



Health Sector Reform
Improving Hospital Efficiency

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The Health Systems Resource Centre is managed for the UK Department for International Development by the Institute for Health Sector Development Limited

Improving Hospital Efficiency

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SOME KEY TERMS

Efficiency - measures how much output is achieved in relation to how much input (resource) is used. More output for the same input achieves greater efficiency as does producing the same output for less input. Typical measures of efficiency are the unit cost (e.g. cost per delivery; drug cost per outpatient) and workload ratios (e.g. inpatient days per nurse).

Hospital performance - is used here as a wider concept than efficiency, in that it takes into account the range of services provided and their quality, as well as how efficiently they are provided. Defining the parameters of performance which are most important helps to guide and monitor hospital management.

Hospital autonomy - describes management arrangements for hospitals where the managers have a greater degree of authority than in a traditional, directly managed public service. Autonomy can include financial management, e.g. freedom to spend within an overall budget, setting pay levels, transferring money between budget heads and selling off assets; personnel management, e.g. hiring and firing staff, setting terms and conditions of employment, reward and discipline; and service development, including offering new services.

Commissioning (or purchasing) - the role of a funding agency in specifying the services a hospital (or other provider) is to provide and the funding it will receive to deliver these.

Privatisation - the transfer of ownership of public assets into private hands, usually by selling them to a private enterprise. This is different from the model of management autonomy applied in the health sector in many countries, which typically involves establishing the hospital as an independent entity still in the public or parastatal sector. With the latter model of hospital autonomy, the new entity is usually given the assets, rather than buying them.

Contracting out - contracting out involves commissioning a private organisation or NGO to provide certain services which were previously managed directly by the public sector, for example the cleaning of the hospital or the laboratory services. It could also involve a management contract for running the hospital as a whole. Usually there is a competitive tendering process to select the best firm to run the service.

Abbreviations

| | |
|------------|---|
| CEO | Chief Executive Officer |
| DMO | District Medical Officer |
| FSU | Former Soviet Union |
| MoH | Ministry of Health (or equivalent) |
| NGO | Non-Government Organisation (typically not-for-profit) |

INTRODUCTION

The purpose of this document

Building and running hospitals absorbs the major share of health expenditure in any country. As demand for hospital care increases and the costs of provision rise, it is essential to make more efficient use of the resources already devoted to hospitals. There are three main types of initiatives in improving hospital efficiency:

Making more efficient use of the resources available across the health system, by reviewing the numbers of hospitals and their distribution, to see whether resources can be better allocated between hospitals and regions, for example by reducing duplication of services or closing some hospitals.

Increasing hospital autonomy and giving managers clear responsibility for performance, so they can make decisions more quickly at a local level based on local conditions and priorities, rather than following centrally determined decisions and regulations.

Introducing measures to make more efficient use of the resources available to the hospital sector, for example by cutting down wastage and abuse in purchasing of supplies, using generic rather than branded drugs, improving procedures and rationalising staff levels and mix to achieve more patient throughput relative to staff inputs.

These approaches are related: greater hospital autonomy with clear responsibility and accountability means that hospital managers have incentives and opportunities to introduce efficiency improvement measures in their hospitals.

Whilst these approaches to improving efficiency are relatively straightforward in principle, the political and organisational realities complicate matters in practice. Closing hospitals or wards will be controversial and the transfer of employment from the civil service to autonomous agencies is sensitive and may be resisted.

The purpose of this publication is to describe some of the practical issues and options involved in introducing these types of improvement initiatives. It is aimed at both policy makers and those responsible for the actual implementation of hospital management reforms. It presents some draft agreements and policies developed in particular countries which may be adapted to local conditions elsewhere or which may prompt ideas in the development of new ones. The next section of this Introduction discusses the international context and impetus for improving hospital efficiency. The main sections then cover:

- Part 1 The case for national review of hospital provision and issues that arise
- Part 2 Hospital autonomy – the concept (Part 2a) and steps required (Part 2b)
- Part 3 Some specific measures for improving hospital efficiency

The need to focus on hospital efficiency

Problems of hospital efficiency can be considered in the contexts of three broad groups of countries: high and middle income countries; Eastern Europe and the former Soviet Union (FSU); and low income countries. Although they have obvious differences there are also considerable similarities in the problems they face and the solutions to them.

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The differences reflect not only per capita health expenditure and variations in disease burden but include cultural and historical influences on funding and services delivery. The similarities, and hence the ability to look internationally for solutions to problems, are:

- the continuing imbalance between resources (especially finance) and demand - whatever the per capita spend - fuelled by population size and age, new technology and greater public expectations;
- the need to shift limited resources to more cost effective interventions in the ambulatory care or primary care settings;
- changes in medical technology which mean that patients typically stay a shorter time in hospital, and hence that throughput per bed can increase;
- above all the realisation that within the hospital sector there are enormous efficiency gains to be made, which would allow considerable increases in both the quality and quantity of service delivery for the same or less expenditure.

High and middle income countries

Whatever their methods of funding health care, the last decade has seen high and middle income countries concentrating on controlling costs through greater efficiency and restricting access. Rising public expectations have made restricting access more difficult politically. The emphasis has been therefore on achieving greater efficiency through reducing beds and hospitals, increasing ambulatory care backed by investment in new technology, introducing management reforms to give hospital managers greater autonomy and restricting funding to interventions of proven efficacy (i.e. encouraging evidence-based medicine). The experience gained in these countries in these areas may have something to offer policy makers and managers in the other two groups of countries.

Eastern Europe and the Former Soviet Union

With very high rates of acute beds and doctors, the key to increasing efficiency in the hospital sector in these countries is reducing capacity. The problem is compounded, not helped, by many of the other changes taking place, such as the splitting of responsibility between ministries and national health insurance agencies and the fragmentation of ownership (with decentralisation to numerous municipalities and other bodies). Unlike in some other sectors, privatisation is not the answer until capacity has been reduced. Without reduction, supply-led consumption is likely to defeat the purpose. Some of the lessons learnt in high and middle income countries may be useful, particularly in handling the political process and integrating bed closures with efficiency gains. Key points are the recognition that improvements in patient throughput made possible by new technology also risk increasing overall costs - often outstripping savings made from bed closures; and that improving primary care often increases hospital referrals rather than decreasing them (as is commonly thought).

Low income countries

In these countries, policy makers, planners, donors and development banks have largely ignored the hospital sector over the last twenty years. Hospitals were viewed as "disease palaces", consuming disproportionate amounts of scarce resources which could be spent more cost effectively on primary care. After the Alma Ata declaration on primary healthcare in

1978, most countries health plans began with statements such as “our priority is primary care”. Yet twenty years later, little real shift in resource allocation has taken place - indeed many countries have moved in the opposite direction. Despite this, many hospitals are in no better shape. Some are grossly overcrowded and have inadequate drugs and supplies; others lie empty making little use of their capital and recurrent investment. There are exceptions but they are usually smaller mission or NGO hospitals. Both categories are being squeezed by the withdrawal of international support and increasingly rely on government subventions and user charges. The private hospital sector is typically small, serving a small minority usually in the major cities, although it is expanding in all countries.

Public hospitals are now just beginning to receive attention, as policy makers and funding agencies realise that the poor need access to hospital care and that poverty is exacerbated by having to pay for it. At the same time, there is much debate on whether hospitals should be run by the public sector or whether ownership and management of hospitals should be in the private sector. The evidence from higher income countries is that if governments wish to control hospital costs and maximise equity of access, they should not leave hospital care to the private sector. This does not mean that the traditional public service system of owning and running hospitals is the only alternative. The focus is now on how to use public finance to buy (or commission) services for the public from a combination of autonomous, NGO and private hospitals.

While policies remain the same - to shift limited government resources, to primary care - there is a need for government financial support to ensure access to the hospital sector for a considerable proportion of the population. For the foreseeable future most hospital care in many countries will be by access to public hospitals – with some movement towards more autonomous hospitals - partly funded by central governments and partly by user charges and health insurance as and when these develop. As a result, attention has been focused on improving the performance of these hospitals ensuring that their services are relevant, efficacious and accessible; experimenting with autonomy; developing commissioning or purchasing skills in their funding bodies; and improving the efficiency and quality of their services.

Part 1 - The Hospital Strategy

The need to review hospital provision

1.1 The number of hospitals and hospital beds available in a country is the cumulative result of a series of decisions by government, private organisations and NGOs taken over many years. The resulting pattern of provision may not be appropriate to the country's current circumstances. For example:

- it may be more than the economy and current systems of health funding can support, so that services are under-funded and hence of poor quality;
- it may encourage over-utilisation of hospital services when other services would suffice (or be of better quality);
- it may differ from the distribution of population, so that some areas are very well served while others are poorly served;
- as medical technology changes, lengths of stay in hospital fall, so that the same number of patients can be treated with fewer beds - or costs rise as more patients are treated in the same number of beds.
- The first stage in considering how to improve hospital efficiency is thus to look at the overall level and pattern of hospital provision to see how much hospital care the country can afford while maintaining a reasonable level of quality.

1.2 Even if the existing system is currently affordable and appropriate, planners need to consider trends that can be expected to affect provision. Middle and higher income countries have found that new medical technology and practices lead to shorter hospital stays. This means more patients can be treated per bed resulting in more treated overall. It also results in higher costs per bed night as patients are treated more intensively and do not remain in hospital for the period of recovery which typically has a lower cost per day. Such trends mean that standing still is not an option - in order to control costs and maintain efficiency the number of hospital beds has to fall. For example, in the UK, the number of acute beds was reduced by almost half between 1970 and 1992, while the number of patients rose by 45%, because the average length of stay in acute hospital beds fell from 12 days in 1970 to 5 days in 1992. Where there is a policy of decentralisation to districts with each district wanting to have its own district hospital, an increase in the number of districts will produce pressure to build more hospitals. A clear hospital strategy can be useful to resist such pressures to which have major cost implications.

Developing a strategy

1.3 To review hospital provisions and make decisions on whether to close or rationalise services, three main factors must be balanced:

- **affordability** - how much funding will be available and how much efficient good quality care this will support.

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- **needs/demand for services**– the structure of the population and its geographical distribution, access to care (including the ability to pay) and hence the likely levels of utilisation
- **the political environment** – the willingness to take difficult decisions on closing hospitals or wards and the options that will be acceptable

1.4 There are three broad steps in developing hospital strategy:

(a) Make projections of the workload likely to be generated by the population. Post utilisation and international comparative data can be used for this, taking into account access factors (physical and financial). Workload data can then be used to project staffing, drugs and supplies levels by major departmental speciality and these can be compared to existing levels to estimate needs.

(b) Analyse how much a typical hospital costs to run at an acceptable level of quality and operational efficiency - by major speciality if possible. This involves a review of staff and non-staff costs and their breakdown by broad activity.

(c) Look at affordability: what financing is likely to be available to run the hospitals? Past trends in funding provide a guide but these will need to be adjusted to allow for future policies affecting funding, plans for adjusting user fees, economic trends and how these are likely to influence funding through insurance contributions or taxation.

1.5 The strategy will be driven by the size of the gap between the costs of running services with the projected funding available. If there is not enough funding it will be necessary to look at options for adjusting provision, for example by closing underused services – whole hospitals or parts of hospitals. Closing whole hospitals will achieve greater savings than cutting back numbers of beds or wards. However this is obviously more difficult politically and may raise access issues. The broad options for closing hospitals will depend on the existing pattern of provision but might include:

- Closing one of the hospitals where there is duplication of services in a single town (for example, where there are both government and NGO hospitals);
- Closing small peripheral hospitals (or converting them to health centres offering primary care) in order to concentrate resources in better staffed, higher quality urban hospitals;
- Closing a specialist referral hospital in favour of certain district hospitals if these are active and providing a cost effective service.

1.6 At the same time, opportunities to raise the funding base may be sought, e.g. by requiring full cost recovery for particular services of lower priority.

1.7 Such decisions may be difficult, but, if services are to improve and serve the poor better, then they have to be made. They require political sensitivity as well as technical considerations of service quality.

1.8 The next critical phase of the hospital strategy is the communication of planned reforms to staff and the population. Experience elsewhere suggests that:

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- it is critical to convince staff first – major selling points may include improved working conditions, access to new technology and improved service quality.
- the public have to be made to think in terms of quality of health care - for example, although some people will have to travel further to get care, the services will be better when they reach them. (Naturally, it is difficult to convince people that closing down their local hospital can improve their health care).

1.9 The discussion above has assumed that there would be a national decision on the hospital strategy, With choices made centrally on which hospitals to close if there is over-provision compared to the resources available. However, there are other approaches to deciding how to cut back provision. Rather than a notional strategy, there can be decentralised approaches, for example:

- funds for health could be allocated to local regions, provinces or districts on a population, basis (possibly weighted by other factors such as health needs, social deprivation or service costs). The region or district authority then has to decide how best to use those funds to achieve the stated objectives;
- districts can use their health budgets to 'purchase' or fund the hospital services they want, leaving the hospital managers to rationalise (or close) their services depending on the amount of funding they can attract.

1.10 The national planning and decentralisation approaches each have their pros and cons:

- The national plan approach it, difficult for notional politicians but if hard decisions are possible it may secure greater equity.
- Decentralising decisions on rationalisation shifts the political sensitivity to local politicians, who may take decisions based on their local interests. The results may not be the most efficient or equitable but may be more acceptable because they were taken locally. However, the local decision makers may avoid making hard decisions and continue to run unsatisfactory services. Therefore, a strong central strategy is often required, even if detailed planning for rationalisation is left to local levels. Public finance allocated to the districts should be tied to clear quality and equity standards.
- Leaving hospitals more to market forces may avoid political problems (but it may not), and removes most of government leverage to achieve equity. Often, a more managed process with a clear policy and strategy for rationalisation will be both more equitable and, in the long run, easier to implement.

1.11 Once the major decisions on the strategy have been taken and any hospital closures or rationalisation have been agreed, the decentralisation option becomes more relevant for running the hospital system, as incentives for improving performance and efficiency can be built in. This approach is covered in **section 2** of this document.

1.12 A specific issue rises with national referral or specialist institutions. These are usually funded at a much higher level than other hospitals (although in fact they are often providing much the same services). Establishing the proper role and funding of referral hospitals can be addressed by explicit central decisions, or can be left to the decentralised decisions of 'purchasing' districts. In practice, often neither may have the skills required to do the job but, in the early years of reforms, a central strategy and budget may be easier to

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control and avoids the need for all districts to make their own agreements with the referral hospitals.

Part 2 Increasing Hospital Autonomy as a Way of Improving Efficiency

2a The case for increasing autonomy/decentralising management

What is meant by increased autonomy?

2.1 The central idea in what has become known as hospital autonomy is the delegation of management authority and responsibility away from central or regional managers to a local level. The typical model is for:

- management powers to be vested in a hospital board, which is responsible for managing the hospital, including the funds provided and the staff employed, and ensuring the hospital delivers the services agreed with the major funding agencies;
- the level of funding and the services to be delivered are set out in a service agreement or 'contract' between the funding agency and the hospital board;
- the composition of the board is designed to bring in local 'ownership' and accountability as well as management expertise.

2.2 The introduction of autonomy usually involves the shift of management responsibility in three main areas:

- **financial management powers are delegated** - so that managers can decide how best to spend the resources available given the particular needs of the hospital and problems that arise during the year; and often management is given the capacity to raise additional revenue, for example from fees or insurance;
- **personal delegation** - so that hospital managers have greater scope to motivate staff, reward good performance and deal with poor performers;
- **service development planning** - so that managers can decide how best to develop their services (within the parameters of government policy).

2.3 However the extent of delegation in each of these areas must be clear - there is a spectrum from allowing limited authority to what might be termed full autonomy where the hospital management can take decisions without reference to the MoH or local government. Thus, for example:

- **Financial management** - limited authority might include capacity to reallocate within budgets during the year, or to purchase goods up to a limited sum. Full autonomy allows the hospital to decide how to spend its budgets, raise capital and sell assets without reference to the major funding authority.
- **Personnel** - some countries have found that they are able to second MoH staff to the hospital, and allow the hospital to select and reject staff but keep them as civil servants on civil service pay scales; others require the hospital to agree any pay rises with central

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ministries before they are introduced; others have gone to full delegation which allows the hospital to decide how many staff to have, set pay levels, and be the employer responsible for recruitment, promotion, discipline, pensions and terms of employment.

- **Service plans;** hospitals might have the authority to prepare plans which have been approved by the central government; or they might be free to develop services and raise funds as they see fit, so long as they meet the service agreement relating to government funds and so long as they fit with other Government regulations on the development of the hospital sector - for example, on the purchase of expensive new technology.

Figure 1: Options for the extent of delegations in different areas

(note that one can select limited autonomy in some areas and full autonomy in others)

| Area | Limited Autonomy | Full autonomy |
|------------------------|---|---|
| Expenditure management | Can reallocate (vire) funds within budgets up to limits | Can allocate and revise budgets without central approval |
| Asset sales | Can sell assets only with MoH approval | Can sell any assets |
| Charging fees | Can collect and retain fees, with fee rates set by MoH | Can set and retain fees (within MoH policy) |
| Borrowing funds | Not allowed to borrow from private sector | Can borrow with Minister's approval |
| Employment status | Staff remain as civil servants, seconded to the hospital. The hospital deploys them and recommends for promotion and discipline | Staff directly employed by the hospital unit, which is responsible for pensions, promotions and recruitment |
| Salary rates | Salaries approved by Government Ministry | Free to determine salary levels and conditions |
| Staff numbers | Approval required for additional staff | Free to set staff numbers and mix |
| Service plans | Full hospital plan has to be agreed with MoH | Hospital can introduce new services as long as it can finance them, within national policies for hospital development |

2.4 While the typical model for hospital autonomy is to have a unit which is managed by a board, there can be variations on this approach, including decentralisation to local authorities or to district health boards, and having the hospital managed as a unit within the district service or combined with the surrounding primary services. These issues are discussed further in **section 2b**. For simplicity, the terminology used in this document is the “autonomy” of a “hospital unit”, with the understanding that the management delegation may be given to a local authority or district health board, and the unit concerned may be a range of services rather than a free-standing hospital.

The UK Example

The UK provides an example of hospital autonomy which has been introduced country-wide (phased in over several years).

- Publicly owned hospitals were transferred to become 'trusts'. these are public bodies run by the boards made up of non-executive and executive directors with a chairman accountable to the Minister for Health.
- New legislation was passed governing the creation and responsibilities of trusts.
- The trust owns the hospital land, buildings and other assets, and is the employer of all hospital staff.
- The trusts are free to develop private services in addition to the services they provide under contract to the districts, and to develop other ways of generating income such as shops or sale of surplus land.
- Some trusts combine hospital and community services, others are separate from community services.
- Trusts receive the great majority of their running costs from health districts which agree annual service agreements with them for provision of health services for their population. The districts are funded on a formula basis by central government, from general taxation.
- Accountability of the Trusts to the Minister is handled by a National Health Service management executive with regional offices.
- While it is difficult to identify the impact of these reforms, hospital managers find their task easier as their objectives are more clearly specified.

Autonomy for the national referral and teaching hospital in Kenya

- In Kenya, the major national referral and teaching hospital, Kenyatta National Hospital, has had some autonomy for several years:
- It has a single line budget from Government, the right to set and retain user fees, and employs its staff on parastatal terms which include higher salaries than other health workers.
- The hospital was given greater autonomy under the existing legislation for parastatals, by standing order.
- It owns land, buildings and other assets.
- It can develop private services, and has successfully done so.
- Most of its funds come from central government, but there is no service agreement. This has allowed the hospital to develop new tertiary services. It has also succeeded in increasing its share of the national health budget, despite the expectation that its share of funding would fall.
- It has introduced user fees, and raised some 20% of costs through fees (mainly the private services).
- The hospital management has made good progress in eliminating unofficial user fees, because they can fire staff caught taking funds.
- Accountability is exercised through the top civil servant of the MoH, who is a member of the board (although here are drawbacks to this approach).
- There have been improvements in efficiency in areas such as maintenance, accounting systems and user fee collection; these were encouraged by conditions attached to a World Bank loan which financed capital investments and training.

Hospital Autonomy in Indonesia

Indonesia introduced greater financial management autonomy for hospitals (Unit Swadana) in 1991.

- One of the major motivations was to encourage hospitals to recover more of the costs from patients. Unit Swadana hospitals are allowed to retain fee revenues rather than remitting them to the government, as in the past.
- Hospital managers can set their own fee levels except in the case of beds reserved for the poor, where fees have to be approved by government. Revenues cannot be used for equipment or construction.
- The hospital manager develops and submits an annual plan and budget covering funding from government and fee revenues.
- The Ministry of Health and provincial and district governments continue to own the hospitals, supervise them and provide some funding.
- The hospital management structure can be decided at hospital level, but hospitals do not have the power to hire or fire staff. The Hospital Director is still appointed by the Ministry of Health.
- A review of experience showed that some hospital fees have risen faster in the Unit Swadana hospitals, and there have been reductions in the number of beds reserved for the poor. This raises concerns for equity of access and suggests mechanisms are required to ensure access for the poor.
- The review found some improvement in attendance by doctors, following introduction of salary supplements, but could not otherwise show improvements in efficiency or quality¹

What is the difference from privatisation?

2.5 Privatisation conventionally has meant the transfer of ownership of public assets into private hands, usually by sale to a profit making private enterprise. Management autonomy in the health sector typically involves establishing the hospital as a legal entity in the public or parastatal sector, rather than a profit making venture. This is partly because, for the medium term at least, governments will remain major contributors to hospitals in order to ensure some equity of access for their populations. Experience suggests that if governments wish to control health expenditure and hospital costs then they should keep the hospitals in the public sector.

2.6 At times, the term privatisation is used to refer to commissioning specific services to be run by the private sector (without changing ownership of the assets). This might only involve contracting out the cleaning of the hospital or the laboratory service, but could also involve a management contract for running the hospital as a whole. Usually there is a competitive

¹ GovindarayR, Chawla M. Experiences with Hospital Autonomy – What can we learn? DPIH, Harvard School, September 1996.

tendering process to select the best firm to run the service. This model could be adopted as a means of increasing autonomy; however, experience of overall management contracts in some low income countries has not been encouraging; there have been better results from contracting out specific services (see **section 3a**).

2.7 This document assumes that the model of management delegation will be to retain hospitals in the public sector but to establish them with more autonomy than typical government departments. The unit might also include community services as well as the hospital itself. The legal options for establishing more autonomous units are discussed further below in **section 2b**).

Advantages and risk of management autonomy

2.8 The potential advantages of decentralising management authority include:

- decisions made locally are based on better information, for example about the priorities for spending funds for maintenance, the staff who are performing best, and local needs;
- decision making should be faster since there will be no need to wait for central approval or centralised procurement;
- there should be greater accountability as the board can monitor how funds are used and what is being done to improve services, it is expected that the board members who represent the local community will have a greater interest in improving local services than civil servants based in the capital city;
- the introduction of service agreements which clearly specify what services are expected for the public funding provided should shift attention to the performance of the hospital, achieving better results than a focus on inputs (which characterises management relationships where the centre is responsible for approving spending and staffing decisions);
- it may be easier to introduce fees or other financing arrangements which improve the hospital's financial position, and there are more incentives to do so if revenue can be retained locally (this is discussed further below).

2.9 These advantages should lead to;

- improved efficiency, with better informed and faster decisions, adapted to local circumstances;
- better morale and motivation, as staff and managers can settle their own problems rather than being constrained by bureaucracy;
- greater local accountability.

2.10 The delegation of management authority has the added benefit of freeing central ministries from operational issues and allowing them to concentrate on policy, resource allocation and performance management. The latter enables central government to specify clearly through annual contracts or service agreements what it wants from the autonomous hospital in exchange for the government funding. Agreements can include performance

targets for quality of care and, as financial systems develop, can enable the government to target its financial support to specific income groups.

2.11 There are also risks associated with granting greater autonomy to local units, which can include:

- weak management capacity leading to poor decisions or misuse of funds;
- inadequate skills to operate new systems such as computerised accounting; corruption in purchasing resulting in poor value for money;
- capacity to hire and fire staff locally which can bring allegations of favouritism or inappropriate choices;
- staff may resist being transferred from the security of the civil service (where this is proposed);
- if funds are not released by the major funding body, the board is left in a difficult position and the service agreement loses its value;
- if fees are introduced, equity may decline - either because better off areas can raise more from fees than deprived areas, and hence achieve better services; or because fee levels exclude poorer residents in the catchment area (if there are not effective exemption arrangements);
- there may be fragmentation and excess capacity as institutions compete rather than collaborate;
- the hospital may not follow government policy on issues such as equipment standards, fees and exemptions, and priority services;
- weak capacity in the commissioning (funding) agency could lead to little gain in overall efficiency or decline in access by target groups.

2.12 Risks can be addressed and minimised by the careful design and introduction of management delegation to meet stated objectives. Key design issues are set out in the following section and the annexes give standard approaches which aim to avoid many of the potential problems.

Deciding whether autonomy is appropriate

2.13 Delegation of management authority over finance and staff to lower levels of organisation, alongside clear specification of expected outcomes, is widely recognised as good management practice in both public and private organisations. Thus while there is a strong case for giving managers greater flexibility in the use of their budgets and deployment of staff, the issue facing health sector managers is the extent of delegation and freedoms within it. The risks identified above need to be assessed for each type of hospital or local authority which is being considered for autonomy. For example, it may be appropriate to give full autonomy in terms of legal status and financial management to large hospitals in the capital and the larger cities, which have capable managers and access to highly skilled board members, but it may be decided that rural hospitals are not yet ready for such managerial

independence and would be better given limited delegation of financial authority within the civil service structure.

The decision on whether and when to delegate is likely to be based on:

- The calibre of both managers and board members available in the area around the hospital unit. As discussed further below, board members should be chosen for their management skills. If such people are unlikely to be available, it may be better to give limited management delegation to hospital managers without creating separate legal boards.
- The extent of financial and information systems in the units - a basic level of accounting skills and records is a pre-requisite for financial delegation; this may be developed in the period leading up to delegation of powers/autonomy.
- The overall hospital strategy - if the government is planning rationalisation of services and particularly closure of a hospital it would be better to introduce these changes first.
- How it fits with broader strategies for decentralisation of services to local levels; in which case proposals to increase hospital autonomy should be consistent with these plans.
- Where there is a need to develop financial/management capacity autonomy should be introduced gradually, as capacity improves and managers gain more experience.

Increasing financial stability of the hospital

2.16 Proposals for increasing management autonomy typically include allowing the hospital to levy fees and raise income in other ways, and to retain the revenue. In some countries, it has been difficult to introduce and increase user fees at the central level, as this may, contradict political commitments or objectives. Levying fees at local level has been found to be more acceptable, partly because the decision makers are able to explain the decision locally. The decision maker may be local authorities or the hospital board. There are drawbacks, notably where the level of fees varies from one area or hospital to another. This can be addressed by restricting the level of fees and clarifying criteria for exemption in service agreements.

2.17 At first sight there may also be a concern that introduction of user fees will reduce access of the poor to services. However, many countries which do not officially have fees in public hospitals found informal charging by staff for various services already exists, sometimes mounting up to substantial amounts. The poor typically have to pay these charges, while people more able to pay, such as local politicians or civil servants, maybe exempted. The conversion to formal user fees can help to regularise the fees paid. Clearly, informal charges should not continue alongside the formal fees.

2.18 Some countries have regulations which prohibit government agencies from retaining revenue they have raised, and require all revenue to be returned to the treasury. In this case, revenue raised from hospital charges has often been disappointing, as staff and managers have little incentive to ensure all revenues are collected and accounted for properly. Establishment of hospitals as separate entities and giving them the power to retain revenues is a means of getting round such regulations. It is clear from experience in many countries that the amount of revenue raised will be much greater if the revenue is retained locally.

2.19 There are various options for raising revenues:

- User fees are relatively simple to introduce and may already exist, either formally or informally. Autonomy will give the hospital managers scope to revise fee levels and to clamp down on unofficial charging
- Insurance is another potential source; there may be existing insurance schemes which hospitals will have the incentive to claim from once they can retain the revenue (such as vehicle insurance to pay for road accident victims). Hospitals can also consider developing local insurance schemes; however they will only be able to attract members if the hospital offers reliable service quality and has significant user fees.
- Development of private wings which charge higher rates, and renting of hospital facilities to private practitioners.
- There may also be scope for selling off or leasing out surplus assets

2.20 However, experience shows that the introduction of new freedoms to raise and retain revenue do not mean that the government can rapidly reduce, its contribution to running costs of public hospitals. The initial mechanism for raising revenue is usually user fees, and these take time to build up to a significant level and rarely exceed 20% of running costs even with the development of private facilities. Furthermore, to make fees or insurance schemes acceptable, it is usually argued that the revenue raised will result in improved services for the user. This will only be achieved if the fees are additional to the level of funding already provided by government. Thus in the short to medium term, revenues will make a contribution to improving services but cannot be expected to replace government funding.

2.21 Increasing the financing available to the hospital is not in itself a means of improving efficiency, although it can lead to improved efficiency if the funds raised are used to provide crucial support or repairs which result in more efficient use of staff and facilities.

2b Preparation for Increased Management Autonomy

2.22 This section identifies the main steps which are required in introducing greater management autonomy for hospitals, and discusses key issues which arise in each case, based on experience in the UK and developing countries. The annexes support the discussion by providing some examples of legislation and policies which can be used as a starting point and adapted to local conditions. The main steps involved are as follows:

- i. Allocating responsibility for work on hospital autonomy.
- ii. Specifying the extent of delegation of authority.
- iii. Identification of the governing entity and composition of the board.
- iv. Drafting legislation.
- v. Determining personnel policies and transition arrangements.
- vi. Developing financial management systems.
- vii. Communications to staff and the public.
- viii. Preparation of service plans.
- ix. Developing service agreements and performance measurement systems.
- x. Selecting and training key managers and board members.

2.23 These steps are broadly in sequence - e.g. **steps ii and iii** are required before, **step iv** can be completed.

Figure 2 indicates the timescale and sequence for implementation.

| Step | Approximate Timing in Months | | | | | | | | | |
|------|------------------------------|---|---|---|---|---|---|---|---|----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| I | | | | | | | | | | |
| ii | | | | | | | | | | |
| iii | | | | | | | | | | |
| iv | | | | | | | | | | |
| v | | | | | | | | | | |
| vi | | | | | | | | | | |
| vii | | | | | | | | | | |
| viii | | | | | | | | | | |
| ix | | | | | | | | | | |
| x | | | | | | | | | | |

Step I - Allocating responsibility for work on hospital autonomy

2.24 The introduction of greater management autonomy is a fairly complex management task in itself. Many countries have found it helpful to designate a small team of senior officials to identify the benefits of increasing autonomy. If there is agreement to proceed, the same team can be commissioned to prepare for the introduction of autonomy. Such a team typically reports to the Permanent Secretary or Minister.

2.25 Staff transfer has proven in to be the most difficult aspect of autonomy as, understandably staff have concerns about their employment and their prospects. Given its sensitivity and the wider implications of personnel reforms, it is suggested that a human resources task force or planning group be set up early in the planning process, which would focus on the issues of employment terms, transfer of staff, staff communications and management training. This group could involve key players such as the ministry responsible for civil service employment and hospital managers and would report to the main autonomy team identified.

Step ii Specifying the extent of delegation of authority

2.26 There are various options for delegating authority, discussed in **section 2a**. This section identifies issues to be addressed when deciding how far to go towards full autonomy. The design issues in the decentralisation of management authority fall into two main areas:

- What is included in the autonomous unit - the hospital, hospital plus surrounding community services, the district or county defined as a local authority;
- Which powers to delegate.

What is included in the autonomous unit?

2.27 There is continuing debate over whether to establish hospitals as units on their own or, whether to combine them with other health services which make up more of the health system for the community in the area. The wider system might include the primary services in the immediate catchment area of the hospital - e.g. the town where it is located. Another option is to make the entire district, or the regional/referral hospital, district hospital and local facilities a unit for the purposes of health service management; this would commonly be termed decentralisation (to districts or regions).

2.28 Advantages of having the hospital as a freestanding entity are, first, it is usually a well defined management unit, with some management systems in place. The task of improving the efficiency and performance of the hospital is clear and the managers can focus on it. The advantages of including the community or primary care service as one unit with the hospital is that the managers can plan for an integrated service, thereby offering incentives, to improve efficiency by shifting simpler activities to (lower cost) primary units, with supervision and referral services by the hospital - e.g. in maternity services. The free standing hospital unit may be most suitable for referral hospitals which cover several districts and are larger units. The integrated hospital and community model is often more appropriate to district hospitals with their surrounding primary services.

2.29 For the purpose of this document, the entity will be referred to as the hospital unit, which may be either the hospital or the hospital with the surrounding area.

Which powers to delegate?

2.30 The choice of which powers to delegate, and which limits to set, will depend both on what is acceptable politically and what will be manageable given the expected level and range of experience of the managers and board members. It may be appropriate to increase the extent of delegation as experience grows.

2.31 Financial management delegation will require decisions on the following options:

- Whether the unit can allocate and approve its own budget, and modify budgets during the year when necessary - this is the basic level of delegation which will probably exist to a limited extent and can be increased by altering financial regulations.
- Whether the unit can raise funds through borrowing either for capital recurrent purposes - it may be appropriate to allow borrowing only with prior approval from the Ministry of Finance.
- What the procedures should be for procurement - whether to modify the normal tender process (e.g. so the hospital has its own tender board) and whether special arrangements should apply for drug purchasing to assure the quality and cost of drug supplies. The benefits of flexibility and speed from local purchasing can be offset against the likelihood of ineffective tendering at local level.
- Whether the unit can sell off assets such as land or vehicles - there may be a case for requiring approval of major asset sales.

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- Whether the unit can raise and retain income from patients and the community; if there is concern that this is too open ended there may be a case for allowing the hospital to raise revenue within fee guidelines set by government.

2.32 These issues can be addressed in the legislation (see **annex 1** for an example) and in the standing financial instructions and standing orders (see **annexes 2&3** for examples).

2.33 Key decisions with regard to personnel include:

- Whether the hospital will have flexibility as the employing unit fully responsible for recruitment, payment, pensions, discipline and removal of staff, with benefits in motivation and deployment. Drawbacks include resistance to transfer out of the civil service by some staff who fear loss of security, and the need to finance pensions for staff, which can be a substantial cost if staff are transferred with pension rights from the civil service.
- If employment is not transferred fully, then on what terms to second staff and how to give the managers levers to be able to improve staff performance - for example, whether managers take civil servants on secondment but can reject those who do not perform.
- Whether the hospital should be free to set salary levels for staff - as these will feed through into funding requirements in future years and there is sometimes a concern that they may cause discontent and pay pressure elsewhere in the civil service. Yet without this flexibility, the managers have a limited capacity to improve performance. There may be a case for requiring agreement on pay levels or the total pay bill in the early years of autonomy, until the board has demonstrated a responsible approach.

2.34 These decisions may also need to fit with a civil service reform programme in some countries. Further issues relating to employment are discussed overleaf.

2.35 In service development, key decisions include:

- Whether there is an approval process for capital developments by the hospital unit (or district), for example for major equipment purchases or building extensions. Whilst, the aim of delegation/autonomy is for the unit to be both innovative and responsive to demand, there is a risk of developments that are contrary to policy or lead to over capacity. Often this is addressed by agreeing with the major funding agency a five-year service or business plan for the unit, and requiring all developments to fall within current health policy, but this is more difficult if the services are expected to be privately funded.
- Which services are to be funded. under the service agreement.

Step iii of the governing structure and board composition

What is the entity to which delegated powers are given?

2.36 Delegation will have to be made to a formally and legally constituted unit or position. Options will vary by country depending on the legal provisions in place. Typically, the main options would appear to be as follows:

- **Privatisation:** i.e. outright sale of the hospital to the private sector. This is not generally recommended. Even if a buyer could be found, the government would continue to be the

major purchaser of services for the foreseeable future. In many developing countries there is inadequate information on costs and activity and case mix to draw up the specification and contracts which would be components of any privatisation process. While these will have to be developed, it will probably be easier to do so as service agreements within the public sector. International experience suggests that the MoH will have more control over costs and roles if the hospital continues within the public sector. This does not exclude the board contracting in a private sector management company or NGO to manage the hospital, although experience in Africa with this approach has not been positive.

- **Establish an autonomous public body corporate:** (also called parastatal, trust, public corporation). Such bodies allow the hospital employ staff, raise revenues, own property, develop its own procurement, enter contracts, sue and be sued. The board is appointed (and could be dismissed) by the Minister of Health. The government, through the MoH or districts, is the major source of finance. It should ensure that its policies are delivered including controlling the amount of government health finance going to hospitals with annual service agreements which include objectives on efficiency and effectiveness. Accountability is exercised through the service agreement, requiring audits and conformity to financial regulations.
- **Transfer to the local authority:** The option of transferring hospitals to local authorities, usually to be run with other local health services, is an option that has been tested in several countries (e.g. Uganda). The advantages can include pre-existing local representation and some management systems in the local authority, and the benefit of integrated planning of district services. The drawbacks may be that the district is not able to devote sufficient attention to hospital efficiency issues because of its wider role, and that management and financial capacity in the local administration may be weak. The local authority may also apply funds intended for health services for other purposes – this may or may not be seen as a desirable exercise of local decision making. Whether this option is appropriate will depend on wider plans for decentralisation and local government reform. The legal framework will normally fall within the wider legislation on local government powers and responsibilities.
- **Establishment of a District Health Board:** The approach of establishing District (or other geographically based) Health Boards has been introduced in various countries (e.g. Zambia, Ghana), in order to have locally representative and locally based bodies able to allocate health resources and manage or commission health services for their population. Boards are established under specific legislation defining the new entities, which are usually accountable to the Minister of Health. This model has the advantage of greater focus on health than local authorities, and can ensure collaboration between hospitals and primary services in the area. On the other hand, it offers less accountability than a locally elected authority. The choice of whether to follow a Health Board or a local government model of decentralising powers will depend on the political framework in each country, and will not normally be driven by health sector concerns.
- **Ownership of teaching hospitals transferred to the University:** One option for teaching hospitals is to transfer the hospital to the university - however, since universities are typically as bureaucratic as central ministries, managerial autonomy may be difficult to achieve by this route. In addition, as the major function of the hospital is to treat patients it is preferable that this is reflected in the ownership by having a separate hospital board. If ownership is not transferred to the university, the relationship between the hospital and the medical school can be clarified in the order setting up the hospital board and it is common to have a university representative on the board. It is also useful to have a

memorandum of understanding between the university and the hospital concerning staff roles in patient care, teaching and research and financial responsibilities.

Specifying the composition of the board

2.37 Depending on the type of entity which will be given responsibility, there may be a need to specify the membership of the management board and the key management posts in the organisation. This will be required for a new entity, such as a District Health Board or a hospital authority/trust.

2.38 The composition and membership of the board of an autonomous hospital unit is a critical factor to its success. Experience has shown that the most successful boards have most or all of the following features:

- composed of people appointed for their managerial or professional skills;
- small in number (preferably less than 12 members);
- comprise a mix of executive and non-executive members (executive members have an operational role in managing the hospital, while non-executive members are not employed by the hospital).
- not made up of representatives from large numbers of political or other organisations;
- board members assist managers by agreeing policy, by questioning and by monitoring performance through regular financial and other reports;
- non-executives do not behave as executives and are not involved in operational matters;
- work as teams bringing together groups of people of status and integrity whom have a range of skills and experience.

2.39 The role of the board is to agree policy on a range of business issues such as finance and human resources and to ensure that good management practices are followed. It is important, therefore, that the board comprises persons of integrity and broad perspective and with recognised personnel skills and professional experience which can strengthen the work of the board. A member - with a legal background - would bring obvious benefits. Other non-executive members, might include business people with entrepreneurial skills and an experienced top manager of another large organisation such as an NGO or a mission hospital with an understanding of finance. The board composition will vary with the size and complexity of the hospital services; for example, a teaching hospital board should include the Dean of the Medical School.

2.40 The board's role is essentially management policy rather than user liaison or accountability of the local population. Hospitals will probably need to set up User Liaison Committees or equivalent for these purposes.

2.41 The board will bring in local representation through the choice of members from the locality and some members who would represent local interests (such as the local mayor and perhaps a member of the users committee). It is not recommended that members

should be ex-officio representatives of local organisations or political groups, because the risk is that they will not be of the calibre and experience expected.

2.42 An issue which has arisen in some countries is whether and how to include the commissioning authority on the board - for example, whether the central MoH should be represented on the board of a national hospital, or whether the local authority should be represented on the board of the district hospital which it funds. The pure model of separating funding of services from provision would suggest not, although in practice the MoH or Local Authority representative (such as the District Medical Officer) can provide a useful link with government policy and a communication channel to keep both sides informed of plans and progress. They may also provide technical skills not readily available from other sources. Their role should be seen in this light - for liaison and technical purposes, and not as the means of accountability, which would be exercised through setting and following a service agreement (*see below*).

2.43 The senior managers of the hospital would also be executive members of the board. Decisions will be required on the number and roles of these senior management positions. The top manager should be accountable for the day to day management of the hospital resources and delivery of services, within policies agreed by the board. Therefore, this is a management position and could be filled by a non-medical or clinically trained professional. For this reason, the senior manager is often entitled Chief Executive. The essential leadership qualities of a successful Chief Executive do not come from medical training, but from the individual, who may be from any background.

2.44 In addition to the Chief Executive, the managers who are selected to be executive members of the board should be those responsible for the functions which are vital to the success or failure of the hospital, typically finance, medicine and nursing.

2.45 Decisions will need to be made on the length of appointment to the board, how non-performers can be removed, and on board procedures. **Annex 3** sets out specimen standing orders which address these issues.

Step iv Drafting Legislation

2.46 Usually the decentralisation of power to local units requires legislation; it may also, require constitutional change. Once the type of governing entity and delegated powers are defined, legislation can be drafted. The three main options for legislative change are:

- a separate act for each hospital unit;
- an enabling act empowering the Minister of Health to establish autonomous hospital units by regulation;
- a decentralisation act affecting all districts or hospitals.

2.47 A separate act might be appropriate if it is envisaged that only one hospital would be made autonomous. If there is likely to be a rolling programme of extending hospital autonomy, a series of separate acts would be neither welcome nor practical.

2.48 An enabling act sets the principles and major parameters for decentralisation and allows for the detailed conditions and timing to vary for individual hospitals without returning to Parliament for approval. A phased introduction of decentralisation/autonomy is possible so

that experience can be gained and the situations of different hospitals can be taken into account. It may be most suitable where the plan is a gradual decentralisation to autonomous bodies corporate. A draft of enabling legislation and an example of a legal notice establishing a decentralised hospital trust is in **annex 1**.

2.49 A comprehensive decentralisation act is more appropriate if the plan is a restructuring of the whole system, as, for example, in Ghana's creation of the Ghana Health Service which established the major national hospitals as autonomous units and transferred hospitals to new District and Regional Health Committees.

2.50 The purpose of the legislation will be to establish the hospital unit and its board, define the system for appointment of the Chief Executive (CE) and employment of staff, specify major financial provisions and delegations, and the vesting of properties and facilities. It is preferable for the legislation not to be too detailed and inflexible - it should not undermine the power of the board and the CE to manage on a day to day basis and should allow aspects that might differ from hospital to hospital or with time (e.g. the composition of the board) to be put in the form of Legal Notices or Orders.

2.51 It may be possible to use existing legislation for example, for the creation of parastatals. However, the risk of this approach is that the regulations within the legislation differ from those proposed for the hospital sector, for example in terms of the role of the a service agreement and the extent of personnel flexibility. If the proposal is a major reform of the health system, it is often felt to be appropriate to bring the proposals to parliament for approval under separate legislation.

Step v Determining Personnel Policies and Transition Agreements

2.52 Employment issues and particularly the transfer of staff from a central civil service to the hospital unit are often the most sensitive and difficult aspects of efforts to improve hospital efficiency through decentralised management. As discussed under **step ii** above, it would be possible to give only a limited role in human resource management to the hospital unit managers; for example, allowing them to be responsible for selecting and rejecting staff on secondment from the civil service and for paying special rates different from civil service rates. But if the hospital managers are to be able to improve staff motivation and performance, they need the capacity to promote, reward and (if necessary) remove unsatisfactory performers or surplus staff. Furthermore, if the managers are to improve the functioning of the hospital, they need the flexibility to adjust the balance between staff and non-staff expenditure and between different categories of staff.

2.53 The shift to a new employer and the change in terms and conditions this entails unsurprisingly often brings resistance and concern from employees. In planning the shift of employment there are three main issues to be addressed:

- how to convince staff and minimise resistance;
- how to implement the transition;
- what employment policies are required.

Gaining Acceptance from the Staff

2.54 Gaining acceptance from staff for the reforms is essential for smooth transition – compulsion is possible but the reforms are likely to be less effective in achieving their goals. Experience suggests the following are critical:

- discuss the planned reforms at an early stage with unions and professional groups particularly doctors;
- as soon as the approach is agreed, there should be systematic communications to all affected staff, explaining the reforms and their implications, and the process for transfer (see **step vii**);
- identify the employment position unambiguously in the legislation establishing the unit;
- ensure there are incentives for staff to trade off the security of civil service employment - whether better terms of employment, better career prospects or more professional satisfaction;
- ensure the selection process is seen as fair and consistent (where relevant).

The transition process

2.55 The transition process is another area which requires careful design and sensitive handling. There are two main approaches which can be adopted to the transition:

- design the new organisation structure and staging requirements, new job descriptions and employment terms, and then select staff to fill the posts;
- transfer the existing staff over to the hospital unit on the existing terms, and then restructure and revise terms and conditions over the following two years or so.

2.56 Obviously a combination is possible, for example the first approach will be necessary for new management posts such as the Chief Executive and Finance Director, while it may be easier to transfer the existing nursing and medical staff in order to avoid disruption to services.

2.57 The advantage of the first approach is that it allows the unit to select the most appropriate staff. Also, if there is a case for reducing numbers, it provides an opportunity to do so while the remaining staff are still civil servants who can be re-deployed elsewhere in the civil service – this may be easier than taking on staff and then making redundancies. On the other hand, the gradual approach to change recognises that managers in place are familiar with the existing arrangements and that there may not be the capacity, in terms of finance or skills, to deal with significant changes in this area. Thus the choice of approach will depend on local circumstances, particularly whether there is a major effort to reduce numbers and raise remuneration, and on the extent of capacity to manage change in employment terms.

Employment policies and terms

2.58 The employment policies that a hospital unit will require will need to address the following issues:

- recruitment procedures;
- disciplinary policy and procedures;
- grievance arrangements;
- performance appraisal and promotion policies;
- equal opportunities.

2.59 The design of policies should not replicate civil service terms and conditions, since part of the objective of changing employment status is to move away from the constraints of traditional civil service regulations towards a more performance led culture. Sample employment policies, are included at **annex 4**.

2.60 The determination of terms and conditions, including salary structure, will obviously be constrained by the finance available. It will be important to establish realistic expectations about the terms of service. Over time, and as efficiency improves and revenue is collected, there may be scope for rewarding good performance and raising pay levels, but this will be limited at the start (unless external finance is available).

2.61 Pension rights are another critical issues. If staff are to leave the civil service to join the hospital unit, their pensions must be assured and financed. Even if their pension for their civil service employment remains a liability of government (as for other ex-civil servants), there will be a need to build up funds to finance the pensions earned working for the hospital unit. In Trinidad, external agency funding was arranged to finance pensions' liabilities.

Step vi Developing financial management systems

2.62 The delegation of authority for financial management will require the hospital unit to establish its own financial systems with which to run the hospital (e.g. the payroll for issuing salary cheques) and which give funding agencies confidence that the finances are properly managed. This will partly be achieved by establishing financial regulations (see **annex 2**) which govern how funds can be released, tendering procedures, banking etc. There also needs to be financial systems established in the hospital to provide information on their use.

2.63 Systems will be required for financial accounting (handling and recording expenditure, income and assets), management accounting (analysing expenditure in ways useful for management) and audit. In financial accounting, the hospital unit will be able to move away from the standard government accounting approach of cash accounting and requirements. This is likely to involve:

- designing a new coding structure so that items and departments have unique account codes. It is suggested that the coding structure should be common for all hospitals to facilitate comparisons;

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- establishing asset accounting, so that records are kept of the value of all assets held by the hospital unit (land, buildings, equipment, vehicles); in commercial practice, allowance is made for their depreciation;
- introducing computerised accounting systems, at least in larger hospitals (if they are in a location where computers can be supported and maintained). There are many commercial accounting packages available which cover the range of accounting functions including payroll, asset accounting and monthly reporting. The choice of package and computers should be consistent with plans for other information systems in the hospital. Again a standard system could be agreed for most hospitals in order to avoid duplication of effort;
- training and bringing in more qualified finance staff to the hospital to improve financial management skills;
- preparing detailed financial procedures for day to day operations within the standing orders and standing financial regulations set by government (e.g. who can sign cheques; banking procedures for fee revenue).

2.64 Management accounting supports the internal organisation of financial responsibility and accountability within the hospital unit. The typical approach is to define a series of cost centres within the unit; allocate resources to these cost centres; and give the person in charge of the cost centre control over at least some of these resources (see also **section 3c**). 'Cost centres' are established for the departments or functions which it is useful to identify for management purposes, usually because they are the provider of certain services and incur costs in producing that service. The management accounts then give a clear picture of the resources used by each cost centre.

2.65 In a hospital, this is likely to involve:

- defining the cost centres - typically clinical specialties or wards (surgery, maternity, outpatients etc.), laboratories, pharmacy, x ray department and so on;
- allocating the main resources which each department uses to their cost centre - initially their staff and budgets for drugs and material;
- reporting expenditure and income by department, usually monthly;
- holding the head of department responsible for the use of resources.

2.66 The information collected in this way can also be used for costing services, for example, of laboratory tests. With time, diagnostic and support department costs can be allocated to the requesting department, allowing a more complete picture of the costs of services.

2.67 Issues that arise in setting up management accounts include:

- Which items to allocate to departments. Initially it is suggested that only resources they directly influence are allocated to cost centres (e.g. drugs, other supplies and staff). Over time, the cost centre accounting can be made more elaborate, with analysis of laboratory use by department and allocation of overheads.
- Gaining the co-operation and involvement of medical and nursing staff - if management accounting is to be useful, they need to see its value; this can be achieved by involving

them in the design of coding and accounting structures; and by giving them (gradually) greater control over their resources, (e.g. the capacity to reduce the number of cleaning staff in their department and use the savings for extra drug supplies).

2.68 The third area to consider in financial management and control is the auditing of expenditure and income. It is likely that the financial regulations will stipulate external audit annually (which may be by the government audit system or by any external auditor). If the hospital leaves the existing government system then there may also be a case for setting up internal audit to re

Step vii Communications to staff and the public

2.69 One of the key mechanisms for achieving a smooth transition to greater autonomy is communication with those affected about the changes from an early stage in the process. This helps to prevent misinformation and the development of resistance and lobbies against the change. The need for communications applies to the staff who will be affected, to the public who use the hospital and to key decision makers such as members of parliament and local councillors.

2.70 The approach to communication needs to be planned and budgeted for from early in the autonomy planning process. The methods that have been found the most useful include:

- meetings with staff and their representatives, with opportunities for questions;
- printed leaflets explaining how the changes will affect staff;
- briefing for the media and of political leaders.

Step viii Preparation of service plans

2.71 As discussed in **Part 1**, it is recommended that the move to autonomy takes place within a clear framework for the development of hospital services and the role of particular hospitals within the national strategy. This will help to define services which government is willing to support in different hospitals, and the cases where public funding may be curtailed. Once a national or regional strategy is clear, it is the role of the hospital unit managers to define more detailed operational/financial plans within the national strategy.

2.72 The hospital unit plan will need to cover:

- services to be delivered by type and volume, with reference to population need;
- a human resources plan, including staffing levels and training priorities;
- plans for new developments, with their justification including financial viability, this may also include plans to improve management systems or capacity;
- financing plans for both recurrent and capital expenditure, showing how expenditure will be financed (for all funding sources, including fees).

2.73 Issues which arise in developing the plan include the following:

- Timing - should a plan be in place before autonomy starts or developed during the first year of operation? This will depend on the quality of operating managers and the political pressure for introducing autonomy; ideally it would be completed before signing the first service agreement and taking over responsibility for the hospital.
- Period of the plan - three years is suggested so funding agencies can see the strategy clearly, a three year rolling plan could form the basis for the service agreement. The hospital managers also need a detailed annual operational plan and budget.
- Whether to make the plan a bidding document to persuade the government and other potential funders to provide more resources, or one which uses realistic funding levels and shows what might be achieved.
- Who develops the plan - in a large referral hospital, there may be a planning officer or section which can lead plan development. In smaller hospital such as district hospitals, the planning will involve the senior hospital managers, perhaps with support from the central ministry or local authority planning department.

2.74 Some hospitals lack good information on service costs related to activity levels and therefore find it difficult to prepare realistically costed plans. This must be recognised in the early stages of management delegation, so that the plans are based on crude castings, while efforts are made in the first few years of autonomy to improve both financial and performance information.

2.75 The starting financial position of the hospital will influence the financial plans. For example, hospitals may have debts from unpaid bills for supplies or utilities. Will the central government take responsibility for the debts, so that the hospital can start with a clean slate, or will funding for them be included? The issue of how the hospital will finance pension commitments for its staff will also need to be addressed in the financial planning.

Step ix Developing service agreements and performance measurement systems

2.76 A key aspect of improving hospital efficiency through increased autonomy is the shift in focus from the specification and management of resource inputs by the centre which and how many staff, detailed allocation of funding, provision of supplies - to a focus on the outputs - which services are delivered and how efficiently. Agreements are made between the hospital unit and the major funding agency /agencies specifying which services will be provided and to what standards, in exchange for the funding provided. Performance is monitored against the agreement. The annual service agreements allow the MoH and other commissioners' of health services to relate expected outputs to finance they provide.

The role of the service agreement

2.77 A service agreement is in contrast to more traditional budgeting arrangements that typically allocate money on the basis of facilities and staff regardless of the quantity and quality of services they provide or the demand made upon services in terms of utilisation.

2.78 Service agreements are a vehicle for linking finance to defined results. For the commissioner, they are a vehicle to implement policy, while leaving the 'hands on' management of services to those more able to do it. For the provider, a service agreement allows it much more freedom in how its facilities, equipment, staff and other inputs are managed. The measure of success is in the quantity and quality of services that result.

2.79 The service agreement provides a basis for the evaluation of the performance of the provider. An annual performance evaluation undertaken by the commissioner and the provider is as important as the service agreement itself. Actual performance can be compared to the targets of the service agreement and differences discussed and analysed to determine why these occurred – and what can be done next year to improve this. Improvements then become targets and are specified in the next service agreement.

2.80 The annual performance evaluations provide a story of what happened year after year, what activity levels were achieved, what expenditure was incurred, what productivity was achieved and what improvements were possible.

2.81 If the service agreement is based on agreed plans for developing the hospital, then they also allow the commissioner to control the pressures of expanding hospital expenditure. There would be explicit identification of funding for any new developments within the annual service agreement, so that, for example, there could not be hidden development of tertiary specialities.

Who is the service agreement between?

2.82 The service agreement is between the agency responsible for funding the services (the 'commissioner') and the hospital or district unit (the 'provider'). One of the issues which may require discussion is who the commissioner of hospital services should be – particularly for regional or national hospitals. The options include:

the central MoH;

- the local (region or district) authority or health board where the hospital is located;
- the regional or district authority or health board where the patients come from.

2.83 The approach will depend partly on how funds are allocated – if funding is decentralised to regions or districts based on population and health needs, then logically the commissioner should be the district that the patients come from – the hospital unit would have an agreement with each district which sends patients. However, it may be preferable to avoid excess complexity and too many agreements, to retain funding for national and possible regional referrals and leave MoH to commission these services. This means that the MoH can control the total allocated to tertiary and referral care and also allows the MoH to rationalise hospital capacity in the country. It also avoids the need for all district authorities/health boards to develop the skills necessary for successful commissioning and reduces transaction costs.

Content of a service agreement

2.84 The agreement typically sets out:

- the parties involved
- the period of the agreement;
- arrangements for variation and for arbitration;
- the level of services of different types which the hospital is expected to deliver (for example , number so outpatients and admissions to surgical, maternity, and other specialities as appropriate);
- the standards to be met
- the level of funding, specifying the basis of funding (for example, the unit costs applied);
- the information requirements and monitoring arrangements.

More details are set out in the document ' Contracting in the Health Sector - a Guide to the use of Contracting in Developing Countries', Roger England, 1997, Institute for Health Sector Development, London.

2.85 The funding arrangement can be set out in several ways (or a combination of these):

- A block contract specifies a sum of money the commissioner will pay the provider, with indicative targets for the service volumes and standards to be provided. They do not usually allow for variation in payment if the workload turns out to be different from the targets, although this will affect the next year's agreement. This is the simplest approach but lacks incentives to improve efficiency. This approach is usually used for the first year or two of contracting as there are rarely data for more elaborate agreements and it helps ensure continuity of services.
- Cost and volume contracts, where the funding is linked to broad volumes of service, e.g. the number of cases in each speciality. The contract allows for variation in payment if the volume of treatment provided is greater or lower than expected. The advantage is the linking of funding to performance. However, more activity may not be the intention of the commissioner or in the interest of patients, and may not necessarily lead to more efficiency. Close monitoring of quality is needed to ensure quantity is not achieved at the expense of quality of care. This will require more information and monitoring, and so is more costly to manage than block contracts.
- Cost per case contracts, where payment depends on the number of individual cases, with billing by the provider after the treatment is given. There is a risk of escalating costs as providers treat more patients. There are also high transactions costs in billing and identifying the costs for different cases. The approach tends to be used in addition to block contracting, for specialised services or where certain commissioners expect to fund only a few patients.

2.86 Thus it is common to start with block contracts and move to a broad cost and volume arrangement, possibly with maximum funding levels and efficiency incentives built in. Unit costs and productivity are often expected to increase from one year to the next.

Incentives to keep to Service Agreements

2.87 Service agreements are not contracts and there can be no recourse to law for failure to meet the targets concerned. There are of course other laws to deal with fraud or theft or the misuse of public funds. Nevertheless, there must be incentives for the providers to meet the targets of the services agreements.

These are:

- the prospect that performance evaluation will reveal that money is being wasted in certain areas and the accompanying threat that it will be deducted from the following year's budget;
- the prospect that the careers of the staff responsible will be affected by promotion or demotion, as performance evaluation identifies good and bad managers.

2.88 For this to be effective, there must be someone clearly identified as responsible and accountable for the performance of the hospital against the services agreement - by both the commissioner and the Management Board or local authority. Typically, this will be the Chief Executive of the hospital unit. Both would have an interest in removing a badly performing manager and would want to give more freedom of decision making to a well performing one. The increased clarity about who is to be held responsible rapidly highlights the need for those individuals also to have more authority over the deployment of resources including staff.

Setting quality standards

2.89 Many countries already have some quality standards in place, for example the agreement may specify these service standards should be followed and also specify other quality standards, such as:

- procedures for ante-natal clients;
- availability of drugs, supplies and tests;
- level of equipment breakdown or cancellation of operations;
- post-operative mortality or infection rates and bedsores;
- waiting times for outpatients and for admissions.

2.90 A distinction can be drawn between these quality and service standards and standards for service inputs, such as the cost of laundry services in a typical hospital, the staff numbers and mix that is the norm, and the average cost of drugs per surgical inpatient. These input standards are extremely useful for deciding how much funding it is reasonable to provide in exchange for a given level of service, and for reviewing efficiency across hospitals (see **Part 3**). They are not, however, recommended for inclusion in service agreements, where the purpose is to allow managers the flexibility to make the best use of resources available to them. If these input standards were included in the service agreement, then the service

agreement would become more like the bureaucratic controls of a centralised system and lose its advantage of leaving resource management decisions to the managers.

2.91 Having defined standards for inclusion in the agreement, the next step is to set the indicators which will be in the agreement (e.g. the maximum waiting time for outpatients).

Key issues that arise in setting standards include:

- Whether to set the ideal standard or one that is more realistic - for example, the desirable standard might be that the 10 most common drugs should be available in the pharmacy every day - whereas a realistic target might be availability 80% of the time. One option is to set standards about or above average level and revise them upwards periodically, or to give each hospital an improvement target (e.g. 10% better than last year).
- Selecting standards which can be measured and monitored - e.g. the number of days per month x-ray services are not available.
- Ensuring standards are used sensitively so they do not distort medical practice in undesirable ways e.g. standards for complex maternity cases which might lead to more caesarean deliveries than are medically necessary.

Performance measurement systems

2.92 Service agreements require the provider to generate appropriate data on service activity levels and quality. Thus one task in the planning stage will be to define the indicators which will be used and plan how these can be collected. There may be advantages in addressing this issue at a national level and designing a common management information system, so that comparisons can readily be made between hospitals and there is not duplication of effort in design of performance monitoring.

2.93 The absence of appropriate data at the beginning may mean that the service agreements for the first year or two have relatively simple performance targets and quality indicators. These can become more elaborate once data are being collected. Examples might be data on waiting times and patient satisfaction, for which practical data collection arrangements will have to be established

Step X Selecting and training key managers and board members

2.94 Once the terms for increasing autonomy are decided and the decision is made to go ahead, the board members and top managers can be identified.

2.95 The Chairman of the board is a key appointment who can make a major contribution to the success of the reforms in improving hospital efficiency. The Chairman must be an independent-minded person with strategic vision. He/she should be a person of stature who has been successful in his/her chosen field and who can offer wise counsel to the Chief Executive of the hospital unit

2.96 The Chief Executive is another critical appointment if the reforms are to result in improved performance. The person would ideally be able to demonstrate management skills, including responsibility for finances and a record of performance improvements

2.97 However, it is likely that at least some board members and senior managers

will not have extensive management experience and would benefit from management training. There are various courses available which can be adapted to local circumstances, such as the Open University course for hospital managers which was successfully adapted for use in South Africa

2.98 In addition, key managers may require specific training, for example in personnel practices for the human resources director or in commercial accounting for the finance director and staff.

2.99 The board and other senior managers will also need specific training in the legislation, financial regulations, standing orders, personnel policies and systems which have been put in place so that they are clear about their roles and responsibilities.

2.100 One approach which allows time for training and briefing the board and top managers, and for their input to service planning, is for them to be selected some time (say 6 months) in advance of the transfer of management authority, and established as a “shadow board” and “shadow Chief Executive”. This allows them to gain experience of the hospital operation and receive training, so they are well prepared for the start of greater autonomy.

2.101 Another target group for training is the officials in the commissioning agency responsible for drawing up and monitoring service agreements. This training could include visits to areas which already have commissioning experience (locally or overseas) to learn from their experience.

Part 3

Measures to Improve Efficiency within Hospitals

3.1 The idea of giving hospital managers greater autonomy is that they will then have the capacity and the motivation to improve the performance of the hospital unit, including the efficiency of services and their quality. Efficiency will not improve automatically - rather the managers will have to take steps to improve the allocation and use of resources. There are various measures, which have been used to help improve efficiency in hospitals, and this section describes some of them. Many of these measures will also be applicable in hospitals that have not been given management autonomy, and can be introduced from the central ministry or by regional or district managers. Not all will be relevant in all cases, but they provide a menu of ideas that can be considered.

- a. Contracting out specific services or functions
- b. Improving procurement and management of drugs, supplies and equipment.
- c. Clinical unit budgets and management.
- d. Changing staffing levels and mix.
- e. Making more efficient use of beds and facilities/improving throughput.
- f. Reducing inappropriate use.
- g. Performance measurement.
- h. Comparisons and value for money studies across hospitals.

a. Contracting out specific services or functions

3.3 Contracting out provision of specific services or functions is one of the options for improving efficiency. Instead of the service being provided by direct employees of the hospital, a separate organisation is contracted to provide that service. In hospitals, this has most commonly been applied to non-clinical services - cleaning, laundry, catering and/or grounds maintenance services. However it can also be used for technical services such as laboratory tests, X-ray, clinical services or even management of the hospital itself (as discussed in **Part 2a**).

3.4 Contracting is likely to bring improved efficiency because it involves:

- clear specification of the service to be provided, with quality standards
- monitoring of service provision
- competitive tendering

3.5 The competition for the contract should result in lower costs for the service provided, as the competing contractors try to offer the specified services at the lowest cost (or better services if the standard is set above current levels). The contractor then has the incentive to provide the services as efficiently as possible, in order to maximise his margin. In order to

ensure that part of the benefits of improved efficiency accrue to the public sector, it is common to include requirements that the unit costs of services falls from year to year, and to repeat the tender process every two or three years. Monitoring of the service is necessary to check that the service is provided fully as specified.

3.6 For these mechanisms to work, there must be a) real competition in awarding the contract b) the capacity to specify and monitor the services and, c) political support for the concept. Without these, the expected efficiency gains will not materialise. For example, in a remote rural hospital setting, there may be few organisations interested in taking up a contract, so that there is no effective competition. If the tender costs are higher than continuing to manage the service directly, contracting out will not be cost effective. Auditing and comparison across hospitals will also be useful to check that contract costs are reasonable.

3.7 Thus the issues to consider in contracting out include:

- having a fair and effective tender
- allowing the existing staff to bid for the tender, as well as outside organisations
- monitoring implementation of the contract - particularly the performance standards;
- central support to contracting, e.g. providing example contracts with service standards and making comparisons of the costs of contracts between hospitals.
- requiring efficiency improvements over time - contracts to have tougher standards or cheaper prices each year;
- central support to contracting, e.g. providing example contracts with service standards and making comparisons of the costs of contracts between hospitals.

b. Improving procurement and management of drugs, supplies and equipment

3.8 Procurement and management of drugs and supplies is an area where there is often scope for major savings and improved value for money. Examples are buying generic drugs rather than branded equivalents, avoiding overstocking with drugs and supplies which then expire, and cutting down on thefts.

3.9 It is not self evident how best to implement drug procurement. Most countries have a central drug procurement agency that buys in bulk for the public sector, and may also sell to NGO or private providers. Advantages of centralised procurement are that large orders allow for international tendering and lower prices and central organisations can establish quality control arrangements. On the other hand, there may be delays in receiving drugs from the central supply, and occasional corruption in the central organisation, undermining its capacity to achieve lower prices and quality.

3.10 Local drug procurement usually means that the hospital can get drugs and supplies more quickly and conveniently because they can buy from local providers. the hospital unit may be able to buy at lower prices locally than those charged by the central agency if there is inefficiency or mismanagement in the central agency. Another reason for low prices, however, may be that the drugs available locally are of poor quality. Local corruption may

also drive costs up. A compromise may be to require tendering for drugs with the central agency invited to tender/compete, although this does not address the risk of poor quality of locally supplied drugs.

3.11 Measures to enhance efficiency in procurement and management of supplies can include:

- training in procurement and stores management;
- auditing of drug supplies, including prices paid and volumes supplied and comparison against caseload and fee income;
- regulations, e.g. that the central procurement agency should compete in all drug tenders, hospitals must keep to the essential drugs list, use generics where available;
- comparisons between hospitals of their drug expenditure against caseload and development of norms for drug use/costs;
- heavy penalties imposed and publicised for mismanagement.

3.12 Similar issues apply with equipment

C. Clinical unit budgets and management

3.13 Clinical unit budgeting is an approach to management within the hospital. Instead of budgets being managed by central managers (e.g. nurses under the Chief Nursing Officer, drugs under the Pharmacist; support staff and maintenance under the Administrator), the budgets and responsibility for managing them are broken down and allocated to departments/units which provide patient services such as surgery, maternity and X-ray departments. The service department can then make decisions on the use of resources available to the department, and alternatives available, e.g. choosing which drugs are the highest priority to buy; whether to repair equipment or buy materials this month.

3.14 Thus clinical unit budgeting extends the principle of delegated management within the hospital. The approach is related to that of cost centres discussed under financial management (**paras 2.65 - 2.68**) since it requires budgets and information on expenditure by department. The extent of delegation will depend partly on the extent to which budget reallocation is allowed (it will be most useful if departments are free to reallocate funds) and capacity at departmental level to take on these roles. It is probably easier to introduce if the hospital is made autonomous but this is not essential.

- The change to unit management should lead to improved efficiency because:
- decisions will be made with better information on needs and priorities;
- medical staff tend to become more cost conscious when they see the effect of treatment decisions on their budget;
- control over resources can increase motivation to improve performance, particularly if it includes retention of some of the income generated by the department;
- it is easier to monitor and compare performance, e.g. drug use by department.

3.16 This is undoubtedly an ambitious reform in the context of hospitals which have operated under traditional central management systems, and may best be introduced gradually, perhaps starting with the delegation of drug and materials budgets, and later staff, diagnostic tests and a share of the income generated. Management accounting systems must support departments which are cost centres.

d. Changing staffing levels and mix

3.17 Hospital staffing levels are typically based on standards or norms set some years ago, based on the conditions then for types of staff, nursing rotas etc. These may not have been adjusted with recent changes in service patterns and new staff cadres. In addition, modern human resources management thinking tends to encourage more flexible use of staff and less restrictive rotas. Reviewing and revising staffing levels in the light of changing service patterns, and possible changes to the functions of particular cadres of staff and to their conditions of service, can improve efficiency.

3.18 Efficiency will only improve if the review leads to either a reduction in the number of staff relative to patient throughput, or a better mix and deployment so that lower cost staff can be used for simpler tasks while the more highly qualified (and high cost) staff concentrate on more skilled roles. The review has to be set up in a way which is likely to deliver this result - experience shows that if medical and nursing staff are asked to say how many staff they would like to have, then it is likely to result in higher costs without necessarily greater efficiency. At least, those undertaking the review must have a financial constraint within which to recommend staffing levels.

3.19 Common issues in the review of staffing include:

- gaining support from the medical and nursing professionals for the proposals - they need to be consulted or involved but recognise the constraints;
- the need to review support staff numbers (cleaners, gardeners, laundry, medical attendants etc.) as well as professionals - often there has been expansion at those levels which are typically employed locally;
- the need to be realistic about the willingness of senior staff to work in rural hospitals or primary units - there is no point setting a staffing pattern which cannot be implemented;
- the need to consider whether incentives or sanctions can be introduced to improve staff deployment patterns including pay and/or training benefits. If the shift to autonomy includes decentralising employment the decision on incentives will rest largely with individual hospital units; however there may be a central role in funding extra incentives or in post-graduate training policy.

3.20 International comparisons can again provide a useful benchmark - for example, a World Bank document on hospitals in Africa based its calculations on 60 staff for a 140 bed hospital or under 0.5 staff per bed.²

² A Framework and Indicative Cost Analysis for Better Health in Africa, World Bank, 1993 and detailed workload calculations in Cambodia reached similar conclusions.

e. Making more efficient use of beds and facilities/improving throughput

3.21 It may also be possible to make more efficient use of facilities. New surgical and anaesthetic techniques reduce length of stay. It is now recognised that it is not necessarily beneficial for patients to stay on in hospital. As noted in **Part 1**, the effect can be dramatic.

3.22 Note that while efficiency improves with this type of change as more patients are treated, the total cost of provision is likely to increase. For example, if post operative stay is shorter, then some relatively inexpensive days spent in recuperation will be replaced by operations on other patients which will be more expensive. Beds must be closed if this is likely to create problems.

f. Reducing Inappropriate use

3.23 A broader efficiency question is whether the hospitals are treating the types of patients they were designed for, e.g. is the district hospital seeing patients who could be adequately dealt with at clinic level, or a specialist referral unit performing normal deliveries and simple operations. The issue here is the efficient use of services - it is not efficient to use expensive and limited hospital facilities and staff if a clinic service is adequate and cheaper; even if the hospital service is not more expensive in practice, it may be better deployed in providing other, more complex services. This is the issue of referral discipline.

3.24 Whilst the problem is widespread, it is difficult to resolve, because it is only partially within the hospital's control. Issues which arise in considering how to improve referral discipline include:

- whether in fact primary services are lower cost than a basic outpatient clinic at the hospital - and if not, how to make them more efficient;
- whether the cost of primary care at the hospital can be reduced, e.g. by using less qualified staff as the first contact point;
- making lower level service more attractive to patients, e.g. through supervision, assuring drug supplies and offering basic diagnostic tests;
- whether patients would actually use clinics if deterred from the hospital – or whether patients prefer the hospital for other reasons (e.g. greater anonymity for treatment of sexually transmitted infections);
- whether to introduce higher fees for patients who are not referred from a primary provider (sometimes known as 'bypass fees');
- how to streamline referrals so patients who are referred have quick access to specialised services and do not have to wait as long as the non-referred patients.

3.25 The situation will only improve if there is an appropriate incentive structure facing the hospital and those referring patients to it - a reason for recommending an integrated management unit of both district hospital and its surrounding community services (see **2.28**). In principle a service agreement can also help with this, by clarifying which types of services the hospital is expected to provide and is funded for. In practice however, such definitions can

be difficult, and may conflict with the hospital's incentive to meet quantitative targets for numbers of patients.

g. Performance measurement

3.26 Improved efficiency generates more outputs for the same, or fewer, inputs. Measuring outputs and inputs enables efficiency to be monitored and opportunities for improvement sought.

3.27 There are different types of measures that can be collected, including:

- **input measures**, e.g. drug use per ward; fuel expenditure; staff attendance;
- **activity measures**, e.g. patient numbers, length of stay, operations done and cancelled, number of lab tests;
- **quality measures** (as discussed in **Part 2b**): e.g. availability of drugs and tests; waiting times for treatment; patients' views on services; community views on the hospital.

3.28 Thus performance measures can be relatively simple. Many are already available; others, particularly community views on services, are not readily available and will be costly to collect, so may only be collected occasionally, for example through a survey.

3.29 Having obtained the information, what is required is a systematic review of the figures and combination of different figures to create efficiency indicators such as:

- number of staff per bed (can differences between wards be justified?); fuel costs per km each month (why did they vary?);
- cost of drugs used per surgical patient (efficiency of drug use);
- revenue per patient (how efficiently is revenue being collected?);
- proportion of the month when lab tests were not available (improving lab performance)

3.30 If these figures are prepared monthly, then odd (or outlying) figures will stand out and can be investigated. They can also be compared with other hospitals, highlighting opportunities for improving management.

3.31 The activity and quality measures can also be used for service agreements with funding agencies. Service agreements help to focus attention on performance rather than inputs and to clarify the role for the hospital. While **Part 2** discussed them in the context of autonomous hospitals, they can also be used for hospitals, which are not formally autonomous, as well as for support to NGO and private services.

H. Comparisons and value for money studies across hospitals

3.32 The previous measures were focused on the hospital level activities to improve performance. An important central role also exists in comparing different hospitals to identify best practice and opportunities for improving efficiency.

3.33 Indicators like those described in **paragraphs 3.27 and 3.29** above can be used for basic comparisons of performance. These figures provide a starting point for further investigation e.g., if a hospital has unusually high drug costs per patient, detailed investigations can show if this is due to poor record keeping, an unusual case mix or mismanagement of drugs.

3.34 It is also useful to include NGO hospitals in such comparisons; analysis of figures will need to consider whether differences in case mix or other factors explain the differences.

3.35 Value for money studies go further than comparisons of indicators, and look in detail at reasons for differences in performance, best practice, and whether there are options for delivering the outputs, which would give the public better value for the money spent. For example, in East Africa government hospitals typically devote a large part of their budget to providing food for patients; a value for money study might consider whether this expenditure provides good value when most patients actually eat food provided by their relatives and NGO hospitals do not find it necessary to provide food at all.

3.36 The function of comparisons and value for money studies is sometimes carried out by a unit within the Ministry of Health (possibly linked with the inspection or quality assurance function). It may also be carried out by a government audit agency or can be contracted out to private consultants.

ANNEX 1: AN EXAMPLE OF LEGISLATION FOR ESTABLISHING AUTONOMOUS HOSPITALS

This example is taken from a report recommending draft legislation for the Government of Uganda to establish hospitals as autonomous public bodies, here called hospital trusts. The model used is an enabling statute which is followed by a legal notice to establish individual hospitals as trusts.

1a. A BILL FOR A STATUTE ENTITLED ‘THE HOSPITAL TRUSTS STATUTE, 1998’

A statute to provide for the Establishment and Incorporation of Hospital Trusts; for control and regulation of Hospital Trusts and for other matters connected to the above.

Be it enacted by the President and the parliament as follows:

PART I - Preliminary

Short title

1. This Statute may be cited as the Hospital Trusts Statute 1998.

2 In this Statute unless the context otherwise requires

"Board" means a board of a Hospital Trust set up under **section 6** and the First Schedule to this Statute; "Chairperson" means the chairperson of the Board of a Hospital Trust appointed under **section 6**; "Chief Executive Officer" means the chief executive officer of the Hospital Trust appointed under **section 9**; "Committee" means the Executive Management Committee and other committees of the trust established under **section 12**; "Employee" means any member of the administrative, technical, professional and other ancillary support staff of a Hospital Trust; "Fees" include any fees or charges payable to a Hospital Trust for the treatment, nursing, accommodation, attendance, food, drugs, dressings, medicines or other supplies or services of whatever kind rendered by the Hospital Trust; "funds" includes money stocks, shares and other securities; "medical care" includes dental care and optical care; "member" means a member of the Board other than the Chairperson or Chief Executive Officer; "Minister" means the minister responsible for health; "Public Service Officer" means the holder of any office the powers of appointment to and the disciplinary and general control over which is vested in the Public Service Commission, the Health Service Commission or the Teaching Service Commission;

PART II – Establishment and Functions of Hospital Trusts

3 (1) The Minister may, by order, establish Hospital Trusts as body corporate to perform such functions as shall be specified in the order

(2) A Hospital Trust established under this section shall: -

(a) have perpetual succession and a common seal and may sue or be sued in its corporate name and, subject to this Statute may do or suffer all other things and acts as bodies corporate do or suffer.

(b) subject to this Statute, be capable of holding and alienating movable and immovable property.

(3) The seal of the trust shall be such device as the trust may determine and shall be authenticated in the manner provided under the Schedule to this Statute.

4. The functions of the trust shall be:

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- (a) to provide efficient systems for the delivery of health care;
 - (b) to facilitate new Systems of health care;
 - (c) to provide the use of health care facilities for service, teaching and research;
 - (d) to operate, construct, equip, furnish, maintain, manage, secure and repair all its property;
 - (e) to collaborate with the Universities by law established in Uganda and any other recognised training institution in the education and training of persons and in research in medicine, dentistry, nursing, pharmacy and bio-medical and health science fields as well as any ancillary and supportive fields;
 - (f) to establish and develop relationships with local, national, regional and international bodies engaged in health care services and similar or ancillary pursuits; and
 - (g) to do all such things as are incidental or conducive to the attainment of the objects of the trust
- 5 Subject to the provisions of this Statute, a Hospital Trust shall exercise its powers and functions in accordance with such specific or general directions as may be given to it by the Minister.

PART III - Boards of Directors

- 6 (1) A Hospital Trust shall be managed by a Board of Directors whose composition, term of office, remuneration and other matters shall be specified in the Order establishing the trust.
- (2) No person shall be appointed member of a Hospital Trust Board if that person:
- (a) has been declared bankrupt or has entered into any composition with his creditors;
 - (b) has been convicted of an offence involving moral turpitude;
 - (c) is unable in the opinion of the Medical Board by reason of infirmity of mind or body, to perform the duties of a member;

Meetings of Board

7. The Second Schedule to this Statute shall have effect in relation to the meetings and procedure of the Board and other related matters specified in that schedule.

Standing Orders (SO), Standing Financial Instructions (SFI)

8. Subject to the requirements of any statute establishing a trust, the board shall prepare written SO and SFI for the conduct of its business which must be subject to the approval of the Audit General.

PART IV - Management and staff of hospital trusts

9. (1) There shall be for each Hospital Trust a **Chief Executive Officer** appointed by the Board on such terms and conditions of service as the Board with the approval of the Minister may determine.

(2) The Chief Executive Officer shall hold office for a term not exceeding five years and shall be eligible for re-appointment

(3) the Office of Chief Executive Officer shall become vacant:-

(a) if the Chief Executive Officer resigns office by writing addressed to the Chairperson;

(b) if in the opinion of the Board the Chief Executive Officer becomes incapable of performing the duties of Chief Executive Officer, and is removed from office.

Functions of Chief Executive

10. (1) A Board of a Hospital Trust may delegate to the Chief Executive Officer such functions and powers as the Board deems necessary or desirable for the administration, management and development of hospital services.

Board Secretary

11. (2) The Secretary shall be responsible for the recording of all the minutes of the meetings of the Board and its committees and shall keep custody of all records and documents of the Board.

Committees of the Board

12. (1) For the better carrying out of its functions, the Board may appoint such committees composed of its members or its members and other persons, as it may consider necessary.

(2) A committee appointed under **subsection (1)** shall deliberate on any matter assigned to it by the Board and make findings and recommendations to the Board.

(3) The Chairman of a committee under this section shall be appointed by the Board from among the members of the Board.

Appointments and Terms of Reference of Staff

13. A Hospital Trust shall employ officers and other employees as it considers necessary for the due performance of its functions and the officers and employees shall hold office on terms and conditions that may be determined by the Board.

Transfer of Service

14.(1) An officer in the public service or in a statutory body, may, with the approval of the appropriate Service Commission and the Board of a Hospital Trust, consent to be appointed on transfer to the service of the Hospital Trust, upon such terms and conditions as may be acceptable to him\herself and the trust.

(2) The officer shall, upon transfer --

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(a) have preserved his/her superannuation or pension rights accruing at the time of the transfer; and

(b) become a member of the pension scheme established under this statute.

(3) Sub-sections (1) and (2) shall apply *mutatli mutandis* to transfers of officers of a Hospital Trust to any section of the public service.

Pension rights and Schemes

15.(1) A Hospital Trust shall establish and maintain a pension, gratuity, superannuation, provident or other schemes for the benefit of its officers employees and their dependants.

(2) A trust shall provide, in the pension scheme, for an employee's service with the trust, prior to the establishment of such pension, gratuity, superannuation, provident or other scheme, to be taken into account in calculating his/her benefits under the pension scheme.

(3) Where an employee of a Hospital Trust dies before the establishment of the pension or other scheme: the trust shall be responsible for payment of superannuation or death benefits accruing to that employee.

(4) The basis for accrual and payment of superannuation or death benefits shall be the same as that which was applicable to the employee prior to his/her transfer or appointment to the trust.

PART V - Financial Provisions

Funds of the trust

16.(1) The funds of the trust shall consist of:

(a) money appropriated to the trust by the Legislature from time to time;

(b) grants, gifts and donations to the trust;

(c) fees and other moneys paid for services rendered by the trust;

(d) moneys that may: in any manner become payable to, or vested in the trust in pursuance of the provisions of this statute or in relation or incidental to the carrying out its functions.

(2) All moneys of Hospital Trust shall be managed through a fund to be established by the Board.

(3) A Hospital Trust may operate a bank account in a bank determined by the Board, and shall be operated in a manner decided by the Board.

Power to Raise Funds

17. (1) For the purpose of carrying out its objects, a Hospital Trust may:

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- (a) charge fees, with the approval of the Minister, for any service provided by the trust;
- (b) receive donations, be a beneficiary under covenants and establish and administer trusts; and
- (c) with the approval of the Minister, build up reserves, the limit of which shall be determined by the Minister.

(2) The reserves and other funds of a Hospital Trust not immediately required to be expended to meet any obligation or discharge any function of the trust, may be invested in such securities as the trust with the approval of the Minister deems fit.

Power to borrow

- (1) Subject to **subsection (2)**, the trust may borrow any money required by it for the efficient exercise of its functions or for meeting its obligations
- (2) Borrowing may be effected only with the approval, in writing, of the Minister responsible for Finance as to the amount, the sources of borrowing and the terms and conditions of the loan.
- (3) The approval of the Minister responsible for Finance in respect of borrowing may be either general or limited to a particular transaction and may be either conditional or subject to conditions
- (4) The trust may not pledge its assets as security for any loan without the written approval of the Minister of Health.

Application of Funds

19. The funds of a Hospital Trust shall be applied in defraying the following expenditure-

- (a) the remuneration, fees and allowances of the members of the Board and of members of committees established by the Board;
- (b) the salaries, fees, allowances, advances, loans, gratuities and pensions of, and other payments, to the staff of the trust;
- (c) the capital and operating expenses, including maintenance and insurance of the property of the trust;
- (d) the making and maintenance of investments by the trust in the discharge of its duties and functions; and
- (e) any other expenditure authorised by the trust in the discharge of its duties, functions and contractual obligations.

Financial Year

The financial year of a hospital trust shall be the twelve months beginning from the 1st day of July and ending on the 1st day of June.

Estimates

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21. (1) The Chief Executive Officer of a hospital trust shall within three months before the end of each financial year, prepare and submit to the Board for its approval, estimates of income and expenditure of the trust for the next ensuing year and may, at any time before the end of a financial year, prepare and submit to the Board for its approval any supplementary estimates;

(2) No expenditure shall be made out of the Fund of the trust unless that expenditure is part of the expenditure approved by the Board under estimates for the financial year in which that expenditure is to be made or in estimates supplementary to that years estimate.

Accounts and Audit

22. (1) A Hospital Trust shall keep proper books of accounts and shall prepare the annual financial statements of accounts for the immediately preceding financial year not later than three months in the following year.

(2) The annual accounts of a Hospital Trust shall be audited by the Auditor General or an Auditor appointed by him.

(3) The trust shall, within three months after the end of each financial year submit:-

(a) to Minister an annual report in respect of that year containing

- (i) financial statements
- (ii) a report on the operations of the trust
- (iii) any other information that the Minister may prior to the completion of the annual report or as otherwise supplementary thereto direct in writing

(b) to the Auditor General:-

- (i) the accounts of the trust for the financial year and
- (ii) the annual report referred under **paragraph (a)** who shall audit the accounts of the trust within two months of the receipt thereof and submit his or her opinion on the accounts and the annual report to the Minister and the trust

(4) The Minister shall cause copies of the annual report together with a copy of the audited accounts to be laid before the legislature at the first available opportunity after receipt of them, but not later than the next sitting of the legislature after the date on which the Minister receives the annual report and the audited accounts.

PART VI - Properties and Facilities

Vesting of Assets and liabilities in trust

23. (1) All rights, assets and liabilities of any hospital for which a Hospital Trust is

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established shall be vested in the trust to the same extent and for the same estate or interest as it were previously vested in the hospital, to be held and enjoyed, sued for, recovered,, maintained, dealt with and disposed of in accordance with the provisions of this statute.

(2) From and after the coming into operation of this Statute, the trust shall be subject to and discharge all obligations and liabilities to which the hospital was subject and shall indemnify the hospital from these obligations and liabilities and from all Costs and expenses in that behalf.

Property dealings by the trust

24. The trust may, with the consent of the Minister

(a) acquire, hold, enjoy and dispose purchase, barter, exchange, devise, any Other way; and of any property by bequest, gift or in any other way; and

(b) lease, accept surrender of leases, reconvey, mortgage, or grant or accept licences, rights of way or easements.

Use of trust Facilities

24. (1) The facilities of a Hospital Trust shall be used for carrying into effect the objects of the trust.

(2) The use of the facilities of a Hospital Trust is

(a) restricted to personnel and organisations approved by the trust; and

(b) subject to such terms and conditions as may be approved by the trust, after consultation with the Minister.

(3) Where health-care is being administered privately, the use of the facilities and approval of personnel to use the facilities shall be at the sole discretion of the trust.

PART VI- Miscellaneous Provisions

26. The Board, may with the approval of the Minister, make regulations generally for the carrying out of the provisions of this Statute.

SCHEDULE : THE SEAL, MEETINGS AND PROCEDURE OF THE BOARD**Seal of the trust**

1(1) The seal of the trust shall be kept under the custody of the Board Secretary.

(2) The affixing of the seal of the trust on any document shall be authenticated by the signatures of the Chairperson and the Secretary and their signatures shall not be required to be witnessed by any other person.

Meetings of the Board

2 (1) The first meeting of the Board shall be convened by the Chairperson and thereafter the Board shall meet for the transaction of business at places and at times as may be decided upon by the Board but the Board shall meet at least four times in a year.

(2) The Chairperson may, at any time, call a special meeting of the Board, and shall call a special meeting upon a written request by a majority of the members of the Board.

(3) The chairperson shall preside at every meeting of the and in his/her absence from any meeting, the members present may appoint a member from amongst themselves to preside at that meeting.

Quorum

3 The quorum at a meeting of the Board shall be half of all the members.

Decisions of the Board

4 (1) Questions proposed at a meeting of the Board shall, subject to a quorum being present, be decided by a majority of the votes of the members present and in the event of an equality of votes the person presiding shall have a second or casting vote in addition to his/her deliberative vote.

(2) Notwithstanding any other provision of this Schedule, a decision may be made by the Board without a meeting by circulation of the relevant papers among the members of the Board and by the expression of the views of the majority of the members in writing but any member shall be entitled to require that the decision be deferred and the matter on which a decision is sought be considered at meeting of the Board.

Disclosure of Interest

5 (1) A member at the Board who has a direct or indirect pecuniary interest in a matter being considered or about to be considered by the Board shall, as soon as possible, after the relevant facts have come to his knowledge, disclose the nature of his interest to the Board.

(2) A disclosure of interest under **subsection (1)** shall be recorded in the minutes of the meeting of the Board and the member making such disclosure shall not, unless the Board otherwise determines in respect of that matter:

(a) be present during any deliberation on the matter by the Board; or

(b) take part in the decision of the Board

(3) For purposes of the making of a determination by the Board under **sub-paragraph (2)** in relation to a member who has made a disclosure under **sub-paragraph (1)**, the member who has made the disclosure shall not:-

(a) be present during the deliberations of the Board for the making of that determination; or

(b) influence any other member or take part in the making, by the Board, of the determination.

Minutes of Meetings

6. The Board shall cause the minutes of all proceedings of its meetings to be recorded and kept and the minutes of each meeting shall be confirmed by the Board at the next meeting and signed by the Chairperson of the meeting.

Board to regulate proceedings

7. Subject to the provisions of the Statute and this Schedule, the Board may regulate its own proceedings.

1b.Example of a Legal Notice

LEGAL NOTICE NO (.)

The Hospital Trusts Statute, 1998

In Exercise of the powers conferred by **section 3** of the Hospital Trusts Statute, 1998,(*name*), being the Minister responsible for Health makes the following Order:

The Mulago Hospital Trust Order, 1998.

Citation

1. This Order may be cited as the Mulago Hospital Trust Order, 1998.

Establishment and incorporation of the trust

2. (1) There is established a Hospital Trust to be known as the Mulago Hospital Trust (hereinafter called “the trust”) which shall be a body corporate in accordance with **section 2** of the Statute and which shall perform and exercise the duties, functions and powers specified in the Statute and in this Order.

(2) The trust shall in accordance with **section 3** of the Statute be under the management of a Board of Directors consisting of six non-executive and four executive members as follows:

- (a) a non-executive chairman appointed by the President;
- (b) the vice-chancellor of Makerere University;
- (c) the Mayor of Kampala;
- (d) the Permanent Secretary (or Director General), Ministry of Health;
- (e) two members appointed by the Minister from the legal and business community with experience in managing large organisations;
- (f) the Chief Executive of Mulago Hospital Trust;
- (g) the Director of Clinical Services;
- (h) the Director of Nursing Services;
- (i) the Director of Finance;

(3) Members of the Board shall hold office for a term of three years from the date of their appointment and shall be eligible for re-appointment for not more than two terms.

Chief Executive

3. There shall be an Chief Executive for the Mulago Hospital Trust who shall be appointed by the Board on such terms and conditions of service as the minister shall, in consultation with the board, determine.

Powers and functions of the trust

4. (1) The trust shall be responsible for the administration, management and development of the hospital established in Kampala known as Mulago National Hospital (hereinafter referred to as 'the Hospital').

(2) (a) The trust shall be the successor of the Government in respect of all rights, duties, obligations, assets and liabilities concerning the Hospital existing at the date of publication of the Order.

(b) All such rights, duties, obligations, assets and liabilities shall be automatically and fully transferred to the trust and any reference to the Government or the Minister for Health or the Permanent Secretary, Ministry of Health or the Permanent Secretary to the Treasury or the Director, Mulago Hospital Complex in connection with the Hospital in any written law or in any contract or document shall for all purpose be deemed to be a reference to the trust established under this Order.

(3) Without prejudice to the generality of **sub-paragraph (1)** the trust shall-

(a) administer the assets and funds of the Hospital in such manner and for such purposes as will promote the best interests of the Hospital in accordance with the Statute;

(b) have power to receive on behalf of the Hospital, gifts, donations, grants or other money and to make legitimate disbursements therefrom;

(c) promote the general welfare of the patients and staff of the Hospital;

(d) Have power to enter into association with other hospitals, health institutions, institutions of higher learning and research organisations within or outside Uganda as the trust may consider desirable or appropriate and in furtherance of the purpose for which the hospital is established;

(e) make bye-laws for the proper and efficient management of the Hospital which byelaws shall be issued by the Executive Director on behalf of the trust and shall not be published in the Gazette but shall be brought to the attention of all those affected or governed by them.

Functions of the Hospital

(4) It is hereby declared that the Hospital is established for the following purposes:-

(a) to receive patients on referral from other hospitals or institutions within or outside Uganda for specialised care;

(b) to provide facilities for medical education for the University of Uganda and for research either directly or through other co-operating health institutions;

(c) to provide facilities for education and training in nursing and other health and allied professions;

(d) to participate, as a national referral teaching and research hospital, in national health planning.

(e) to carry out out-reach programmes in the furtherance of the above.

(f) to provide district hospital services for Central Regions as agreed with the MoH and the relevant districts.

(g) such other duties as agreed with the MoH

Finances

In addition to any gift, grants, donations or other moneys which the trust may receive on behalf of the Hospital, there shall be paid to the trust by way of grants, in every financial year, out of money appropriated by Parliament for the purpose such sum as the Minister may determine as being necessary to enable the trust to carry out its functions, having regard to estimate for that year approved under section 20 of the Statute.

Made on theday of..... 1998.

..... **Minister of Health**

Annex 2

An Example of Standing Financial Instructions

(.....) Hospital Trust Board

Standing Financial Instructions

(First Draft)

Contents

- I Introduction
- II Estimates, Budgets and Budgetary Control
- III Annual Accounts and Reports
- IV Cash Limit Control
- V Banking Arrangements
- VI Security of Assets
 - VI I Security of Cash, Cheques and Other Negotiable Instruments
- VIII Payment of Staff
- XI Payment of Accounts
- X I Income
- XI Condemnations, Losses and Special Payments
- XIII Internal Audit
- XIII Information Technology
- XIV Contracting and Purchasing

I. Introduction

1. These Standing Financial Instructions are issued in accordance with (*insert legal reference*) and all other enabling powers, for the regulation of the conduct of the trust, its members. Officers and agents in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders of the trust.

2. Within the Instructions it is acknowledged that the Chief Executive and Director of Finance will have ultimate responsibility for ensuring that the trust meets its obligation to perform its functions within the financial resources made available to it. The Chief Executive has overall executive responsibility for the trust's activities and its responsible to the trust for ensuring that it stays within its cash limit. .

3. Any expression to which a meaning is given in the (Health Service Acts) or in the Financial Directions made under the Acts shall have the same meaning in these instruction;and

- (a) "Trust means the (Name) Hospital Trust.
- (b) "Budget" means an amount of resources expressed in financial terms proposed by a trust for the purpose of carrying out over a specific period all or part of the functions of the trust.
- (c) "Chief Executive" means the chief officer of the trust (who is directly accountable to the trust).
- (d) "Director of Finance" means the chief financial officer of the trust.

4. The trust shall delegate executive responsibility for the performance of its functions to the Chief Executive. Members shall exercise financial supervision and control by requiring the submission and approval of budgets within approved allocations, by defining and approving essential features of financial arrangements in respect of important procedures and financial systems, including the need to obtain value for money, and by defining specific responsibilities placed on officers.

5. So far as is possible, the Chief Executive and Director of Finance should delegate their detailed responsibilities but retain their overall accountability. The extent of delegation should be kept under review by the trust.

6. All staff severally and collectively are responsible for the security of the property of the trust, for avoiding loss, for economy and efficiency in the use of resources and for the conformity with the requirements of Standing Orders, including Standing Financial Instructions.

7. It shall be the duty of the Chief Executive to ensure that existing staff and all new employees are notified of their responsibilities within these instructions.

8. The Director of Finance shall be responsible for the implementation of the trust's financial policies and for co-ordinating any corrective action necessary to further these policies.

9. Without prejudice to any other functions of officers of the trust, the duties of the Director of Finance shall include the provision of financial advice to the trust and its officers, the design, implementation and supervision of systems of financial control and the preparation and

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

10. The Director of Finance shall keep sufficient records to show and explain the trust's transactions, such as to disclose with reasonable accuracy, as at any time, the financial position of the trust at that time.
11. The Director of Finance shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his or her duties shall be to his satisfaction.
12. The Director of Finance shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal check to supplement these instructions.
13. Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these Instructions, it shall be deemed to include such other officers who have been duly authorised to represent them, e.g. Chief Internal Auditor.
14. All references in these Instructions to "Office" shall be deemed to include Consultant Medical staff as appropriate.
15. All references in these Instructions to the masculine gender shall be read as equally applicable to the female gender.

II Estimates, Budgets and Budgetary Control

1. The trust has a responsibility to prepare and submit financial plans in accordance with the requirements of the (*insert legal reference*). It shall perform its functions within the total of funds available through the contractual framework and from other sources allowing for any planned changes in working balances during the year; all plans, financial approvals and control systems shall be designed to meet this obligation.
2. The Director of Finance shall ensure that adequate statistical and financial systems are in place to monitor and control all contracts for patient services and facilitate the compilation of estimates, forecasts and investigations as may be required from time to time.
3. The Director of Finance shall, on behalf of the Chief Executive, prepare and submit budgets within the limits of available funds to the Board for its approval prior to the commencement of each financial year. In addition:
 - (a) he must review the bases and assumptions used to prepare the budget and advise the trust whether they are realistic;
 - (b) he shall have the right of access to all budget holders on budgetary related matters. These should relate to income and expenditure in that year and have supporting statements in order to explain any matter material to the understanding of those budgets.
4. The Director of Finance shall provide the trust with a regular report showing:-

(a) the income and expenditure of the trust since the last report and for the financial year to-date, in comparison with the corresponding proportions of the approved budget to-date.

(b) his opinion of the trust's expected position at the year end.

5. The Director of Finance shall be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the trust to fulfil its statutory responsibility to meet its Annual recurrent expenditure and capital cash limits.

6. The Director of Finance shall devise and maintain a system of budgetary control and all managers whom the trust may empower to engage staff or otherwise incur expenditure, collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, workload, or manpower variances from budget, and the Director of Finance shall be responsible for providing budgetary information and advice to enable the Chief Executive and other operational managers to carry out their budgetary responsibilities and issuing to all relevant staff rules and procedures governing the operation of budgets.

7. The Chief Executive may, within budgetary limits approved by the trust, delegate a responsibility for a budget or a part of a budget to operational Managers to permit the performance of defined activities. The terms of delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of service and the provision of regular reports upon the discharge of these delegated functions to the Chief Executive.

8. Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purposes shall revert to the immediate control of the Chief Executive, unless covered by the delegated powers of virement.

9. Expenditure for which no provision has been made in an approved budget and not subject to funding under the delegated powers of virement shall only be incurred after authorisation by the Chief Executive or the trust as appropriate.

10. The Director of Finance shall keep the Chief Executive and the trust Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

III Annual Accounts and Reports

1. The Director of Finance, on behalf of the trust, shall prepare, certify and submit annual accounts to the Minister in respect of each financial year in such a form as the Minister may prescribe (*insert legal reference*).

2. The Director of Finance shall prepare and submit financial returns to the Minister in respect of each financial year.

3. The annual accounts and financial returns shall be prepared in accordance with the guidance and the timetables required by the Minister.

4. The Director of Finance shall prepare and publish an Annual Financial Report in accordance with current guidelines on local accountability and provide such other financial data as may be specified from time to time by the Minister.

IV Banking Arrangements

1. The Director of Finance shall advise the trust upon the provision of banking services.
2. The Director of Finance shall be responsible for establishing a bank account at a nominated branch of a bank specified in (*insert reference*) or such other bank as the Minister may direct to be used for:-
 - (a) the receipt of all income
 - (b) the funding of any subsidiary account; and for no other purpose.
3. The Director of Finance shall advise the bankers in writing, including a copy of the trust's resolution, of the conditions under which each account shall operate. All funds shall be held in accounts in the name of the trust. No officer other than the Director of Finance shall open any bank account in the name of the trust.
4. The Director of Finance shall advise the bankers of any alterations in the conditions of operation of accounts that may be required by financial regulations to the health service or by resolution of the trust as may be necessary from time to time.
5. The balances of accounts holding public funds shall be maintained at the lowest practicable levels. Any subsidiary bank account opened in the name of the trust and operated on a single signature may not at any time be overdrawn. The main account shall be permitted to be overdrawn only to the extent of any net credit balance on subsidiary bank accounts maintained at the same branch in the same name.
6. Cheques or other orders drawn upon the main bank account referred to at **paragraph 5** shall be signed by two people, one of whom shall be the Director of Finance or an Assistant of his authorised by the trust to act in that behalf and the other of whom shall be drawn from a panel of officers nominated by resolution of the trust.
7. An officer or officers shall be nominated in writing to authorise the payment of money from any subsidiary bank account. Payments drawn on subsidiary bank accounts shall be authorised as follows:-
 - (a) By the use of pre-printed or pre-signed cheques without a hand-written signature where the security procedures have been approved by the trust.
 - (b) Manually produced cheques to be signed by any one authorised officer if under (*sum*) drawn on account.
 - (c) Manually produced cheques to be signed by two authorised officers.

All blank cheques to be treated as Controlled Stationery, in the charge of a duly designated officer controlling their issue.

8. Subsidiary accounts shall be funded by bank transfers drawn on the main account and signed by two persons, one of whom shall be the Director of Finance or nominated assistant and the other drawn from a panel of such members/officers as the trust may determine from time to time.
9. The Director of Finance may enter into a formal agreement with the bank for payments to be made on behalf of the trust from bank accounts maintained in the name of the trust. Where such an agreement is entered into the Director of Finance shall ensure that the security regulations of the trust relating to the bank accounts in question are observed.
10. The Director of Finance should review the banking needs of the trust at regular intervals to ensure that they reflect current business patterns and represent best value for money. Following such reviews, the Director of Finance shall determine whether or not re-tendering for services is necessary.
11. As a minimum, the Director of Finance shall be responsible for completing a competitive tendering exercise and entering into a new contract by (date). Thereafter, future tendering exercises should be undertaken when demanded by changed circumstances, or at intervals not exceeding 5 years from a previous tendering exercise.

VI Security of Assets

1. Each employee has a responsibility to exercise a duty of care over the assets of the trust and it shall be the responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to trust assets. Persistent or substantial breach of agreed security practices shall be reported to the relevant Manager.
2. The Chief Executive shall define the items of equipment to be controlled, and, wherever practicable, items of equipment shall be marked as trust property. Items to be controlled shall be recorded and updated in an appropriate register. These shall include all capital assets.
3. The form of record and method of updating shall be as required by the Chief Executive as advised by the Director of Finance and shall incorporate all requirements extant for capital assets. This shall include a separate record(s) for equipment on loan from suppliers.
4. The up-to-date maintenance and annual checking of asset records shall be the responsibility of designated Budget Holders for all items for which the initial purchase or replacement is within their budgetary responsibilities.
5. All discrepancies found on checking the records shall be notified to the appropriate executive director and to the Director of Finance, who may also undertake such other independent checks as he considers necessary.
6. Registers shall be maintained to record all controlled items issued to individuals, and where practicable, receipts shall be obtained.
7. Records shall also be maintained and receipts obtained for all contents of furnished lettings.
8. Any damage to the trust's premises, vehicles and equipment or any loss of equipment or supplies shall be reported by staff in accordance with the agreed procedure for reporting losses. (See also **Section X - Condemnations, Losses and Special Payments**)

9. On the closure of a facility, a check as in **paragraph 4** above shall be carried out and a designated Officer shall certify a list of items held showing eventual disposal.

VII Security of Cash, Cheques and Other Negotiable Instruments

1. All receipt books, tickets, agreement, forms, or other means of officially acknowledging or recording amounts received or receivable, shall be in a form approved by the Director of Finance. Such stationery shall be ordered and controlled by him and subject to the same precautions as are applied to cash.

2. All officers whose duty is to collect or hold cash shall be provided with a safe or with a lockable cash box which will normally be deposited in a safe. The officer concerned shall hold only one key and all duplicates shall be lodged with the trust's bankers or such other officer authorised by the Director of Finance, and suitable receipts obtained. The loss of any key shall be reported immediately to the Director of Finance. The Director of Finance shall arrange for all new safe keys to be despatched directly to him from the manufacturers. The Director of Finance shall be responsible for maintaining a register of authorised holders of safe keys.

3. The opening of incoming post shall be undertaken by two officers and all cash, cheques, postal orders and other forms of payment received by an officer other than a cashier shall be entered immediately in an approved form of register. All cheques and postal order shall be crossed immediately "Not negotiable A/c (name of trust)". The remittances shall be passed to the cashier from whom a signature shall be obtained.

4. Official money shall not under any circumstances be used for the encashment of private cheques.

5. All cheques, postal orders, cash etc., shall be banked intact promptly in accordance with the Director of Finance's procedures, to the credit of the main account. Disbursement shall not be made from cash received, except under arrangements approved by the Director of Finance which will be rare.

6. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the trust from responsibility for any loss.

7. During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in his place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8. All unused cheques and other orders shall be subject to the same security precautions as are applied to cash: bulk stocks of cheques shall normally be retained by the trust's bankers and released by them only against a requisition signed by the Director of Finance.

9. The use of a cheque-signing machine and/or cheques with a pre-printed signature included shall be subject to such special security precautions as may be required from time to time by the Director of Finance.

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

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

VIII Payment of Staff

1. No Officer may engage or regrade staff, or hire agency staff, unless so authorised by the Chief Executive and then only in accordance with the agreements under (*enter legal reference*) and within the limit of his or her delegated budget.

2. Each employee shall be issued with a contract, which shall comply with current employment legislation and be in the form approved by the trust.

3. A certified appointment or such other documents as he may require shall be sent to Director of Human Resources immediately upon the employee commencing duty.

4. A termination of employment form and such other documents as the Director of Human Resources may require shall be submitted to him in the prescribed form immediately upon the effective date of an employee's resignation, retirement or termination being known. Where an employee fails to report for duty in circumstances that suggest that he has left without notice, the Director of Human Resources shall be informed immediately.

5. A variation form shall be sent to the Director of Human Resources, immediately upon the effective date of any change in the state of employment or personal circumstances of an employee being known.

6. All time records, pay sheets, and other pay records and notifications shall be in a form agreed between the Director of Finance and the Director of Human Resources and shall be certified and submitted in accordance with their instructions.

7. The Director of Human Resources shall be responsible for the final determination of pay, including the verification that the rate of pay and relevant conditions of service are in accordance with national and/or local agreements.

8. The Director of Finance shall determine the dates on which the payment of salaries and wages are to be made, having regard to the rule that it is undesirable to make payments in advance.

9. All employees shall be paid by bank credit transfer, unless otherwise agreed by the Director of Finance. No officer shall be authorised to agree any other form of payment with an employee without the prior agreement of the Director of Finance.

XI Payment of Accounts

1. The Director of Finance and Chief Executive shall be responsible for the prompt payment of accounts and claims. The term 'payment' includes any arrangements established within a

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region to settle payments upon a non-cash basis. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

2. All authorised officers shall inform the Director of Finance promptly of all money payable by the trust arising from transactions which they initiate, including contracts, leases, tenancy agreements and other transactions. To assist financial control, a register of regular payment should be created.
3. The Director of Finance shall be responsible for designing and maintaining a system for the verification, recording and payment of all accounts payable by the trust. This responsibility shall also cover the payment of invoices relating to clinical services provided to residents of the Region.
4. Where an officer certifying accounts relies upon other officers to do preliminary checking he or she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.
5. In the case for contracts for building and engineering works which require payment to be made on account during progress of the works the Director of Finance shall make payment on receipt of a certificate from the appropriate Technical Consultant or Officer. Without prejudice to the responsibility of any Consultant, or Works Officer appointed to a particular building or engineering contract, a contractor's account shall be subjected to such financial examination by the Director of Finance and such general examination by the Works Officer as may be considered necessary, before the person responsible to the trust for the contract issues the final certificate. To assist financial control, a contracts register should be established.
6. The Director of Finance may authorise advances on the imprest system for petty cash and other purposes as required. Individual payments must be restricted to the amounts authorised by the Director of Finance.

X Income

1. The Director of Finance shall be responsible for designing and maintaining systems for the proper recording, invoicing and collection of all monies due, including the creation of a register for regular income, which shall incorporate the principles of internal check and separation of duties in accordance with the approval of the Director of Finance.
2. All Officers shall inform the Director of Finance of money due to the trust arising from transactions, which they initiate, involving all contracts, leases, tenancy agreements, and other transactions. Responsibility for arranging the level of rentals for newly acquired property and for reviewing rental and other charges regularly shall rest upon the Director of Finance who may take into account independent professional advice on matters of valuation. The Director of Finance shall be consulted about the pricing of goods and services offered for sale and regional or national negotiated rates shall be observed. (See also Section XIV Contracting and Purchasing.)
3. The Director of Finance shall ensure that appropriate systems exist for the recovery of outstanding debts.
4. Income not recovered shall be dealt with in accordance with **Section X Condemnations, Losses and Special Payments**.

5. Disposal of scrap material and items surplus to requirements shall be dealt with in accordance with the trust's Standing Orders.

XI Condemnations, Losses and Special Payments

1. Losses fall into three categories and the action required is dependent on this classification. The categories are defined as:

Category 1 Losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness.

Category 2 Losses apparently caused through the inefficient operation of administrative controls or financial control systems.

Category 3 Other losses.

2. Any officer discovering or suspecting a loss of any kind must directly notify his or her head of department, who will immediately, or without undue delay dependent on the seriousness of the loss, inform the Chief Executive. The Chief Executive will likewise inform the Director of Finance within a timescale appropriate to the financial size of the loss.

3. Where a criminal offence is suspected, the Chief Executive shall immediately inform the Police, except where fraud is thought to be involved. If the case involves suspicion of fraud, then the Director of Finance shall be informed immediately and he will be responsible for deciding at what stage the Police should be notified. (See also **Part XII Internal Audit**)

4. For **Category I** losses, except those which in the judgement of the Chief Executive are of a trivial nature and where fraud is not suspected, the Director of Finance will immediately notify:

- (a) the trust for appropriate action
- (b) the Statutory Auditor

5. All unserviceable articles shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Chief Executive. A record in a form approved by the Director of Finance shall be kept of all articles submitted for condemnation and the condemning officer shall indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the counter signature of a second officer authorised for the purpose by the Chief Executive.

6. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Executive who shall take appropriate action. Where there are reasonable grounds to suspect that a criminal offence has been committed, action shall proceed as in **paragraph 2** above.

7. The trust shall approve the writing-off of losses within the limits delegated to it from time to time by the Ministry of Health. The trust shall delegate its responsibility to approve write-off and authorise special payments to the Chief Executive and Director of Finance acting jointly, for losses other than those classified as **Category 1**.

Losses:

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1. Losses of Cash due to (*amounts to be inserted*)
 - (a) theft, fraud, arson, etc. (**category 1**)
 - (b) overpayments of salaries, wages, fees and allowances
 - (c) other causes, including unvouched or incompletely vouched payments, overpayments other than included in 6, loss by fire (other than arson); physical cash losses and losses of stamps or similar cash equivalents
2. Fruitless payments (including abandoned Capital Schemes)
3. Bad debts and claims abandoned
 - (a) in-patients
 - (b) out-patients
 - (c) private patients
 - (e) other
4. Losses etc. of Equipment and Property in stores and in use due to:-
 - (a) incidents of the service (as a result of fire, flood etc., motor vehicle accidents, damage to vehicles)
 - (b) theft, fraud or arson (whether proved or suspected), neglect of duty or gross carelessness;
 - (i) Bedding and Linen
 - (ii) Other Equipment and Property
 - (c) discrepancies and unexplained losses
 - (i) Bedding and Linen
 - (ii) Other Equipment and Property
 - (d) Other causes

Special Payments

5. Compensation payment (made under legal obligation)
6. Ex gratia payments:
 - (a) extra-contractual payments to contractors

- (b) compensation payments (including payments to patients and staff for loss of personal effects)
- (c) private street works charges with the advice of the (local equivalent of UK District Valuer)
- (d) other payments

7. Extra-statutory and extra-regulatory payments

(N.B. if it comes to light, after a payment has been made, that it is of this nature, the requirement to seek authority of the trust Board may be waived, provided that the amount of the payment does not exceed).

8. The Director of Finance shall maintain a Losses and Special Payments Register in which details of all **Category 1** and **Category 2** losses shall be recorded as they are notified. **Category 3** losses may be recorded in summary form. Write-off action shall be recorded against entries in the Register.

9. The Director of Finance shall be authorised to take any necessary steps to safeguard the trust's interest in bankruptcies and company liquidations.

10. The Chief Executive shall maintain a system for the authorisation of clinical negligence claims for payment.

xii Internal Audit

1. The Director of Finance shall be responsible for ensuring that there are arrangements to measure, evaluate and report on the effectiveness of internal control and efficient use of resources including the use of an internal audit service bought in for the purpose.

2. The role and objectives of internal audit are to review, appraise and report to management upon:

(a) the soundness, adequacy and application of financial and other management controls;

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

(c) the extent to which the trust's assets and interests are accounted for and safeguarded from losses of all kinds arising from;

(i) fraud and other offences

(ii) waste, extravagance and inefficient administration, poor value for money or other cause

(d) the suitability and reliability of financial and other management data developed within the organisation;

(e) the adequacy of follow-up action to Audit reports

Management's responsibility is to establish systems of internal control for operations for which it is responsible to ensure that these are properly run.

Internal Audit's basic objective is, therefore, to assist the various levels of management in discharging their duties and responsibilities by carrying out appraisals and making the necessary appropriate recommendations to management for operations under its control.

3. The Director of Finance shall prepare and submit to the Board Strategic Audit Plans to indicate the extent of audit cover proposed and to demonstrate the ability of the anticipated audit resource to address the trust's internal audit need.

The Director of Finance shall report regularly to the Chief Executive on the extent of audit cover achieved, providing a summary of audit activity during the report period, and detailing the degree of achievement of the approved plan.

4. The Internal Auditors shall be entitled, without necessarily giving prior notice, to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case, they shall have a duty to safeguard the confidentiality);

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

(c) the production or identification by any employee of any trust cash, stores or other property under the employee's control;

(d) explanations concerning any matter under investigation or review.

5. When a matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property of the trust or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance shall be notified immediately. (See also **Section X - Commendations, Losses and Special Payments**).

6. The Director of Finance, shall investigate cases of suspected fraud, misappropriation or other irregularities in consultation with the Police where appropriate.

7. The Internal Auditors shall report direct to the Director of Finance and shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take remedial action within a reasonable period shall be reported to the Chief Executive. Where in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the most senior Internal Auditor shall have access to report direct to the Chairman of the trust.

XIII Information Technology

- 1.** The Director of Finance shall be responsible for the accuracy and security of the computerised financial data of the trust.
- 2.** The Director of Finance shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the trust's data, programs and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, (*legal reference equivalent to the UK Data Protection Act 1984*).
- 3.** The Director of Finance shall ensure that adequate (reasonable) controls exist over data entry; processing; storage; transmission and output to ensure security; privacy; accuracy; completeness and timeliness of the data, as well as the efficient and effective operation of the system.
- 4.** The Director of Finance shall ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment.
- 5.** The Director of Finance shall ensure that an adequate management (audit) trail exists through the computerised system.
- 6.** The Director of Finance shall satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another Hospital Trust or any other agency, assurances of adequacy will be obtained from them prior to implementation.
- 7.** The Director of Finance shall ensure that contracts for computer services for financial applications with another Hospital Trust or any other agency shall clearly define the responsibility of all parties for the security; privacy; accuracy; completeness and timeliness of data during processing; transmission and storage. The contract should also ensure rights of access for audit purposes.
- 8.** Where another Hospital Trust or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls outlined in **2,3** and **4** are in operation.
- 9.** The Director of Finance shall ensure that adequate controls exist to maintain the security; privacy; accuracy and completeness of financial data sent over transmission networks.
- 10.** Where non-financial computer systems have an impact on corporate financial systems the Director of Finance shall satisfy himself that:
 - (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy.
 - (b) data produced for use with financial systems is adequate; accurate; complete and timely and that a management (audit) trail exists.
 - (c) Director of Finance staff have access to such data. (Subject to the need to protect patient confidentiality).

11. The Director of Finance shall satisfy himself that such computer audit reviews as he may consider necessary are being carried out.

XIV Contracting and Purchasing

1. Tendering and Contracting - Financial Limits

See the trust's **Standing Orders Paragraphs (paras**)

2. Official Orders

2.1. No goods, services or works other than works and services executed in accordance with a contract and purchases for petty cash shall be ordered except on an official order and contractors shall be notified that they should not accept orders unless in an official form. Verbal orders shall be issued only by an officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued as soon as possible and ideally the next working day. The order should be clearly marked "confirmation order". For petty cash purchases see **Section (XI)**.

2.2. Official orders shall be consecutively numbered in a form approved by the Director of Finance and shall include such information concerning prices or costs as he may require. The order shall incorporate an obligation on the contractor to comply with the conditions stipulated in writing on or with the order as regard delivery, carriage, documentation, variations, etc.

2.3. Requisition forms shall only be issued to and signed by officers so authorised by the Chief Executive. Lists of authorised officers shall be maintained for management control purposes.

2.4. Order forms shall only be issued to and signed by officers so authorised by the Chief Executive. Lists of authorised officers shall be maintained for management control purposes and copies supplied to the Director of Finance.

2.5. Details of all orders placed should be available to the Director of Finance either in paper form or accessible through a computerised purchase ledger system.

2.6. The Director of Finance should ensure that appropriate delegation arrangements are in existence to ensure that no order is issued for any item for which there is no budget provision, unless authorised by senior officers approved by the Chief Executive or Director of Finance.

2.7. Orders shall not be placed in a manner devised to avoid the financial limits specified by the trust.

2.8. No order shall be issued for any item or items for which an offer of gifts, reward or benefit has been made to staff, other than:

- (a) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
- (b) conventional hospitality provided it is normal and reasonable in the circumstances, such as lunches in the course of working visits.

Trusts themselves should meet the costs of inspection visits for staff advising on the purchase of equipment, etc.

Annex 3: An Example of Standing Orders

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.....(name) HOSPITAL TRUST STANDING ORDERS

GENERAL PROVISIONS

PART I INTERPRETATION

1.1 In these Standing Orders, unless the context otherwise requires:

- (a) "trust " means the (*name*) Hospital Trust.
- (b) 'Minister' means the Minister of Health.
- (c) 'Ministry' means the Ministry of Health.
- (d) 'Chairman' means the Chairman of the trust .
- (e) 'Member' means a member of the trust, not including the Chairman.
- (f) 'Non-Executive member' means a member who is not an Executive member and who is appointed under **paragraph 4.1** .
- (g) 'Executive member' means a member of the trust who is a member by virtue of appointment under **paragraph 4.2**.
- (h) 'Chief Executive' means the Chief Executive of the trust.
- (i) 'Budget' means an allocation of resources expressed in financial terms by the trust for the purpose of carrying out over a specified period of function or functions of the trust.
- (j) An expression which is defined in the (*name of Act which establishes Trust*) shall have the same meaning as in that Act.
- (l) References to the male gender should be interpreted as the female gender as appropriate.

1.2 The Chairman shall be the final authority on the interpretation of these Standing Orders. In this he shall be advised by the Chief Executive.

PART II APPLICATION AND DISTRIBUTION

2.1 These Standing Orders shall apply, as appropriate, to the Chairman and all members and to all staff of the trust; and to the systems operated and procedures followed by them in performance of their duties on behalf of the trust.

2.2 The Chief Executive shall ensure that a copy of these Standing Orders and of any amendments thereto, is given to each member and to appropriate Officers.

PART III SUSPENSION, VARIATION AND AMENDMENT OF STANDING ORDERS

3.1 Except where this would contravene a statutory provision or direction made by the Minister any of these Standing Orders and Standing Financial Instructions may be suspended

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at any meeting of the trust provided that at least two thirds of the whole number of members are present and that a majority of the members present signify their agreement. The reason for the suspension shall be recorded in the minutes.

3.2.These Standing Orders shall not be varied except upon notice of motion under Standing Order No. 8:

Provided that:

- (a) at least two-thirds of the whole number of members are present at a meeting at which it is considered; and
- (b) at least two-thirds of the number of members present and vote to signify their agreement to the motion; and
- (c) such a variation does not contravene a statutory provision or Direction made by the Minister.

PART IV MEMBERSHIP

4.1 Eligibility for Membership

The trust Board shall comprise non-executive and executive members in accordance with *(regulation which establishes the trust)*.

4.2 Tenure of Office of Members

Subject to paragraph **4.4** the tenure of office of a Chairman or non-executive member shall be specified on making the appointment, but shall not exceed three years and members may be eligible for re-appointment.

4.3 Termination of Tenure of Office of a Non-Executive Member

The Chairman or a non-executive member may resign at any time by giving notice in writing to the appointing trust.

Where during his period of membership a non-executive member is appointed as Chairman of the trust, his tenure of office as a member shall terminate.

A member who is absent without leave for three consecutive meetings of the trust is deemed to have vacated his seat.

4.4 Abolition of Hospital Trust

If the trust ceases to exist the offices of non-executive and executive members will cease to exist.

PART V MEETINGS

5.1 Calling Meetings

The Chairman may call a meeting of the trust at any time. If he refuses to call a meeting after a request for one, signed by at least one third of the whole number of members, has been presented to him, or if, without so refusing, he does not arrange for a meeting to be held within seven days after the requisition has been presented to him, a meeting may be called forthwith by one third of the whole number of members.

5.2 Frequency of Meetings

Ordinary meetings of the trust shall be held at regular intervals at such times and places as the trust may determine.

5.3 Notice of Meetings

Before each meeting of the trust, a notice of 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 it on his behalf, shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to him at least three clear days before the meeting.

Want of service of such notice on any member shall not affect the validity of a meeting. In the case of meeting called by members in default of the Chairman the notice shall be signed by those members and no business shall be transacted at that meeting other than that specified in the notice.

5.4 Notice of Motions

Subject to the provisions of **Standing Order No. 12**, a member desiring to move a motion at a meeting shall send a notice thereof, together with the name of another member willing to second the motion, to the Chief Executive to reach him at least seven clear days before the Meeting. The agenda for the meeting shall include all notices so received which are in order. This Standing Order shall not prevent any motion being, without notice:

(a) withdrawn; or

(b) moved on any business mentioned on the agenda for a meeting.

5.5 Chairman of Meeting

At any meeting of the trust, the Chairman shall preside. If he is not present, such member (who is not also an executive of the trust) as the members present shall choose shall preside.

5.6 Record of Attendance

The names of members present at a meeting of the trust shall be recorded.

5.7 Quorum

No business shall be transacted at a meeting unless at least one half of the whole number of the Chairman and members are present.

5.8 Motions

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

(b) When a motion is under discussion or is immediately about to be discussed, it shall be open to any member to move:

- (i) an amendment to the motion;
- (ii) the appointment of an ad hoc committee to deal with a specific item of business;
- (iii) an adjournment of the discussion of the meeting;
- (iv) that the meeting proceed to the next business;
- (v) that the question be now put;

Such a motion, if seconded, shall be disposed of before the motion which was originally under discussion or about to be discussed. In the case of motions under (ii) (iii) (iv) and (v) there shall be no discussion prior to a vote.

5.9 Motion to Rescind a Resolution

Notice of a motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of four other members. When any such motion has been disposed of at a meeting of the trust, it shall not be competent for any member other than the Chairman to propose a motion to the same effect within six months of that meeting.

5.10 Conduct of Meetings

5.10.1 Subject to the provisions of these Standing Orders, the decision of the Chairman of the meeting on the agenda for the meeting and its conduct on questions of order, relevance and regularity (including procedure of handling motions) and his interpretation of these Standing Orders shall be final.

5.10.2 The Chairman of the meeting shall give such direction as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press as to ensure that the trust's business shall be conducted without interruption or disruption.

5.10.3 The public and representatives of the press shall be afforded facilities to attend a meeting of the trust as soon as possible after the start of each financial year at which will be presented and discussed:

- (a) a review of the trust's performance in the proceeding year; and
- (b) its plans, goals and targets for the current year.

but shall be required to withdraw upon the trust resolving that representative 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 about which would be prejudicial to the public interest.

5.10.4 Matters to be dealt with by the trust following the exclusion of the public shall be confidential to Members of the trust who will not reveal the contents of the papers presented as confidential or the contents of the discussions appertaining thereto outside of the trust unless this restriction is lifted by the trust.

5.11 Voting

5.11.1 At a meeting of the trust, every question shall be determined by a majority of the votes of the Chairman and members present and voting on that question and, in the case of any equality of votes the person presiding shall have a second and casting vote.

5.11.2 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands: provide that, upon any question a paper ballot may be taken either at the direction of the Chairman of the meeting or consequent upon a motion to that effect duly proposed and seconded and carried.

5.11.3 If at least three members present at the meeting so request, the voting on any question shall be recorded so as to show how each member present voted or did not vote.

5.11.4 If a member so requests, his vote shall be recorded by name.

5.11.5 Absent members shall not vote by proxy.

5.12 Minutes

The minutes of the proceedings of a meeting shall be drawn up and entered in a book kept for that purpose by the Chief Executive and submitted for agreement at the next ensuing meeting of the trust where they shall be signed by the person presiding at it.

5.13 Interest of Chairman and Members in Contracts and Other Matters

5.13.1 Subject to the following provisions of this Standing Order, if the Chairman or any members who has a pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the trust at which that contract or other matter is the subject of consideration, he shall at the meeting as soon as possible after its commencement disclose the fact and shall not take part in consideration or discussion of the contract or other matter nor vote on any question relating to it.

5.13.2 The Chairman or any member who has a pecuniary interest will be excluded from a meeting of the trust while the matter is under consideration.

5.13.3 Any remuneration, compensation or allowance payable to the Chairman or a member by virtue of (legal reference) shall not be treated as a pecuniary interest for the purpose of this Standing Order.

5.13.4 Subject to **Paragraph 5.13.5** a member shall be treated as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

(a) he or a nominee of his is a member of a Company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

(b) he is a partner or is in the employment of a person with whom the contract is made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration. In the case of two persons closely related, the interest of one shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

5.13.5 For the purpose of this Standing Order but not by way of limitation of the generality of Paragraph **5.13.1**, a person shall not be treated as having a pecuniary interest in any contract proposed contract or other matter by reason only of:

(a) his membership of a Company or other body, if he has no beneficial interest in any securities of that Company or other body;

(b) an interest in any other Company, body or person with which he is connected as mentioned in **Paragraph 8.4** of this Standing Order which is so remote or insignificant that it cannot reasonably be regarded as likely to influence him in consideration or discussion of or voting on any question with respect to that contract or matter.

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

5.14 Petitions and Deputations

5.14.1 Petitions shall be received by the Chairman on behalf of the trust and shall be reported to the next meeting of the trust. If a petition consists of more than one sheet only those signatures shall be considered valid which are written on sheets headed by the prayer of the petition or on the back of such sheets.

5.14.2 Deputations: the trust shall only receive a deputation if the subject on which the deputation wishes to address the trust is, in the opinion of the Chairman or the person presiding at the meeting, a matter of urgency. The trust on agreeing to receive a deputation may specify the number of persons to be received; and no deputation shall exceed five in number. Not more than two members of a deputation shall address the meeting for a total not exceeding ten minutes, and the matter shall not be further considered by the meeting until the deputation has withdrawn.

PART VI COMMITTEES

6.1 Appointment of Committees and Sub-Committees

6.1.1 Subject to any directions by the Minister, the trust may, and if directed by him shall, appoint Committees of the trust or, together with one or more other health authorities, appoint joint Committees, consisting in either case, wholly or part the Chairman and members of the trust or Authorities or wholly of persons who are not members of the trust or Authorities.

6.1.2A Committee or joint Committee appointed under this Standing Order may, subject to such direction as may be given by the Minister or by the trust or Authorities, appoint Sub-Committees consisting wholly or partly of members of the Committee or joint Committee (whether or not they are members of the trust or Authorities or the committee of the trust or Authorities) or wholly of persons who are not members of the trust or Authorities or the Committee of the trust or Authorities in question.

6.1.3 These Standing Orders as far as applicable and subject to appropriate variation shall apply to meetings of any Committees and Sub-Committees established by the trust.

6.1.4 The Chairman shall be an ex officio member of all Committees and Sub-Committees of the trust.

6.2 Arrangements for Exercise of Functions

Subject to any directions by the Minister, the trust may make arrangements for the exercise, on its behalf, of any of its functions by a Committee, Sub-Committee, joint Committee appointed virtue of Standing Order No. 19, Paragraphs 1 or 2, or by an Executive of the trust, in each case subject to such restrictions and conditions as the trust thinks fit.

PART VII CUSTODY AND SEALING OF DOCUMENTS

7.1 Custody of Seal

The Common Seal of the trust shall be kept by the Chief Executive in a secure place.

7.2 Sealing of Documents

Documents shall be sealed only upon the trust of the Chairman. The Seal of the trust shall be affixed in the presence of the Chairman, or of another member of the trust and of the Chief Executive, Director of Finance or other Executive authorised by the trust for the purpose.

7.3 Register of Sealing

The Chief Executive shall keep a register in which he or another Executive of the trust authorised by it for the purpose shall enter a record of the sealing of every document. Every such entry shall be made when the document is sealed and shall be signed by those present. Entries in the register shall be consecutively numbered.

PART VIII APPOINTMENT OF OFFICERS

8.1 Canvassing of, and Recommendations by, Members

8.1.1 Canvassing of members or of any Committee of the trust directly or indirectly by or on behalf of any candidate for an appointment under the trust may disqualify the candidate for that appointment.

8.1.2A A member should not solicit for any person any appointment under the trust or recommend any person for such an appointment, but this Paragraph shall not preclude a member from giving a written reference concerning a candidate's ability, experience or character for submission to the trust.

8.2 Relatives of Members of Officers

8.2.1 Candidates making application for any appointment under the trust shall be required to disclose in writing whether, to their knowledge, they are related to any member or the holder of any senior office of the trust. Failure to disclose such a relationship shall disqualify candidates and, if they are appointed, shall render them liable to instant dismissal. Every member and Senior Officer of the trust shall disclose to the trust any relationship between himself and a candidate of whose candidature that member or Senior Officer is aware. The Chief Executive shall record any such disclosure in a register to be kept for the purpose which shall be open to inspection by any member.

8.2.2 Where the relationship of a candidate to a member or Senior Officer of the trust is disclosed, the principles of **Standing Order No. 5.13** headed "Interest of Chairman and Members in Contracts and Other Matters" shall apply.

PART IX TENDERING AND CONTRACT PROCEDURE

9.1 Duty to Comply with Standing Orders

The procedure for making contracts by or on behalf of the trust shall comply with these Standing Orders and shall comply with The Regional Health Authorities (Contracting and Services) Regulations, 1994 (which form Appendix 1 of these Standing Orders).

9.2 List of Approved Firms

9.2.1 The Supplies Officer will normally keep lists of approved firms from whom tenders and quotations may be invited. These lists include any firm which has applied for permission to tender provided the Supplies Officer is satisfied as to its technical and financial competence.

9.2.2 The (*Estates Manager or equivalent*) will normally keep lists of approved firms from whom tenders and quotations may be invited. These lists are compiled from firms which have applied for permission to tender and which have satisfied the (*Estates Manager or equivalent*) as to their technical and financial competence and shall be organised into trade and value groups appropriate to their business and size.

9.2.3 Where the Board or a Committee determines that an invitation to tender shall be selective the trust shall normally only use firms from the list maintained by these officers.

9.3 Competitive Tendering

The procedures for competitive tendering cover the following:

- Establishment of a Tender Committee
- Tenure of Committee Members
- Powers of Committee
- Quorum
- Meetings
- Emergencies
- Decisions of a Board or Committee
- Minutes
- Disclosure of Interest
- Invitation to Tender
- Submissions of Tender
- Tender fees, deposits

- Tender boxes
- Receipt of Tender
- Withdrawal of Tender
- Opening of Tenders
- Consideration of Tenders
- Acceptance of Tender
- Form of Contract
- Performance deposits, bonds
- Disposal of surplus a unserviceable goods
- Confidentiality of documents
- Disqualification and prohibition from being awarded a contract

These SOs should be adhered to at all times. The following Standing Orders regarding competitive tendering are in addition and should not be regarded as conflicting with them.

9.4 Admissibility of Tenders: Building, Engineering and Maintenance Works

9.4.1 If the number of tenders received is insufficient to provide adequate competition, or tenders are amended, incomplete, qualified or otherwise not strictly competitive, they shall be dealt with as the Board determines. Such decisions shall be recorded in the minutes with the reasons.

9.4.2 Late tenders shall be dealt with in accordance with **Standing Order 9.5.1**.

9.5 Admissibility of Tenders: Goods and Services

9.5.1 Late Tenders

No tender received after opening has taken place shall be considered. Subject to this overriding provision, technically late tenders, that is to say, those dispatched in good time but delayed through no fault of the tenderer shall be regarded as having arrived in good time. Other tenders received after the due time but before opening has actually taken place, may be considered if the members present at the opening in accordance with **Standing Order 9.4.1**, so decide.

9.5.2 Incomplete Tenders

Incomplete tenders, that is to say, those from which information necessary for the adjudication of the tender is missing, and amended tenders, that is to say, those amended by the tenderer on his own initiative either orally or in writing after the due time for receipt, shall not be considered unless the Supplies Officer or the Works Officer thinks that there are likely to be exceptional advantages, for example, where marked financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the good faith of the tenderer. The Tender Committee shall decide whether that tender or another shall be accepted or fresh tenders called for.

9.5.3 Clarification of Tenders

Necessary discussion with a tenderer to clarify technical aspects of his tender before the award of a contract shall not disqualify the tenderer.

9.5.4 Tenders Not Strictly in Accordance with Specification

If the lowest tender is not strictly in accordance with the specification, it may be considered provided that the Tender Committee considers that there are likely to be exception advantages (**as defined in Standing Order 9.5.2**) in accepting it. In these circumstances, the tenderer may be asked to revise his tender to conform to the specification and if he does so, his tender shall be dealt with in the same way as incomplete tenders (**Standing Order 9.5.2**).

9.6 Acceptance of Single Tenders

Where only one tender is sought or received, the Tender Committee shall, as far as is practicable, ensure that the price to be paid is fair and reasonable.

PART X MISCELLANEOUS

10.1 Signature of Documents

Any document which will be a necessary step in legal proceedings on behalf of the trust shall unless any enactment otherwise requires or authorises, be signed by the Chief Executive or by another Officer duly authorised by the trust for this purpose.

10.2 Urgent Decisions

The Chief Executive (or, in his absence, his nominated deputy) may take such urgent action as he may think fit in respect of any matter which would normally be considered by the trust provided that, prior to taking such action, he has consulted the Chairman of the trust and that the taking of such action is subsequently reported at the next meeting of the trust.

10.3 Interest of Officers in Contracts

If it comes to the knowledge of an Officer of the trust that a contract in which he, or any person related to him, has a direct or indirect pecuniary interest is proposed to be or has been entered into by the trust he shall at once give notice of the fact in writing to the trust. The provisions of this Standing Order shall also apply to any registered medical practitioner who fulfils a management advisory role to the trust.

10.4 Standards of Business Conduct

The provisions contained in the(*name*) about the standards of conduct expected of all staff when their private interests may conflict with their public duties and the steps which trust employers should take to safeguard themselves and the trust against conflict of interest should be regarded as binding on all staff.

10.5 Standing Financial Instructions

Standing Financial Instructions adopted by the trust shall have effect as if incorporated in these Standing Orders.

Annex 4: Specimen Employment Policies

(Name) Hospital Trust Employment Policies (Draft)

Contents

- I General
- II Recruitment Policies
- III Equal Opportunities Policies
- IV Performance Appraisal Policies
- V A Procedure for Dealing with Capabilities
- VI Grievance Procedures
- VII Disciplinary Policy, Procedures & Rules

I General

For the purpose of these Regulations, working days are Mondays to Fridays inclusive but excluding Bank Holidays and extra statutory days.

II Recruitment Policies

1. Objectives

To ensure that job vacancies will be filled as efficiently as possible with the best qualified candidate.

2. Policy

It is the policy of trusts to fill appointments by a process of open competition and to offer employment to the applicants possessing the best qualifications fitting the overall requirements of a particular job concerned. Trust recruitment policy covers both new entrants to the trust and advancement within the service of the trust. The policy also provides for proper controls on manpower complements.

3. Procedures

A job specification will be prepared for each post. This will include the experience and qualifications required. All medical, nursing and paramedical staff must be currently registered with the appropriate board, council or recognised licensing trust.

Criteria for selection of personnel of a high calibre:

- a) educational background including appropriate academic qualifications;
- b) previous experience;
- c) proven skills;
- d) desirable character traits, including satisfactory character references;
- e) employment references;
- f) competence and ability,
- g) potential for growth and development.

Where necessary, appropriate tests will be carried out to determine the suitability of persons to fill positions which require special professional or technical skills.

Not less than two references will be required from applicants for employment in the trust. The references should come from persons of some standing in the society who have known the applicant for at least five years.

Where the applicant had been employed previously, a reference will be required from the previous employer.

References from close relatives of applicants are not acceptable. The trust may waive certain of the requirements above in cases where the position to be filled is either of a professional or specialist nature and the application is supported by appropriate documentary evidence.

Employees who leave the service of the trust in good standing may be re-employed in suitable vacancies which may arise in the future. However, such employees may not claim seniority nor be entitled to benefits or privileges enjoyed based on previous service with the trust, as long as they had received benefits in respect of such services.

In addition to seeking candidates for positions internally, the trust will use external sources to obtain qualified personnel.

Three members of management shall sit as a Selection Panel to select persons for appointment to positions other than department heads and senior professionals. The Selection Panel shall comprise of an officer from the Human Resources Department as Chairperson and shall include the head of the department or unit where the vacancy exists and a member of management most likely to make a worthwhile contribution in the selection.

For positions of Head of Departments and where senior professional appointments are to be made, the Selection Panel should be increased to five top management personnel.

Background in employment and educational qualifications are to be verified prior to the offer of employment to an applicant.

The Human Resources Department will maintain a channel of communication through which new employees can obtain information, answers to questions and discuss problems with managers, supervisors or Human Resources Management personnel.

III Equal Opportunities Policy

1. Objectives

To ensure that trusts follow equal opportunity practices and to specify the actions trusts will take in order to promote equality of opportunity for all employees and all those who use its services.

2. Policy

It is the policy of the trust to ensure that no user of its service, or prospective or existing employee, receives less favourable treatment on the grounds of age, race, sex, colour, disability, nationality, ethnic origin, marital status, religion, sexual orientation and real or suspected HIV/AIDS infection.

The trust will aim to ensure that all employees are recruited, trained and promoted on the basis of their ability to do the job and the need to provide efficient, effective and appropriate services.

Any employee who feels he/she has been discriminated against may raise the matter by using the trust's Grievance Procedure. There will be no victimisation of any employee who makes or helps someone else to make a complaint.

The trust will investigate fully all reported incidents of alleged discrimination. Any employee who is believed to have discriminated against others will face disciplinary action in accordance with the trust's Disciplinary Procedure.

3. Responsibility for Policy Implementation

The trust Director of Human Resources is responsible for co-ordinating the implementation, monitoring and review of the equal opportunities policy and practice. All managers have a responsibility to ensure that this policy is communicated to all staff and is applied within their area of responsibility.

All employees will be expected to observe this policy and co-operate in its implementation.

4. Communication of the Policy

All staff will be notified of this policy. Reference will also be made to it in the staff handbook, in advertisements for staff, recruitment literature, training courses and materials.

5. Specifications

Advertising and Recruitment Literature

The trust will incorporate a statement of its commitment to equal opportunities in all its advertisements and in recruitment literature.

Selection Criteria and Tests

The trust will ensure those selection criteria and all tests are related to job requirements and are not unlawfully discriminatory, or culturally biased.

Staff Involved in Recruitment and Selection

All trust staff involved in appointment procedures must undergo basic training in fair and non-discriminatory methods of recruitment and selection.

The trust's policy and procedure on recruitment and selection will be reviewed by the Division of Human Resources of the Ministry of Health to ensure that it fully meets the requirements of this policy.

Discipline

Acts of direct or indirect discrimination will not be tolerated and will be treated as disciplinary offences to be dealt with under the trust's Disciplinary Procedure. This will apply not only to relationships between employees but also in relation to an employee's conduct towards patients, visitors, contractors or anyone else with whom the employee comes into contact in the course of his/her employment. Particular care will be taken to deal effectively with all complaints of discrimination and victimisation. It will not be assumed that such complaints are made by those who are unduly sensitive.

Grievances

Grievances arising from issues contained in this policy will normally be processed through the trust's agreed Grievance Procedure. It is recognised, however, that employees often find it difficult to approach their immediate superiors in cases involving discrimination. The first point of contact in instances of this nature may therefore be personnel department or a Trade Union representative.

Training, Promotion and Career Development

The trust will not discriminate in the provision of training. Appropriate training will be provided to enable staff to perform their jobs effectively. Additionally, the trust will provide further training to ensure that disadvantaged groups have equal opportunities for promotion and career development.

General areas of training will include:

- a) the trust's policy, employees' own personal liability and the nature of discrimination;
- b) communications training;
- c) general Equal Opportunities awareness training relating to employment and service provision;
- d) an Equal Opportunities module will continue to be included in the induction programme for new staff;
- e) the attention of staff will be drawn to training opportunities as they arise.

IV Policy on Performance Appraisal

1. Objectives

The Hospital trust's policy on Performance Appraisal is designed to:

- a) maintain or improve the job satisfaction and morale of each member of staff by letting him or her know that his or her superior is interested in his or her job progress and personal development;
- b) pinpoint and correct bad work habits;
- c) serve as a basis for promotions and transfers when the abilities of staff are objectively assessed;
- d) provide an opportunity for each member of staff to discuss job problems and interests with his or her superior;
- e) assist an employee's superior in determining the employee's potential for further advancement and development;
- f) advise the employee of his or her strengths and weaknesses and what is expected of him or her in his or her position;
- f) build and strengthen the superior and subordinate relationship.

2. Procedures

Trusts will undertake regular reviews of employees performance and potential for advancement. The procedures developed for this will be fair and explicit and the results will be conveyed to the employee. Employees will be encouraged to participate in these reviews, to discuss the results with the relevant trust Human Resource personnel during interview and will have the right to submit their reaction to the review.

Reviews will cover:

a) Employee Strong Points: Every employee has strong points that qualify him or her for his or her current position, e.g. intelligence, proper attitude, enthusiasm, excellent job knowledge, professionalism. devotion, loyalty. etc.

b) Employee Weak Points: Points that may lead one employee from growing within his or her job or from being promoted, e.g. lacks job knowledge, unwilling to accept responsibility, no disciplinary control, constantly late for work, excessive absenteeism, unable to follow instructions, etc.

c) Recommendation for Improvement: Mutual goals are to be set for employees to reach before the next performance appraisal. The recommendations should specifically state methods to correct weaknesses or prepare employees for future promotion.

d) Employee Potential for Increased Responsibility: Indicate where employee could be ready for further responsibility, e.g. can the employee handle larger workloads or duties in a higher position? Do employees possess the professionalism and skills and exhibit eagerness to accept greater responsibility to make them promotable?

Superiors should indicate the kinds of positions staff would be able to handle effectively after a period of probation. An employee's skills that are not currently being used in an employee's current job should be identified (including book keeping, accounting, computer use etc.).

Reviews will avoid:

a) The "Halo" effect - the tendency to overrate a favoured employee because he/she:

- i) has done good job in the distant past
- ii) has a pleasing manner or personality and/or always agrees with superiors
- iii) does an outstanding job a day or a week prior to being appraised
- iv) is a glib talker, has an impressive appearance or an advanced academic degree
- v) has a good paper record rather than accomplishments
- vi) has no complaints and is always saying everything is going well.

b) The tendency to apply the same rating to all employees in a group.

c) The tendency only to see the best or the weakest points in employees without recognising that there are weaknesses in the best of us and some strong points in the poorest of us which could be developed.

3. Classification of Levels of Performance

Unsatisfactory:

Applicable where an employee's performance is constantly unsatisfactory and does not measure up to the requirements of the job. Improvement is necessary. Job assignments are not accomplished in a timely manner and are generally incomplete.

Checks on assignments need to be made consistently. Directions have to be given in the manner in which work must be performed.

Fair:

Applicable where an employee's performance occasionally meets the standards required for the job. Performance of duties is slightly below what is considered acceptable. Improvement is necessary in many material aspects of the job. Assignments are not generally completed on time and are lacking in several respects. Deficiencies have to be pointed out from time to time. There is lack in understanding many of the job functions and the overall objectives of the job.

Good:

Employee's performance of most duties is adequate. Consistently meets most standards in an acceptable manner. Rarely exceeds the required standard. Some improvement may be necessary in certain aspects of the job. Assignments are generally completed on time and in a comprehensive manner. Directions and review of work are necessary for completeness. Understands most duties and overall objectives of the job. Is able to make meaningful contributions within his or her sphere of operations.

Very Good:

Employee performs all duties and carries out responsibilities in a comprehensive and efficient manner. Little room for improvement. Ability to complete assignments on schedule. Work is consistently above standard. Very occasionally standard of work is not met. On the other hand, occasionally work is far above acceptable standard. Generally works independently and work is reviewed for progress. Handles assignments in a professional manner. Makes worthwhile contributions even outside his or her area of operations.

Outstanding:

Work is performed consistently far above standard required. Duties are performed and responsibilities carried out in an efficient and comprehensive manner. Time, manpower and funds where applicable, are all used efficiently in carrying out assignments. Considered highly knowledgeable by superiors, peers and subordinates alike. Advice and assistance are sought out from time to time. Consistently makes significant contributions to the overall effectiveness of his or her trust, department or unit. Typically accurate, timely, decisive and comprehensive in carrying out assignments. Aggressively seeks to expand scope of activities and always ready to assume additional responsibility.

4. Factors to be Appraised

Specific Review Functions

- a)ability to get along with others
- b)acceptance of responsibility
- c)appearance
- d)attendance and promptness
- e)attitude
- f)ingenuity
- g)initiative
- h)knowledge of the job
- i)judgement
- j)promptness in completing assignments
- k)quality of work
- l)output
- m)motivation
- n)discipline
- o)self confidence

V Procedure for Dealing with Capability

1. Objective

The purpose of this procedure is to establish a fair process for the review and resolution of problems concerning an employee's capability to perform his/her work.

2. Definition

2.1 Capability is assessed by reference to the skill, aptitude and knowledge of the employee in regard to the job they are employed to perform. This procedure is designed to assist where poor performance indicates a lack of ability/skill.

2.2 It does not cover incapability due to ill health nor does it cover failure to make use of abilities through laziness or negligence.

2.3 Where poor performance is considered to be due to an unwillingness to carry out duties properly, rather than inability to do so, it is appropriate to follow disciplinary procedures for misconduct. Where incapability is due to ill health the sickness absence procedure will apply.

2.4 Where the circumstances of the case suggest a combination of factors such as capability and unwillingness, the principle reasons for action should be selected and the appropriate procedure used. The use of this procedure does not preclude the use of any other procedure where it would be appropriate.

3. Stage of the Procedure

3.1 Informal Stage

Trust managers will constantly monitor the performance of all their staff. Where that performance is deemed to be inadequate, it will be necessary to set out in a clear and understandable way, where and how the performance falls short of the required standard and how and what improvements are expected.

The manager should meet with the member of staff to ensure a clear perception of the role to be undertaken so that the employee is clear of what the manager requires. Clarification of that role should be given to the employee in writing.

If these measures prove unsuccessful in gaining the required standard, managers should move to the First Formal Stage, after seeking advice from the Human Resources Department and advising the employee of the intention to do so.

3.2 First Formal Stage

Managers should advise the Human Resource Department of their concerns. These may well be in the following areas.

- Clear, specific examples of failings, e.g. inaccuracy, poor results, slow work rate etc.
- Valid criticisms about the employee's attitude /interpersonal skills.
- Direct observations of the employee by the manager.

In some cases it is difficult to prescribe accurately the actual standards required. The test in areas such as this is always one of reasonableness.

Where it is agreed between the manager and the Human Resource Department that the failure is such that this procedure should be used then the procedure will be as follows:

- a) A formal meeting will be held involving the manager and the member of staff and a trade union representative if requested - in which case a member of the Human Resource Department should also be present.
- b) Prior to the meeting, the manager will advise the member of staff in writing of the shortcomings in performance that have led to the meeting and that the meeting is being held within the Capability Procedure.

The meeting will allow a full discussion of the shortcomings to establish:

- any given reason for the deficiency
- agreement on future standards to be attained (these should be at an obtainable level within the time scale set)
- the support available to help achievement i.e. training
- the time scale for monitoring - this should be sufficient to reasonably allow for the improvement required but not be unduly prolonged.

The agreed points will be recorded and it will be made clear that continuing failure to achieve a required standard may eventually lead to dismissal.

Following the commencement of the First Formal Stage it is important that the manager keeps the Human Resource Department and the employee up to date with progress achieved (or the lack of it). Review meetings should be held regularly.

If and when it becomes evident to the manager that the required standards are not met and are unlikely to be met within the prescribed timescale, then it may be necessary to use the Second Formal Stage. Before doing so the manager and the Human Resource Department should give full consideration to:

- the steps taken to encourage improvement
- the levels of improvement attained
- any extenuating circumstances identified
- the possibility of alternative employment if appropriate.

3.3 Second Formal Stage

If the Second Formal Stage is to be used, the employee will be given at least 5 working days notice of the meeting, informed of the opportunity to be represented and provided with written notification of the shortcomings.

At the Second Formal Stage meeting, the employee should be reminded of the details of the Informal Stage and the First Formal Stage and the targets set/agreed.

A full discussion should take place on the levels of current performance, shortcomings and the reasons for failing.

Additionally any alternative employment available should be discussed and recorded. The Human Resource Department may offer assistance in helping an employee seek such an alternative internal job. Where a suitable offer is refused this should be recorded.

At the end of the Second Formal Stage meeting the following should have been agreed/set:

- new objectives detailing required performance levels
- a time scale for achievement (this should not normally exceed 4 weeks)
- any support or training to be provided.

It should be made clear that failure to meet the required standards will result in dismissal.

3.4 Final Stage

Where, after discussion with the Human Resources Department, it is agreed to proceed to the Final Stage, at least 5 working days notice should be given of the meeting. The employee should be advised of the right to representation.

At the meeting, the employee should be advised of the continuing failure to reach acceptable standards and full details should be given. Any extenuating circumstances should be considered.

Where it is decided to dismiss this should be on the grounds of capability. The employee should be dismissed with notice and informed of their right to appeal, in line with the appeals procedure.

VI Grievance Procedure

1. General

The Grievance Procedure of the Hospital trust gives all employees the right to seek redress of grievances relating to their employment and encourages such grievances to be settled promptly and as close as possible to the point of origin. It aims that management should do everything reasonable and possible to ensure good working relationships and an efficient and contented workforce.

2. Terms of Reference

Grievances may be individual or collective and may relate to the application or interpretation of existing agreements or contracts of employment, or to claims by employees or proposals by management about local terms and conditions of employment, working practices or job descriptions. The policy differentiates between collective grievances and individual grievances but in general they are dealt with through the same procedure. Reference to 'employee' in this document may also mean 'employees'.

3. Collective Grievance

A collective grievance is one which directly affects more than one employee and may involve more than one department, or more than one staff Organisation or trade union. Where a collective grievance affects more than one department, the grievance shall first be raised with the manager or employee who is responsible for all those staff involved. This may mean referral to a higher level of trust in the procedure.

4. Employee Representation

The employee may choose to be accompanied by a Trade Union/Staff Organisation Representative or a colleague at all stages in the procedure. The Trade Union/Staff Organisation Representative may choose to handle the employee's grievance either with them or for them. For the purposes of this document a Trade Union Representative is a Shop Steward, Branch Officer, Full-time official or a representative of a professional Organisation.

5. Consultation with Personnel

The departmental or unit head, manager or employee who received the grievance shall seek the advice of the trust Human Resources Department at every stage in the procedure. A Human Resources Department representative will attend the Grievance Hearing as appropriate.

6. Stages in the Procedure

A grievance should initially be raised at the lowest appropriate stage in the procedure within the employee's own department. Generally, this would mean that the employee would raise the matter with his or her immediate superior. It is important that any grievance is dealt with quickly and as early as possible within the time limits given. However, this time limit may be extended by mutual agreement at any stage.

The employee must be given the opportunity to discuss the issue with the appropriate officer at each stage of the procedure. Both the employee and management may produce evidence from witnesses. At every stage, including Stage One when the matter is referred to the Head of Department, grievances must be put in writing by the employee or a representative acting on his or her behalf. A grievance must be considered at each stage in the procedure. In the event of a grievance originating at the level of Stage Three, it may automatically be referred to Stage Four in the procedure.

Supervisory Level

In some instances it will be possible for an employee's immediate superior or supervisor to deal with minor problems or grievances. An employee may, therefore refer the matter to this person, otherwise the procedure may be invoked initially at Stage One.

6.2 Discussion

The Employee is advised to approach his or her manager for a discussion on any grievance matter. The Manager, for his part, should endeavour to resolve the issue by talking it through.

6.3 Stage One

An Employee has the right to raise an issue of grievance in writing with his Head of Department. If the Head of Department is a person named at Stage Two, or Stage Three of this procedure, then the procedure should start at that stage as appropriate.

The issue should be heard and considered by the Head of Department within 5 working days of it having been referred to him or her.

A reply recording the decision shall be given in writing to the employee after the hearing/discussion. Management should ensure that this is not delayed and it should normally be sent immediately with a copy to the representative. Every effort should be made to resolve the issue at this level.

6.4 Stage Two

If agreement cannot be reached at Stage One of the procedure, the employee has the right to raise the issue in writing with the hospital or primary care unit manager. The issue should be discussed by the departmental head, unit administrator, director of nursing services or other relevant manager within 5 working days of it having been referred to him or her. The procedure for the hearing and the reply to be given in writing will be as in Stage One.

6.5 Stage Three

If agreement cannot be reached, the issue shall be referred to the appropriate trust Director or General Manager who should consider it with the departmental head, director of nursing or other relevant manager concerned and also with the trust Human Resources Department. The matter should be discussed within 10 working days. The procedure for the hearing and the reply to be given in writing will be as in Stage One.

6.6 Stage Four

Where the Stage Three procedures fail to resolve a grievance, there is a right to seek a hearing before a panel of the Hospital Trust. This should be put in writing to the trust Human Resources Director who will arrange for a panel to meet as soon as possible, within a five-week period, on a date agreed with the appropriate Trade Union.

7. Details of Proceedings

To avoid any misunderstanding, differing interpretation and future grievances and in case the matter is referred to a higher level - an accurate record of the grievance hearing/discussion, the agreement decision and the action to be taken will be placed on the employee's personal or the appropriate departmental file. A copy should be given to the employee and his or her representative.

8. Failure to Resolve a Grievance

Grievances, which are not resolved internally by the trust procedure, may, in some instances, be referred to the (*Ministry of Labour or the Industrial Court or equivalent*).

Disciplinary Policy, Procedure and Rules

1 Introduction

The aim of this section is to formulate arrangements that will ensure a fair, effective and consistent method of dealing with disciplinary matters throughout the trust.

Each manager has responsibility for ensuring that all members of staff have been made aware of the Disciplinary Procedure and Rules of the trust. Each member of staff should be informed of the standards of conduct and work performance expected in their job. Reference to this document will be made for all new staff who will be encouraged to familiarise themselves with its content.

2 Application

The procedures and rules apply to all staff employed by the trust including medical and dental staff on matters concerning their personal conduct and general work performance but excluding staff of independent contractors providing a contract for service to the trust.

Matters relating to the professional conduct or competence of medical and dental staff will continue to be dealt with in accordance with the procedures laid down by the Ministry of Health. In cases of disability, including drugs or alcohol addiction of medical staff the procedures should be considered along with those of the Ministry of Health. Management must provide employees with 5 working days notice to attend meetings.

3 Representation

In all cases where action under **Sections 9** and **10** of this document is being implemented the employee has the right to be represented by his or her trade union or professional association, or to be accompanied by a colleague or a friend not acting in a professional capacity. It is the responsibility of each employee to arrange representation which should meet the dates set for a hearing.

4 Representative of a Trade Union or Staff Organisation

In cases where disciplinary action may be taken against an accredited representative of a recognised trade union or staff Organisation, the trust Human Resources Department must always seek to discuss the details of the case with a full-time official of the Organisation concerned.

5 Counselling

Counselling is not part of the formal disciplinary procedure and as such will not be formally recorded on the personal file, although a note should be made to record that counselling has taken place. Counselling will take place on an informal basis and would be relevant to minor misconduct, carelessness or incompetence (see **Capability Procedure**). The objective of such discussion is to remedy the matters of concern - disciplinary action should follow only where such problems persist. A member of staff who fails to respond to counselling should be made aware that this could lead to disciplinary action.

6 Duration of Warnings

Where an oral warning is issued it will remain in force for six months. Where a written warning is issued under the procedure, it will remain in force for a period of 12 months from the date of issue and subject to review, may be removed from the file, with the exception of warnings involving patient-related matters which will remain in perpetuity.

7 Suspension from Duty

Suspension from duty is not, in itself, a disciplinary measure and will normally be on full pay, other than in exceptional circumstances. Suspension must not be used to imply guilt or misconduct, the purpose being to investigate the full circumstances of the allegation which has been made. By mutual agreement, suspended staff may be deployed on other related duties until the investigations are complete. Local representatives of the appropriate staff Organisation will be informed of a suspension.

Trust to suspend from duty will be vested in the trust Human Resources Department. In the absence of the appropriate manager, the most senior manager on duty and at night/weekends the duty officer may suspend on full pay. Such action must be reported to the employee's manager and the Human Resources Departmental the earliest opportunity.

An employee who is suspended must be informed clearly of the reason. Following such action written confirmation of the action and reasons must be sent to the employee as soon as possible. Continuation of suspension is not automatic and suspension should be reviewed if it extends to six weeks in the first instance and thereafter at four weeks intervals.

8 Stages of Disciplinary Action

The stages of disciplinary action are set out below. On occasion, it may be necessary, according to the severity of the offence, to move to a written warning or dismissal where the previous stages of the procedure would be seen to be inappropriate.

(a) Oral Warning

(b) No Right of Appeal: Note of Warning kept on employees files 6 months

(c) Failure to Respond: First Written Warning

(d) Right of Appeal by writing to the trust Director of Human Resources within 15 working days.

(e) The record of the interview/hearing including a statement of the expected standard of conduct and the consequences of failing to reach that standard must be sent to the employee and his or her representative within 7 working days. The record will be on the employees file for 12 months.

(f) Regular Reviews where indicated. Confirmed in writing and kept on file.

(g) Failure to Respond: Final Written Warning

(h) Right of Appeal by writing to the trust Director of Human Resources within 15

working days.

(i) The record of the interview/hearing including a statement of the expected standard of conduct and the consequences of failing to reach that standard must be sent to the employee and his or her representative within 7 working days.

The record will be on the employees file for 12 months.

(j) Regular Reviews where indicated. Confirmed in writing and kept on file.

(k) Failure to respond: Dismissal

(l) Right of Appeal by writing to the trust Director of Human Resources within 15 working days.

(m) The record of the interview/hearing must be sent to the employee and his or her representative within 7 working days. The record will be on the employees file.

9 Investigations

Investigation will be carried out into the incident, witnesses interviewed and statements may be taken, where appropriate.

Where it is seen to be appropriate, an investigatory meeting will be held as a result of which action may or may not ensue. Copies of statements to be used will be forwarded to the employee prior to the meeting.

Employees will have the right to trade union representation at an investigatory meeting.

Where, following an adjournment, it is decided that disciplinary action is appropriate as a result of an investigatory meeting, the member of staff concerned will be informed of the allegation, that disciplinary action will be taken and asked whether they have anything further to add to their case including mitigating circumstances. After a further adjournment the procedure will assume disciplinary status at the appropriate point in the format in Appendix B.

10 Format of a Disciplinary Hearing

The disciplinary hearing will take place in accordance with the format laid out below:

An invitation to interview should make clear the nature of the allegation and enclose copies of any supporting statements which will be referred to by management in the process of decision making. At least 5 working days notice should be given of the interview.

Management should explain the format of the interview and introduce those present, making clear that the interview is a disciplinary one. Management should state the nature of the allegation and outline the supporting evidence.

The employee or his/her representative should be invited to state their case, ask questions, present statements if appropriate (which should be provided to the Human Resources Department at least one working day prior to the interview) and offer any mitigating circumstances.

Management will have the discretion to ask anyone who has made a statement to attend if such attendance would assist in clarification before any decision is made.

After full questioning and discussion management should summarise the main points concerning the offence, the main points raised by the employee (and if necessary any points which are to be verified).

The interview should then be adjourned to enable management to consider all the matters raised and check any points which may require verification. If facts are disputed management should decide on the balance of probability, which version is true.

The interview should be reconvened to inform the individual of the decision and the penalty if any. Before deciding on a penalty management should consider:

- (a) The gravity of the offence.
- (b) The penalty applied in similar cases.
- (c) The individuals general record and disciplinary record
- (d) Any mitigating circumstances
- (e) Whether the proposed penalty is reasonable in all the circumstances

Where the penalty involves a "warning" management should explain clearly:

- (a) How long the warning will last.
- (b) The right of appeal (if appropriate) and the steps required to lodge it.
- (c) What improvement is expected
- (d) The consequences of failure to improve.

Where dismissal is involved (and where appropriate) the right to notice and compensation in lieu of notice should be explained.

The offence, the decision, reasons for the decision, any improvement period, consequences of further misconduct and appeal details should all be confirmed in writing and conveyed to the employee within 7 working days.

11 Summary Dismissal

Summary dismissal is dismissal without notice and will only be used in cases of gross misconduct that include:

Assault

Assault on a patient, fellow employee or member of the public. This includes fighting, physical or serious verbal abuse.

Corrupt Practices

Receipt of money, goods or pecuniary advantage in respect of any services rendered.

Defrauding the trust

Any deliberate attempt to defraud the trust or a member of staff or a patient or member of the public. This includes falsifying of time records and particularly clocking offences.

Incapacity through Drink or Drugs

Incapacity to perform normal duties owing to the consumption of alcohol or misuse of drugs.

Negligent Behaviour

Any action or failure to act which seriously threatens the health and safety of a patient, employee or member of the public.

Malicious Damage

Intentionally causing any damage to the property or reputation of the trust, patients, employees or members of the public, including breaches of confidentiality and trust.

Unauthorised or Unlawful Possession of Property

Any unauthorised or unlawful possession of property of the trust, patients or members of the public.

Sexual or Racial Harassment

Harassment is defined as: "Repeated, unreciprocated and unwelcome comments, looks, actions suggestions or physical contact that is found objectionable and offensive and that might threaten an employee's job security or create an intimidating environment".

12 Criminal Action

Where events giving rise to disciplinary action are the subject of police investigation or legal process, management reserves the right to take disciplinary action. It is the duty of the employee to inform the employer if criminal proceedings are being pursued for an offence/s committed outside the working environment.

A criminal offence (or alleged criminal offence) outside employment may lead to dismissal in certain circumstances. The main consideration will be whether the situation is one that makes the individual unsuitable for his/her type of work, or unable to satisfactorily fulfil their contractual obligations. Misconduct outside the trust where it has a direct bearing upon the trust's operation or reputation will also render a member of staff liable to disciplinary action, including dismissal.

13 Right of Appeal

Employees who are aggrieved by the disciplinary action which results in the issue of a Written Warning or Dismissal, have the right of appeal against such action to the panel set up by the trust Board.

An appeal should be addressed to the Director of Human Resources in writing within 15 working days of the date of the letter confirming the action taken, outlining in full, the employee's case for Appeal.

14 The Appeal Panel

The appeal panels will be constituted as follows:

14.1 Against a Written Warning

A panel drawn from a pool of senior managers who will have had no previous involvement with the discipline of the member of staff concerned, together with a senior Human Resources Department manager.

14.2 Against a Dismissal

A panel of 3 plus the Director of Human Resources or his/her nominated representative who will attend and act in an advisory capacity. The panel will be chaired by a non-executive Board member with employer status. The panel members will have had no previous involvement with the case.

14.3 Hearings

There will be dates throughout the year set aside for the purpose of hearing appeals against dismissal. Once an appeal has been lodged the case will be allocated for the next available date. Every effort will be made to hear appeals within 3 months of their being lodged.

15 Procedure for Appeals

The management and the employee should both submit a written Statement of Case, to be received at least 10 working days before the hearing.

The chair will have the discretion to ask anyone having made a statement to attend if the chair believes such attendance will assist in clarification. Such witnesses are normally open to questions from the Appeal Panel only.

The management will be asked to state the background to the case and give the reason(s) for the original decision.

The appellant (or representative) puts their case explaining why he/she is appealing.

Any evidence should have been provided prior to the hearing and all parties (but particularly the appellant) given the opportunity to comment on it. Discussion and questions to/from all parties should be encouraged.

The chair of the panel should then summarise the evidence and facts from both sides before adjourning to reach decisions.

The chair of the panel should then call all parties back to the room to announce the decision and to give the reasons for that decision. It should be made clear that the decision is final. The decision and reasons should be confirmed in writing and conveyed to the employee within 10 working days.