fully satisfactory	
Grand Total	7

Q13: The Board is clear as to its role in relation to Governance across the Trust?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	3
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Q14: The Board is the right size to ensure effective decision making?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	
3 Some of the time/Average	2
4 Most of the time/Above average	5
5 All of the time/Fully satisfactory	
Grand Total	7

Q15: Is a succession plan in place?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	3
3 Some of the time/Average	2
4 Most of the time/Above average	2
5 All of the time/Fully satisfactory	
Grand Total	7

Theme 3 Leadership

Q16: Does the Board periodically review organisational culture and plan to maintain a positive culture?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	3
3 Some of the time/Average	3
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Q17: Does the Board collectively and individually model behaviours consistent with organisational values and culture?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	3
3 Some of the time/Average	1
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Q18: Does the time spent on strategy result in defined proposals to be incorporated into the business plan?	
N/A	
1 Hardly ever/Poor	1
2 Occasionally/Below average	3
3 Some of the time/Average	2
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Q19: Is the Board satisfied that it has identified the strategic risks facing the organisation, and that it has the controls to manage them?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	1
4 Most of the time/Above average	5
5 All of the time/Fully satisfactory	
Grand Total	7

Q20: The Board focuses on the right questions and can challenge effectively?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	5
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Q21: Does the Board keep abreast of changes in the external environment and considers their impact on the strategic direction of the Trust?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	2
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Q22: Does the Board spend sufficient time discussing the organisation's strategic direction?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	3
3 Some of the time/Average	3
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Theme 4 Effectiveness

Q23: The Board assures itself that patient safety and quality issues are being addressed?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	6
4 Most of the time/Above average	
5 All of the time/Fully satisfactory	
Grand Total	7

Q24: Is the Board Assurance Framework effective?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	5
4 Most of the time/Above average	1
5 All of the time/Fully satisfactory	
Grand Total	7

Q25: Communication between the Board and its Committees is adequate and effective?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	
3 Some of the time/Average	4
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Q26: The Board has an effective working relationship with the Executive Team?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	3
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Theme 5 Stakeholder Engagement

Q27: Does the Board inform and involve key stakeholders in its work and check their views?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	5
4 Most of the time/Above average	
5 All of the time/Fully satisfactory	
Grand Total	7

Q28: The Board has clearly identified open channels of communication with Staff and external Stakeholders in order to improve patient care?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	4
4 Most of the time/Above average	2
5 All of the time/Fully satisfactory	
Grand Total	7

Q29: Does the Chair ensure that there is sufficient challenge on each issue on the Board's agenda?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	1
4 Most of the time/Above average	4
5 All of the time/Fully satisfactory	
Grand Total	7

Theme 6 Behaviours

Q30: The Chair demonstrates good listening skills?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	1
4 Most of the time/Above average	4
5 All of the time/Fully satisfactory	
Grand Total	7

Q31: Board meetings encourage a high quality of debate with robust and probing discussions?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	
3 Some of the time/Average	1
4 Most of the time/Above average	6
5 All of the time/Fully satisfactory	
Grand Total	7

Q32: The Board responds positively and constructively to bad news in order to encourage future transparency?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	
3 Some of the time/Average	1
4 Most of the time/Above average	6
5 All of the time/Fully satisfactory	
Grand Total	7

Q33: The Chair operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	2
4 Most of the time/Above average	4
5 All of the time/Fully satisfactory	
Grand Total	7

Q34: Executive and Non-Executive Board members have a frank and open relationship with each other and each Director understands his/her own personal Board level responsibilities?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	1
3 Some of the time/Average	3
4 Most of the time/Above average	3
5 All of the time/Fully satisfactory	
Grand Total	7

Q35: The Board has a good understanding of key people issues, particularly those regarding Transformation?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	4
4 Most of the time/Above average	2
5 All of the time/Fully satisfactory	
Grand Total	7

Q36: All Board members attend and actively contribute at meetings?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	3
3 Some of the time/Average	2
4 Most of the time/Above average	2
5 All of the time/Fully satisfactory	
Grand Total	7

Q38: All Board members have sufficient time and commitment to fulfil their responsibilities?	
N/A	
1 Hardly ever/Poor	
2 Occasionally/Below average	2
3 Some of the time/Average	5
4 Most of the time/Above average	
5 All of the time/Fully satisfactory	
Grand Total	7

Q39: Board members undertake ongoing personal development activities to update their skills and knowledge?	
N/A	
1 Hardly ever/Poor	1
2 Occasionally/Below average	1
3 Some of the time/Average	5
4 Most of the time/Above average	
5 All of the time/Fully satisfactory	
Grand Total	7

Paper for submission to the Public Board of Directors on 4 April 2019

TITLE:	Audit Committee Summary Report to the Board of Directors		
AUTHOR:	Richard Miner – Committee Chair	PRESENTER:	Richard Miner – Committee Chair
CLINICAL STRATEGIC AIMS			
<i>Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.</i>		<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>	<i>Provide specialist services to patients from the Black Country and further afield.</i>
ACTION REQUIRED OF BOARD :			
Decision	Approval	Discussion	Other
		Y	Y
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
High level of confidence in delivery of existing mechanisms / objectives	X General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery
RECOMMENDATIONS FOR THE BOARD:			
To note the assurances received via the Committee, the decision taken in accordance with the Committee's terms of reference and action any items referred to the Board.			
CORPORATE OBJECTIVE:			
All			
SUMMARY OF KEY ISSUES:			
The attached provides a summary of the assurances received at meeting, the decisions taken, the tracking of action for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.			

IMPLICATIONS OF PAPER:		
RISK	N	Risk Description:
	Risk Register: N	Risk Score:
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC Y	Details: Links to all domains
	NHSI Y	Details: Links to good governance
	Other N	Details:

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	18/03/2019	Richard Miner	yes	no
			x	
Declarations of Interest Made				
None				
Assurances Received				
<p>That changes to the BAF and Corporate Risk Register, are now separately summarised so that the Audit Committee is more easily able to exercise its oversight.</p> <p>In respect of completed internal audit reports</p> <ul style="list-style-type: none">▪ Risk management and board assurance framework – Partial Assurance▪ General Ledger and Financial Reporting - Substantial Assurance▪ Data Security Review, Medical Devices – Partial Assurance▪ Consultant Job Planning – Partial Assurance▪ Learning from Deaths – Reasonable Assurance▪ Senior Medical Leave – Partial Assurance▪ Diagnostics, Red Dot Process – Reasonable Assurance <p>In addition, 2 pieces of advisory work were completed in respect of Data Security Protection Toolkit and Division and Directorate Governance and Performance Reporting.</p> <p>The IA programme has reached sufficient stage to enable the Head of Internal Audit to deliver his report and this is currently in draft form (as “an adequate and effective framework but with further enhancements”).</p> <p>154 out of 192 Internal Audit recommendations have been closed with 38 remaining open, however, at the time of the Audit Committee, none were overdue.</p> <p>That there had been no further areas for investigation by the Local Counter Fraud Specialist (LCFS).</p> <p>Noted the activity since January by the external auditors (PwC) and in particular the emphasis which will be on the Trust's own assessment on Going Concern and the work necessary on the MEA valuation.</p> <p>Noted the assurances received at the Caldicott and Information Governance Group Meeting on 5 March 2019 in respect of Health Records, Data Quality and Information Governance.</p> <p>The preparedness of the Trust through Summit following the demise and recovery plan for Interserve.</p> <p>The annual effectiveness review was positive.</p>				

Decisions made/Items approved

- Ratified policies agreed by the (executive) Policy group in respect of Information Governance, NVEPOD, NICE and Clinical Audit.
- Approved the Internal Audit Plan/Strategy for 2019/20 subject to its distribution to other NEDs for comment.
- Approved the LCFS Work Plan for 2019/20.
- Approved the Charitable Funds Audit Plan (and materiality levels) and fees for 2018/19.

Actions to come back to Committee (Items Committee / Group keeping an eye on)

- Continued monitoring of the BAF
- The outstanding Annual Governance Statement will now be tabled at the Audit Committee on 22 May for approval (draft to be circulated beforehand).
- The Annual Review of Declaration of Gifts, Hospitality and Interests will be tabled in the same way.
- The status of overdue Internal Audit recommendations to ensure these are not overdue.
- Delegated authority was provided to the Director of Finance to agree the external audit fee for 2018/19 arising from the External Audit Plan.

Items referred to the Board / Parent Committee for decision or action

- Issues arising from Internal Audit reports
- Board delegation to enable Audit Committee to approve reports including report and accounts, quality account, Charitable Funds, letters of representation and Use of Resources on behalf of the Board.

Paper for submission to the Board of Directors on 4th April 2019

TITLE:	Appointment of Responsible Officer		
AUTHOR:	Julian Hobbs, Medical Director	PRESENTER	Julian Hobbs, Medical Director
CLINICAL STRATEGIC AIMS			
	<i>Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.</i>		
ACTION REQUIRED OF COMMITTEE			
Decision	Approval	Discussion	Other
N	Y	N	
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<input checked="checked" type="checkbox"/> High level of confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> General confidence in delivery of existing mechanisms / objectives	<input type="checkbox"/> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<input type="checkbox"/> No confidence in delivery
RECOMMENDATIONS FOR THE COMMITTEE			
The Board are asked to note the contents of the report and approve the proposal to combine the roles of Responsible Officer and Medical Director from 30 th April 2019.			
CORPORATE OBJECTIVE:			
SO1, SO2, SO5			
SUMMARY OF KEY ISSUES:			
<ul style="list-style-type: none"> The current Responsible Officer is due to step down from his post Two options are available to the Trust; Advertise for a Responsible Officer or Combine the roles of Responsible Officer and Medical Director Advice from the regional Responsible Officer supports the combination of the Medical Director and Responsible Officer Roles The paper requests the support of the board to combine the two roles 			
IMPLICATIONS OF PAPER:			
RISK	N	Risk Description:	



The Dudley Group
NHS Foundation Trust

	Risk Register: N		Risk Score:
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details: Effective, Responsive, Well Led
	NHSI		Details:
	Other		Details:

Appointment of Responsible Officer

1.0 Purpose of the paper

To update the Trust Board as to the responsibility and function of the Responsible Officer (RO), refresh information given about the Current RO stepping down at the end of his three year tenure and to outline proposals for the this statutory function to be recombined with the Medical Director role.

2.0 Background

The Medical Profession (Responsible Officer) Regulations came into force on 1 January 2011 and were amended on 1 April 2013 (The Medical Profession (Responsible Officers) (Amendment) Regulations 2013). The regulations require all designated bodies to nominate or appoint a Responsible Officer (RO).

As such all Doctors registered in the UK with the GMC require a separate licence to practice. Maintaining this licence requires them to be of good standing and engaged with appraisal and revalidation on a 5 year rolling cycle.

The Responsible Officer has oversight of appraisal and revalidation and has a key and legal responsibility to ensure medical staff are fit to practice. They are responsible for liaising with the GMC and ensuring that frameworks of clinical governance are in place to ensure patient safety.

3.0 Current position

Three years ago the previous Medical Director was appointed as interim CEO and a decision was made to split the MD and RO roles. Mr Stonelake was appointed as RO and underwent the appropriate training.

In July 2018 we reviewed a communication from the regional RO outlining the current view that this split was no longer the preferred option and outlining additional assurances required if this arrangement was in place in a designated body. This advice was further underlined and reinforced by the GMC external liaison officer for Dudley.

The current RO will step down at the end of his three year term and as part of preparations for this three other senior medical staff have undergone the RO training to support the current process and provide succession planning.

4.0 Options

In light of the outlined changes 2 options are available to the Trust;

1. The current split of Responsible Officer and Medical Director roles is maintained with a new RO advertised and appointed.
2. The Responsible Officer and Medical Director Role are combined

5.0 Proposed Option

The proposal supported by the regional RO is that the split function at the Trust ceases and the roles of Responsible Officer and Medical Director are combined. As this is a statutory appointment it requires the approval of the Trust Board.

Following approval of the Board the necessary steps to transfer these responsibilities to the new combined RO/ MD function will take place.

The combined role will take effect from the 30th April 2019.

6.0 Recommendation

That the Board supports and approves the proposed arrangement for the Medical Director and Responsible Officer roles to combine from 30th April 2019.

Paper for submission to the Trust Board on 4th April 2019

TITLE:	Clinical Excellence Awards 2018/19 – Annual Report		
AUTHOR:	Marcia Hylton, Resourcing Planning Lead	PRESENTER:	Andrew McMenemy, Director of Human Resources
CLINICAL STRATEGIC AIMS			
Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.			
ACTION REQUIRED OF BOARD / COMMITTEE / GROUP:			
Decision	Approval	Discussion	Other
			Y
OVERALL ASSURANCE LEVEL			
Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
<div><input type="checkbox"/></div> High level of confidence in delivery of existing mechanisms / objectives	<div><input checked="" type="checkbox"/></div> General confidence in delivery of existing mechanisms / objectives	<div><input type="checkbox"/></div> Some confidence in delivery of existing mechanisms / objectives, some areas of concern	<div><input type="checkbox"/></div> No confidence in delivery
RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:			
To receive the report and acknowledge the delivery of the Local Clinical Excellence Awards for 2018/19.			
CORPORATE OBJECTIVE:			
SO3: Drive service improvements, innovation and transformation			
SUMMARY OF KEY ISSUES:			
The attached annual report is a summary of the Local Clinical Excellence Awards (LCEA) process for 2018/19 with further details associated to the allocation of the awards.			
IMPLICATIONS OF PAPER:			
RISK	N	Risk Description:	
	Risk Register: N	Risk Score:	

COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	N	Details: Safe, Effective, Responsive and Well Led.
	NHSI	N	Details:
	Other	Y	Details: Local Clinical Excellence Awards Guidance 2018-2021 (England) requiring publication of Annual Report to Trust Board and JLNC.

Local Clinical Excellence Awards 2018/19

Annual Report

Introduction

The Local Clinical Excellence Awards (LCEAs) recognise and reward NHS consultants in England who perform over and above the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions.

To be considered for an award, eligible doctors must demonstrate achievements in developing and delivering high-quality patient care and commitment to the continuous improvement of the NHS.

The national CEA (NCEA) scheme is administered by the Advisory Committee on Clinical Excellence Awards (ACCEA). It is managed on the committee's behalf by a full-time secretariat in the Department of Health and Social Care (DHSC), and Wales has a secretariat in the Welsh Assembly Government. ACCEA provides separate guidance on national awards

Background Information

Existing LCEAs Local clinical excellence awards granted prior to 1 April 2018 under existing local clinical excellence awards schemes in place as at 31 March 2018.

New LCEAs Local clinical excellence awards granted between 1 April 2018 and 31 March 2021.

Future LCEAs Local performance awards granted from 1 April 2021.

Process

All new LCEAs awarded from April 2018 are non-pensionable and paid annually by lump sum. New LCEAs may be awarded for a period of between one and three years. National award holders who hold an award in the NCEA scheme in place as at 1 April 2018 will not be eligible to hold a local award.

Existing LCEAs awarded prior to April 2018 will remain consolidated and pensionable. Existing award holders who are successfully awarded a new LCEA will retain the existing LCEA as a consolidated and pensionable award and will receive an additional non-consolidated and non-pensionable payment for the new LCEA award.

For example, a consultant with a level 4 award (existing LCEA) might receive a new LCEA on a time-limited basis. They would therefore continue to receive a level 4 award paid on a monthly and pensionable basis. They would also receive a time limited payment as an annual lump sum representing the value of new CEA, in addition to the consolidated payment.

Variations to the local award rounds

From 1 April 2018, employers can work with the joint local negotiating committee (JLNC) to agree new variations as deemed locally appropriate. This could include, for example, agreeing the total value of new payments that can be awarded to a consultant in any one year. However, all new LCEAs must be time-limited and non-pensionable.

Eligibility

Doctors are not eligible for an award if they are:-

- a) a locum consultant. Although if subsequently appointed to a substantive consultant post, it will be acceptable for their application to draw on evidence from their time as a locum consultant
- b) consultants working exclusively in a general management position (such as chief executive or general manager) without a specific clinical role
- c) a consultant within their first year of appointment to the consultant grade
- d) a consultant in receipt of a local level 9 CEA or a national CEA.

Equality & Diversity

The Equality & Diversity information can be found in:-

Appendix 1 Consultant by gender and age group

Appendix 2 Consultant by ethnicity and area

Appendix 3 Consultant by part time and gender

Funding

From April 2018 to March 2021.

Until the end of March 2021, the minimum investment ratio for new LCEAs awarded from April 2018 is set at 0.3 points per eligible consultant annually.

This funding cannot be deferred and must be awarded in that year, unless there is agreement with the JLNC that any uncommitted funds will be carried forward and spent on awards in the following year.

At a minimum:

- funding for new LCEAs in 2018/19 financial year will be recurrent for two further years until March 2021
- funding for new LCEAs between 1 April 2019 and 31 March will be recurrent for one further year until March 2021
- funding for new LCEAs between 1 April 2020 and 31 March 2021 will be for one year.

The funding details are in the attached LCEA Financial Monitoring report.

CEA panel

The Clinical Excellence Awards panel met on Thursday February 14th to discuss and award points.

The panel consisted of:-

Chair	Jenni Ord
LNC Chair	Mr Ashraf El-Dalil
CEO	Diane Wake
Medical Director	Dr Julian Hobbs
Panel Members	Dr Karen Douglas, Dr Alex Wolinski, Mr Ashraf El-Dalil, Dr Jane Dale, Mr John Barry, Dr Atef Michael, Dr Julian Sonksen, Dr Peter Doyle, Mr Anthony Kawesha.
HR Resourcing	Marcia Hylton

Due to the change in process for the 2018 to 2021 award rounds, there were extensive discussions and it was decided there needed to be a follow up meeting to award the points after receiving further clarification on the changes that had been made to the process and how we would implement them.

The follow up panel met on 28th February.

This panel consisted of:

Chair	Jenni Ord
LNC Chair	Mr Ashraf El-Dalil
HR Director	Andrew McMenemy
Medical Director	Dr Julian Hobbs
Panel Members	Dr Karen Douglas, Dr Alex Wolinski, Mr Ashraf El-Dalil, Dr Jane Dale, Mr John Barry, Dr Atef Michael, Dr Julian Sonksen, Dr Peter Doyle, Mr Anthony Kawesha.
HR Resourcing	Marcia Hylton

It was decided that the 18/19 round would be paid for one year and the points were awarded as appropriate.

Awarding of Points

- There were 169 eligible consultants
- There were 35 applications
- There were no rejected applications
- There was one appeal from a part time consultant regarding their award being pro-rated. The national guidelines state that this is the process that should be followed and although advised by the BMA that this is the case they and NHS Employers also advised that as we are running a local scheme, we are free to agree with any changes to our current scheme as agreed by the LNC.
- The Chair of the LNC confirmed that the LNC supports a local variance to the national scheme, so the Trust can award all consultants the full amount for each point, regardless of their part time status.
- The Chief Executive was in agreement.
- One consultant who was already on CEA level 8 was awarded 2 points. As the maximum that can be awarded at local level is 9, he was awarded 1 point and 1 point was carried over to the following year.
- Two consultants received national bronze awards under the national CEA scheme. These awards are administered by the Advisory Committee on Clinical Excellence Awards (ACCEA).

Points awarded by the LCEA

Points	Monetary Value	Number of Consultants awarded
1	£3,016.00	21
2	£6,032.00	12
3	£9,048.00	2

Notification of awards

The consultants were written to and informed of the outcome on 12th March 2019.

24 consultants received payment of their award with their March salary.

11 consultants have incomplete mandatory training records. Payment is withheld until confirmation of 100% completion of mandatory training has been received. The expectation is they will all be paid with their April salary.

National CEA Awards 2018/19

The National CEA awards remain consolidated and pensionable. The amounts awarded are as follows :-

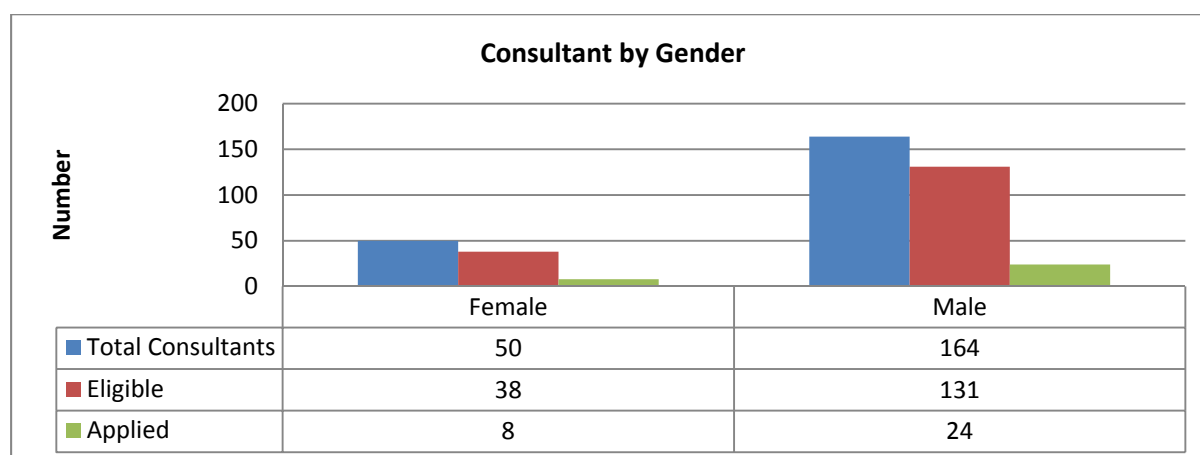
Bronze	£36,192
Silver	£47,582
Gold	£59,477
Platinum	£77,320

The national CEA's are centrally funded.

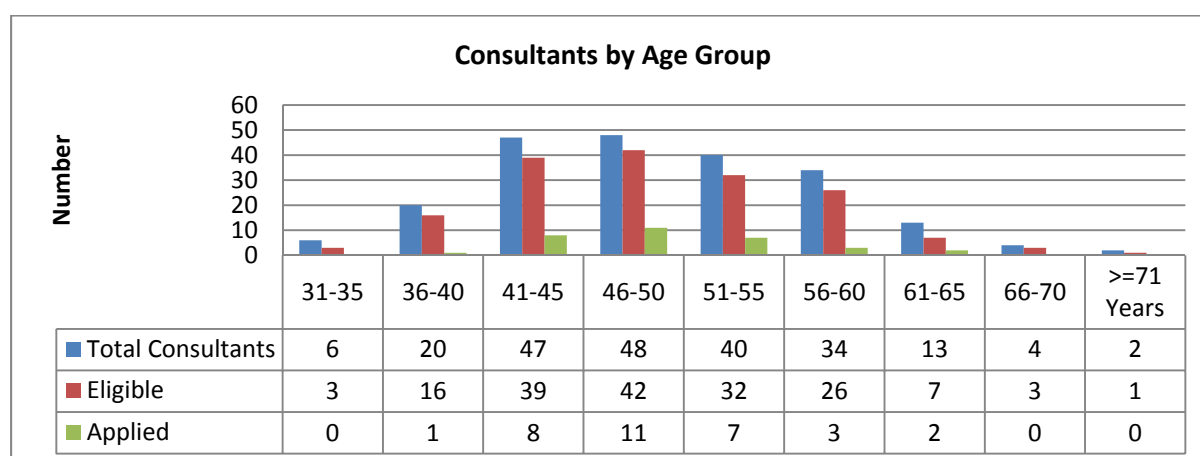
The next LCEA round

The next round of the Local Clinical Excellence Awards for April 19 to March 20 will commence in June 2019.

APPENDIX 1

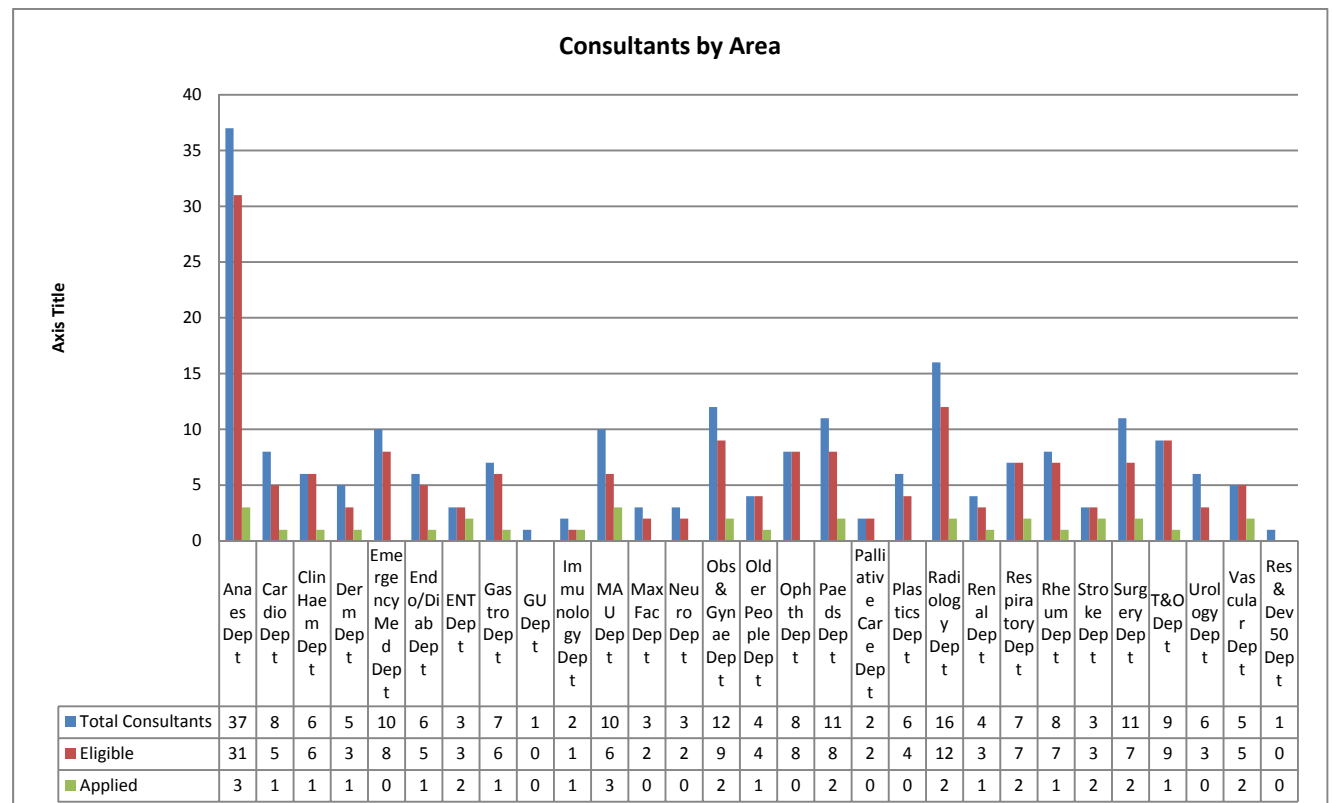
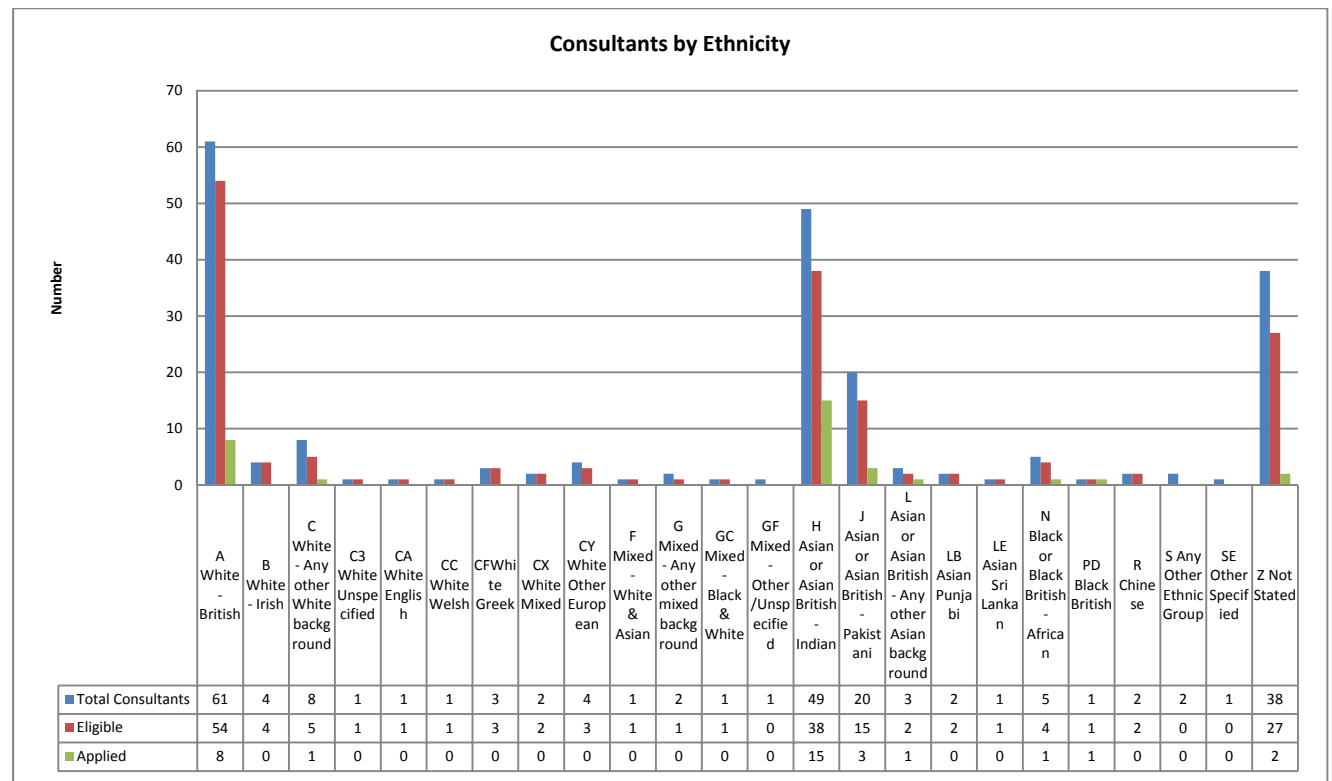


Please note: the number of females who applied should read 10 and males 25.



- 23% of the consultant workforce is female, 77% is male.
- 22% of those eligible for the 2018/19 round is female.
- 29% of those who applied is female and 71% is male.

APPENDIX 2



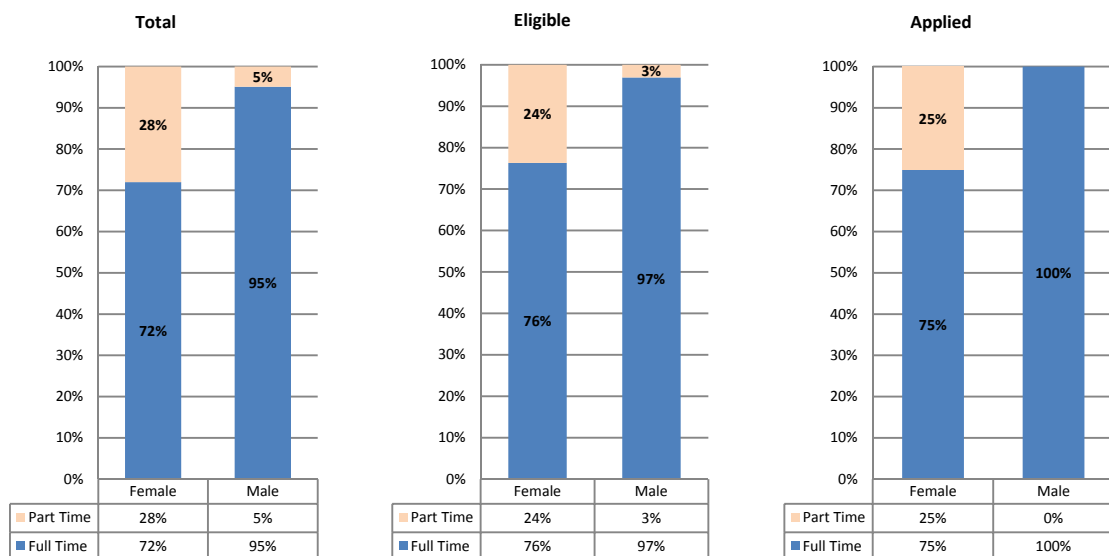
APPENDIX 3

Part time consultant breakdown by gender

Total	Full Time	Part Time	Grand Total
Female	36	14	50
Male	156	8	164
Grand Total	192	22	214

Eligible	Full Time	Part Time	Grand Total
Female	29	9	38
Male	127	4	131
Grand Total	156	13	169

Applied	Full Time	Part Time	Grand Total
Female	6	2	8
Male	24		24
Grand Total	30	2	32



- 28% of all part time consultants are female, 5% are male
- 24% of eligible part time consultants for this round are female, 3% are male
- Of all the part time applicants, 20% are female and none are male.

Dudley Group Local CEA Financial Monitoring Status: 2018 Award Round

Value of CEA point for the purpose of calculating the minimum investment in Local CEAs

£3,016.00

Numbers of Consultants Value of Awards

Opening Position for 2018 Award Round.

Number of eligible Consultants (by headcount) as at 1 April 2018	169	
Outturn spend on consolidated awards (pre 1 April 2018) as at 31 March 2018		£456,778
Spend on consolidated awards (pre 1 April 2018) as at 1 April 2018		
Projected total spend on consolidated LCEAs in 2018/19		£410,522
Investment in LCEAs at 0.3 per head for the 2018 Award Round		£152,911
Projected Total spend on LCEAs (old and new) 2018/19		

Outcome of 2018 Round

Consultants Receiving new awards	35	£153,816
Overspend/under spend on new awards		-£905
Breakdown		
Consultants receiving single value point	21	£63,336
Consultants receiving double value points or 2 single value points	12	£72,384
Consultants receiving 3 points	2	£18,096
Consultants receiving 4 points or 2 double value points	0	£0

New pre-commitments for 2019 and 2020 Rounds

Two Year Awards single value point	2	£6,032
Two Year Awards double value points or 2 single value points	2	£12,064
Two Year Awards of 3 points	1	£9,048
Two year Awards 4 points or 2 double value points	0	£0
Three Year Awards single value point	5	£15,080
Three Year Awards double value points or 2 single value points	2	£12,064
Three Year Awards of 3 points	0	£0
Three Year Awards 4 points or 2 double value points	0	£0
Total precommitment in 2019/20		£54,288
Total precommitment to date in 2020/21		£27,144

Projected 2019 Round Investment at current rates

Projected eligible Consultants (headcount) as at 1 April 2019	169	
Anticipated CEA Investment in 2019/20 @ 0.3 per head plus 2018/19 investment		£305,822
Carry forward costs from any 2018 Round over/underspend plus any pre-commitment from the 2018 Round		£55,193
Estimated Net Investment Available in 2019/20 for new awards		£250,630
Projected Spend on consolidated LCEAs 2019/20		£370,048
Anticipated National CEA Reversion costs for 2018 NCEA Round		£24,112
Total Projected Spend on LCEAs old and new 2019/20		

Notes

1. Eligible consultants includes consultants employed under the Terms and Conditions – Consultants (England) 2003 as amended as at 1 April 2018. Consultants should have at least one year's experience and should not hold L9 award, a national award or distinction award. The Review Body may deem other consultants eligible such as clinical academics and those on the pre-2003 contract terms.
2. It is assumed the maximum award made to any individual consultant is normally 3 single value points, but in practice there is no limit (unless there is an agreement otherwise). Where more than 4 points or 3 double value points are awarded additional information should be provided.
3. Existing LCEA Spend is being tracked for the purposes of informing post 2021 negotiations and to assist employers as they calculate minimum spend on awards from April 2021.
4. Overspends or Underspends might occur when insufficient quality applications are received (underspend) or where applications can't be separated (overspend) or where applications are made on appeal (overspend).
5. National CEA reversions will need to be funded by employers from outside the minimum investment requirements for the 2019, 2020 and 2021 Award Rounds. In this example, a Level 7 reversion creates a pressure outside the funding ratio.
6. The value of Local CEA awards may be uplifted following recommendations from the Review Body on Doctors' and Dentists Remuneration that are accepted by the government.
7. New award on-costs include Employer National Insurance Contributions (ENIC) only. Costs for pre 1 April 2018 awards should include ENIC in addition to Employer Pension Contributions (EPC) and costs associated with uplifts to the value of awards from Additional Programmed Activities (APA).
8. Does not consider savings/costs associated with consultants with a time limited awards moving between trusts or leaving the NHS.

On cost scalars:

APA - applies to pre 1 April 2018 consolidated award costs only. In practice this scalar will vary between employers.	0.14
EPC - applies to pre 1 April 2018 consolidated award costs only. Given as at 2018/19 financial year	0.1438
ENIC - Given as at 2018/19 financial year	0.138