The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 3 September, 2015 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – P. Harrison, A. Baines**		D Badger	To Note	9.30
2.	**Declarations of Interest**		D Badger	To Note	9.30
3.	**Announcements**		D Badger	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 2 July 2015	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 2 July 2015	Enclosure 2	D Badger	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D Wardell	To Note & Discuss	10.00
	7.2 Nursing Staffing Report	Enclosure 5	D Wardell	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	D Wulff	To Note & Discuss	10.20
	7.4 Workforce and Staff Engagement Committee Exception Report	Enclosure 7	A Becke	To Note & Discuss	10.30
	7.5 Audit Committee Exception Report	Enclosure 8	R Miner	To Note & Discuss	10.40
	7.6 Audit Committee Annual Report	Enclosure 9	R Miner	To Note	10.50
	7.7 Complaints Report	Enclosure 10	G Palethorpe	To Note	11.00
	7.8 Integrated Dashboard	Enclosure 11	P Taylor	To Note	11.10
	7.9 Review and Approval of Trust Constitution	Enclosure 12	G Palethorpe	To Approve	11.20
	7.10 Annual Plan Quarter 1 Updates	Enclosure 13	P Taylor	To Note	11.25
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 14	J Fellows	To Note & Discuss	11.35

9.	**Any other Business**				11.45
10.	**Date of Next Board of Directors Meeting** 9.30am 3 September 2015, Clinical Education Centre		D Badger		11.50
11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		D Badger		11.50

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 2nd July, 2015 at 9:30am in the Clinical Education Centre.

Present:

David Badger, Chairman
Richard Miner, Non Executive Director
Jonathan Fellows, Non Executive Director
Paul Taylor, Director of Finance and Information
Ann Becke, Non Executive Director
David Bland, Non Executive Director
Paula Clark, Chief Executive
Paul Harrison, Medical Director
Paul Bytheway, Chief Operating Officer

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Julie Bacon, Chief HR Advisor
Glen Palethorpe, Director of Governance/Board Secretary
Yvonne O'Connor, Deputy Chief Nurse
Jeff Neilson, Head of Research and Development

15/073 Note of Apologies and Welcome

Apologies were received from Dawn Wardell, Anne Baines and Doug Wulff.

15/074 Declarations of Interest

There were no declarations of interest.

15/075 Announcements

The Chairman notified the sad news regarding a member of nursing staff that had died on the evening of Tuesday, 30th June, 2015. Hugh Davies had been a shift lead on B6 and had worked for the Trust for 25 years. He was very highly thought of by patients and colleagues and will be sadly missed. A minutes silence will be held at midday on Monday, 6th July, followed by a Eucharist Service in the Prayer Room at 12.30pm. A book of remembrance will also be opened. The Board passed on condolences to the family, friends and colleagues of Hugh.

15/076 Minutes of the previous Board meeting held on 4th June, 2015 (Enclosure 1)

The minutes of the previous meeting were approved by the Board as a true and correct record of the meetings discussion and signed by the Chairman.

15/077 Action Sheet, 4th June, 2015 (Enclosure 2)

15/077.1 Chief Executive's Report – Junior Doctors

The Chairman confirmed that he will write to Andy Whallett.

All other items appearing on the action sheet were noted to be complete, for update at a future Board meeting or appeared on the Board agenda.

15/078 Patient Story

Liz Abbiss, Head of Communications and Patient Experience presented the patient story. The story related to a patient who had suffered three strokes over previous years and had experienced three spells of care. During his previous episode of care, three years earlier, he felt that he had experienced poor care from the Trust. His latest episode of care had been a very different experience for the patient and he was extremely grateful and appreciative of the care received. Mrs Becke, Non Executive Director, confirmed that it would have been useful to hear about the experience of his family during his latest episode of care as this is why he had previously been disappointed by the care provided.

The Chairman and Board noted the patient story and the lessons learned.

15/079 Chief Executive's Overview Report (Enclosure 3)

The Chief Executive presented her Overview Report, given as Enclosure 3, including the following highlights:

- **Nursing Times Awards:** The Board noted that three members of staff had been shortlisted for an award.

- **Deanery FY1 Visit:** Feedback had been very positive.

- **JAG Accreditation:** The Trust had received full JAG accreditation.

- **Friends and Family Test Performance:** Presented in the papers for information. The Chairman asked if the Trust was intending to push again within clinical areas. The Chief Executive confirmed that staff will be continually reminded to pursue patients for feedback. The Board noted that Community Services had received 100% recommendation. The Chairman confirmed that he would inform the CCG Chair of this excellent news.

- **Department of Health Visit to the Emergency Department 23rd June 2015:** The Chief Operating Officer updated the Board on the very positive feedback following the visit.

- **Vanguard Bid:** Discussed in private session.

- **Black Country Alliance:** To be discussed on the private agenda.

- **Carter Review of NHS Operational Productivity:** Report to be received later in the year.

The Chairman and Board noted the report and agreed to write to the 3 members of staff shortlisted for a Nursing Times Award to congratulate them on behalf of the Board.

The Board noted the Deanery update and that the Trust would continue to push on the ED Friends and Family test results and noted the DoH visit feedback.

The Chairman to notify the CCG Chairman of the excellent Community Services Friends and Family test performance.

A letter to be written to the staff shortlisted for a Nursing Times Award, congratulating them on behalf of the Board.

15/080 Patient Safety and Quality

15/080.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Deputy Chief Nurse presented the Infection Prevention and Control Exception Report given as Enclosure 4, including the following points to note:

MRSA: No cases to report.

C.Diff: In May the Trust exceeded the target trajectory by one case. There had been one case to report for June which brings the Trust back in line with trajectory. There had been two deaths with C.Diff noted on the death certification, these will be reported as serious incidents and in depth RCAs completed.

Norovirus: Continued good performance.

The Medical Director confirmed that he is keen to improve antibiotic stewardship and is meeting with staff to progress this.

The Chairman and Board noted the positive report and that the Trust is within trajectory at Quarter one for C.Diff, and the continued good performance for MRSA and Norovirus.

15/080.2 Nurse Staffing Report (Enclosure 5)

The Deputy Chief Nurse presented the Nurse Staffing report given as Enclosure 5.

There had been issues in Maternity around the midwife to birth ratio and the Board noted that the risks were due to vacancy level and will continue until September. The Trust had recently undertaken a successful recruitment drive for midwives and this will help the position. The Chief Executive confirmed that the Board needs to understand how the case mix had moved.

The Trust was moving to an electronic system for collecting data from July.
No red alerts had been identified on the staffing sheet.

The Director of Finance and Information commented that it was positive to see that the graph at the Appendix contained the most green (safe) areas since the Board had started to receive the report.

The Chairman and Board noted the positive report and graph and list of mitigations together with the issues in Maternity.

15/080.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)

The Director of Governance/Board Secretary tabled the Clinical Quality Safety Patient Experience Committee Exception Report, given as Enclosure 6. The Director of Governance/Board Secretary was looking at the timing of the Board and its Committees. The Board noted the following key areas:

- Positive assurances were received around Stroke Swallowing Screening, National Clinical Audits, performance of key quality indicators, mortality review process, reporting and dealing with SI's and National Children's Inpatient and Day Case survey. The Survey will be discussed at the Patient Experience Group and reported back to the Clinical Quality, Safety and Patient Experience Committee

- A list of decisions and items approved by the Committee were noted in the report.

- A number of actions were scheduled to be presented to the Committee and these were also noted by the Board.

The Chief Executive confirmed that in relation to the survey the Trust will be undertaking further work on communication.

The Chairman and Board noted the report and assurances received and noted the follow up regarding surveys and decisions and actions scheduled to be presented to the Committee and thanked Mr Bland, Non Executive Director, for Chairing the meeting.

15/080.4 Workforce and Staff Engagement Committee Exception Report (Enclosure 7)

Ann Becke, Committee Chair, presented the Workforce and Staff Engagement Committee Exception Report, given as Enclosure 7, the following key issues were noted:

- Staff Health and Wellbeing Group: Currently being established.

- Trust People Plan: Approved by the Committee.

- National Staff Survey Results/Staff Friends and Family Report: The Trust is placed in the top 25% nationally.

- Annual Appraisal Review: The Trust exceeded the 85% target, now raised to 90%.

- Deep Dive on Sickness: Top three causes identified.

- Mandatory Training – Annual Compliance Report: Compliance had increased by 2.7%.

- Mandatory Training Future Development Report: The Trust is aligning its mandatory training to the national Skills for Health Core Skills Training Framework.

The Chairman and Board noted the report and the positive staff survey results, good news on appraisals and mandatory training. The Chairman noted the work being done to improve sickness rates.

15/080.5 Approval of Standards of Business Conduct Policy (Enclosure 8)

The Director of Governance/Board Secretary presented the Approval of Standards of Business Conduct Policy, given as Enclosure 8.

Minor amendments had been made to the policy and forms and the Board noted that the report had been presented to the Audit Committee.

The Board approved the policy.

15/080.6 Mortality Report (Enclosure 9)

The Medical Director presented the Mortality Report given as Enclosure 9.

The Board noted that the Trust is increasing its target for the mortality tracker system.

With respect to the increase in crude mortality, graph on page 13, the Trust appears in the middle of the plot and the Board noted no cause for concern.

The Board noted that SHMI and HSMR are on a downward trajectory, detailed graphs were on page 6 of the report.

The Medical Director confirmed that the Trust is developing its mortality review process.

The Board noted page 8 of the report providing an update on mortality alerts. The Trust was awaiting a response from the CQC for two alerts.

The Medical Director confirmed that the Nick Black report was still to be published.

The Chairman and Board noted the annual report, noted that a regular mortality report is presented to CQSPE and also that the Chair, Chief Executive and Non Executive Director attend regular mortality/morbidity meetings. The Chairman noted the downward trends in the two indicators used.

15/080.7 Quality Accounts (Enclosure 10)

The Deputy Chief Nurse presented the Quality Accounts, given as Enclosure 10.

The Board noted that the report had now been submitted to Monitor.

The report included the External Auditor's review. The review concluded that the report and data consistency meets requirements. There were six recommendations with minor issues detailed on page 20 of the report.

The Quality Report also details the priorities for the next year.

The Chairman and Board noted the Quality Accounts and External Auditor's Review.
The Board agreed the reporting arrangements as set out on pages 20 to 22 of the report.
The Board noted the Junior Doctors Survey and quality outcomes.

15/080.8 Corporate Risk Register and Board Assurance Framework Report (Enclosure 11)

The Director of Governance/Board Secretary presented the Corporate Risk Register and Board Assurance Framework Report, given as Enclosure 11.

The Board noted the revised format of the report.

A summary of the Corporate Risk Register was included and records the Trust's key risks linked to each of the Trust's six objectives.

Key divisional risks were presented at page 5 of the report.

The second part of the report lists assurance against risks around delivery of each objective. Positive assurances and gaps in assurance are identified.

Mr Bland, Non Executive Director, confirmed that it was a comprehensive report. He asked about the relative difference in some of the risk ratings. The Director of Governance/Board Secretary confirmed that this will be progressed through the Risk and Assurance Committee.

Mr Miner, Non Executive Director, confirmed that he will meet with the Director of Governance/Board Secretary outside of the meeting as Chair of the Audit Committee to go through the report. He particularly wanted to look further at the Trust's Strategic Objectives.

Mrs Becke, Non Executive Director, asked if Vanguard should appear on the Corporate Risk Register. The Director of Governance/Board Secretary confirmed that this is being discussed at the Risk and Assurance Group and will be debated again in the next meeting. The Chairman confirmed that there is concern around this issue and this was noted by the Board.

The Chairman and Board noted the report and the increased risk around cancer and workforce, noted the new risks and emerging risk around Vanguard. The Chair of Audit Committee and Director of Governance/Board Secretary will meet to review assurances received by Committees.

Director of Governance/Board Secretary and the Chair of the Audit Committee to meet to review assurances.

15/080.9 Research and Development Report (Enclosure 12)

The Head of Research and Development presented the Research and Development Report, given as Enclosure 12.

The Head of Research and Development confirmed that funding had changed to activity based for research.

All funding had been received from the Cancer Research Network or commercial trials and not from the Trust.

The Medical Director stated that the Department should be congratulated for its efforts.

The Chairman asked if there was any work that the Board could do to assist the Department with its research efforts.

Mrs Becke, Non Executive Director, asked how much patients value drug trials. The Head of Research and Development confirmed that Rheumatology and Haematology patients see the value.

Mrs Becke, Non Executive Director, asked if the Board could assist with the three issues identified in the paper. The Head of Research and Development confirmed that assistance in obtaining notes would be helpful. The Chairman asked for an update on availability of notes.

The Chairman and Board noted the constructive and positive report, improvement in external funding and issues raised and in particular availability of medical notes.

The Board to receive an update on the availability of case notes at its September meeting.

15/081 Finance

15/081.1 Finance and Performance Report (Enclosure 13)

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Report, given as Enclosure 13.

After two months the Trust was £1.7m better than plan. The Board noted that some of the variance related to cost savings and achievement of CIP remains a risk.

Performance targets are being met and the Board noted that Diagnostics are now back on track and the issue with cancer waiting times and that an action plan had been produced.

Items approved by the Committee included the payment to ATOS of £1.4m to resolve the service issue in the previous year's accounts. The Committee agreed to delegate approval to the Board to approve the Dudley Clinical Services accounts and recommend that the Workforce Committee look at turnover rates. The Chief HR Advisor commented that turnover rates are not useful as a Trust level figure.

The Chair of the Workforce Committee confirmed that the Committee does monitor the turnover level.

Future items to the Committee will include investigation of the recommendations from the Carter Review.

Items referred to the Board by the Committee included the frozen investment in the IT Data Centre, which was included on the Private Board agenda and the requirement of the Board to delegate authority to the Finance and Performance Committee to approve the Charitable Fund accounts at its July meeting.

The Chief Operating Officer provided an update on cancer waits. The Board noted the position for May was 81.9% and 87.5% for June.

The Chairman and Board noted the report and the good progress on financial and clinical performance.

The Chairman asked that the reference to Monitor for ED performance is removed from the report since this has not been an issue for many months. The Board noted the actions, decisions made and items approved.

The Board approved the Dudley Clinical Services accounts subject to circulation and no further comments.

The Board noted the items referred back to the Committee.

The Board approved the delegated authority to July Finance and Performance Committee to approve the Charitable Fund accounts.

15/082 Any Other Business

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

15/083 Date of Next Meeting

The next Board meeting will be held on Thursday, 3rd September, 2015, at 9.30am in the Clinical Education Centre.

Signed ……

Date …….....

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 2 July 2015

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
15/062	Chief Executive's Report – Junior Doctors	The Chairman to write to Andy Whallet and the team.	DB	2/7/15	Done
15/069	Audit Committee Exception Report	The Director of Finance and Information to write to LCFS to advise them of the assurances received from the Summit Board.	PT	2/7/15	Done
15/079	Chief Executive's Overview Report	The Chairman to notify the CCG of the excellent Community Services Friends and Family test performance. A letter to be written to the staff shortlisted for a Nursing Times Award, congratulating them on behalf of the Board.	C C	3/9/15 3/9/15	 Done
15/080.8	Corporate Risk Register and Board Assurance Framework Report	Director of Governance/Board Secretary and the Chair of the Audit Committee to meet to review assurances.	GP/RM	3/9/15	Done
15/080.9	Research and Development Report	The Board to receive an update on the availability of case notes at its September meeting.	PH	3/9/15	Update to October Board

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 3rd September 2015

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Paula Clark, CEO**	**PRESENTER**	**Paula Clark, CEO**
CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6			

SUMMARY OF KEY ISSUES:

- Friends and Family
- BCA Vanguard bid update
- Royal College of Midwives National Awards

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details: Effective, Responsive, Caring**
	Monitor	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF BOARD / COMMITTEE / GROUP: ***(Please tick or enter Y/N below)***

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD: The Board are asked to note and comment on the contents of the report

The Dudley Group NHS
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CORPORATE OBJECTIVES : *(Please select for inclusion on front sheet)*

SO1:	**Deliver a great patient experience**
SO2:	**Safe and Caring Services**
SO3:	**Drive service improvements, innovation and transformation**
SO4:	**Be the place people choose to work**
SO5:	**Make the best use of what we have**
SO6:	**Plan for a viable future**

CARE QUALITY COMMISSION CQC) : *(Please select for inclusion on front sheet)*	
Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves food outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and that people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

The Dudley Group NHS
NHS Foundation Trust

Chief Executive's Report – Public Board – September 2015

Patient Friends and Family Test - Update:

Community (July 2015)

The number of responses has dropped significantly compared to the previous month and work is on-going with local managers to improve the situation. The Trust continues to achieve the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members.

Community Services	Apr 15	May 15	Jun 15	Jul 15
Community Nursing Services – percentage recommended	100%	100%	95%	83%
No of responses	5	24	58	24
Rehab and Therapy services – percentage recommended	100%	100%	100%	100%
No of responses	9	11	20	47
Specialist Services – percentage recommended	95%	95%	95%	100%
No of responses	22	20	38	19
Combined score – percentage recommended	97%	98%	96%	96%
Total responses	36	55	116	90
National Average percentage recommended	96%	95%	95%	n/a*

**national data not published at time of writing this report*

Inpatient FFT (01.08.15 – 16.08.15 provisional)

The Trust continues to achieve the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members.

Date range	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015 provisional
Number of eligible inpatients**	6053	5926	6469	6482	2934
Number of respondents	984	928	936	987	455
Ward FFT percentage recommended	96%	97%	98%	97%	98%
Ward response rate	**16%**	16%	14%	15%	15%
National Average percentage recommended	95%	96%	96%	n/a*	n/a*

**national data not published at time of writing this report*

Key for inpatient RAG rating

% of footfall (response rate)	*<25%*	*25-30%*	*30-40% +*	*40%+*
FFT percentage recommended	*<95%*	*96%+*	*97%+*	
FFT scores based on Nov 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*	

A&E FFT (01.08.15 – 16.08.15 provisional)

The percentage of friends and family who would recommend the Trust's A&E during the period 1st – 16th August increased to 92% compared to 90% for April. The latest published NHS England figures are for June show The Dudley Group scored 92% compared to the national average of 88% (June) which puts us below the top 30% of trusts nationally. Locally, this puts us third behind Walsall with 94% and Worcester Acute with 95%.

The A&E information does not include the Urgent Care Centre; this is reported separately by Malling to NHS England.

Date range	April 2015	May 2015	Jun 2015	Jul 2015	Aug 2015 Provisional
Number of eligible A&E patients	3858	3851	3994	4057	2117
Number of respondents	326	589	469	289	139
A&E FFT recommended percentage	90%	90%	92%	90%	92%
A&E response rate	8%	15%	12%	7%	7%
National Average percentage recommended	88%	88%	88%	n/a*	n/a*

**national data not published at time of writing this report*

Key for A&E RAG rating

% of footfall (response rate)	*<15%*	*15-20%*	*20%+*
FFT percentage recommended	*<94%*	*94%*	*95%+*
FFT scores based on Nov 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*

Maternity FFT (01.06.15 – 15.06.15 provisional)

The Trust continues to score well and remains in the top 20% of Trusts with those who say they are extremely likely or likely to recommend our maternity services to friends and family.

Maternity Area	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015 provisional
Antenatal Score, percentage recommended	95%	96%	98%	99%	100%
Response rate	30%	39%	24%	37%	42%
Birth, percentage recommended	100%	100%	100%	100%	100%
Response rate	26%	20%	14%	21%	23%
Postnatal ward, percentage recommended	100%	100%	98%	99%	100%
Response rate	26%	20%	14%	21%	23%
Postnatal community, percentage recommended	100%	100%	93%	96%	100%
Response rate	8%	10%	12%	8%	5%

Key for maternity RAG rating

% of footfall (response rate)	*<15%*	*15%+*	
Antenatal	*80+*	*76-79*	*<76*
Birth	*89+*	*86-88*	*<86*
Postnatal ward	*81+*	*75-81*	*<75*
Postnatal community	*90+*	*84-89*	*<84*

FFT scores based on Mar 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*

Outpatients FFT (01.08.15 – 16.08.15 provisional)
The Trust has not met the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members. The Patient Experience Team is working closely with managers to address the 'You said, we did' actions to improve the patient experience. NHS England does not require the submission to include eligible population figures.

FFT Outpatients Services	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015 Provisional
Number of respondents	49	93	82	66	14
Outpatients recommended percentage	84%	82%	82%	88%	86%
National Average percentage recommended	92%	92%	92%	n/a*	n/a*

**national data not published at time of writing this report*

Improving the FFT Response Rates
The Patient Experience Team is working closely with managers across the Trust to reinforce the importance of maintaining response rates on or above target. To support response rate growth, several initiatives that will be rolled out during the next two quarters that include;

- Friends and Family App launch early September 2015
- Refresh of the Trust FFT test webpage September 2015
- Introduction of FFT SMS response option for A&E in Q3 and then phased roll out to other areas across the Trust by end of 2015/16.

BCA Vanguard bid:
We have heard that we have been shortlisted as one of the 28 bids being taken through to the shortlist stage from the 65 applications. We are required to attend a two day event on 7th and 8th September at which we will present our vanguard proposal and view and vote on the other contenders. We do not as yet know the timeline for final selection or the numbers that will go forward.

Royal College of Midwives National Awards:
The Trust's service for female genital mutilation was awarded a "runner up" in the Award for Excellence in Maternity Care category at the 2015 RCM National awards ceremony.

Enclosure 4

The Dudley Group NHS
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Paper for submission to the Board of Directors September 2015 - PUBLIC

TITLE:	**Infection Prevention and Control Forum**		
AUTHOR:	Dr E Rees, Director of Infection Prevention and Control	**PRESENTER**	Mrs D Wardell, Chief Nurse

CORPORATE OBJECTIVE:

SO1 – Deliver a great patient experience
SO2 – Safe and caring services
SO3 – Drive service improvements, innovation and transformation
SO4 – Be the place people chose to work
SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

- No post 48 hr MRSA bacteraemia cases
- No Norovirus cases
- No outbreaks or incidents
- At 26/8/15 the Trust is 3 cases over trajectory for this point in the year of 11 cases.

IMPLICATIONS OF PAPER:

RISK	**Yes**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** Safe and effective care
	Monitor	**Yes**	**Details:** MRSA and C. difficile targets
	Other	**Yes**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF COMMITTEE

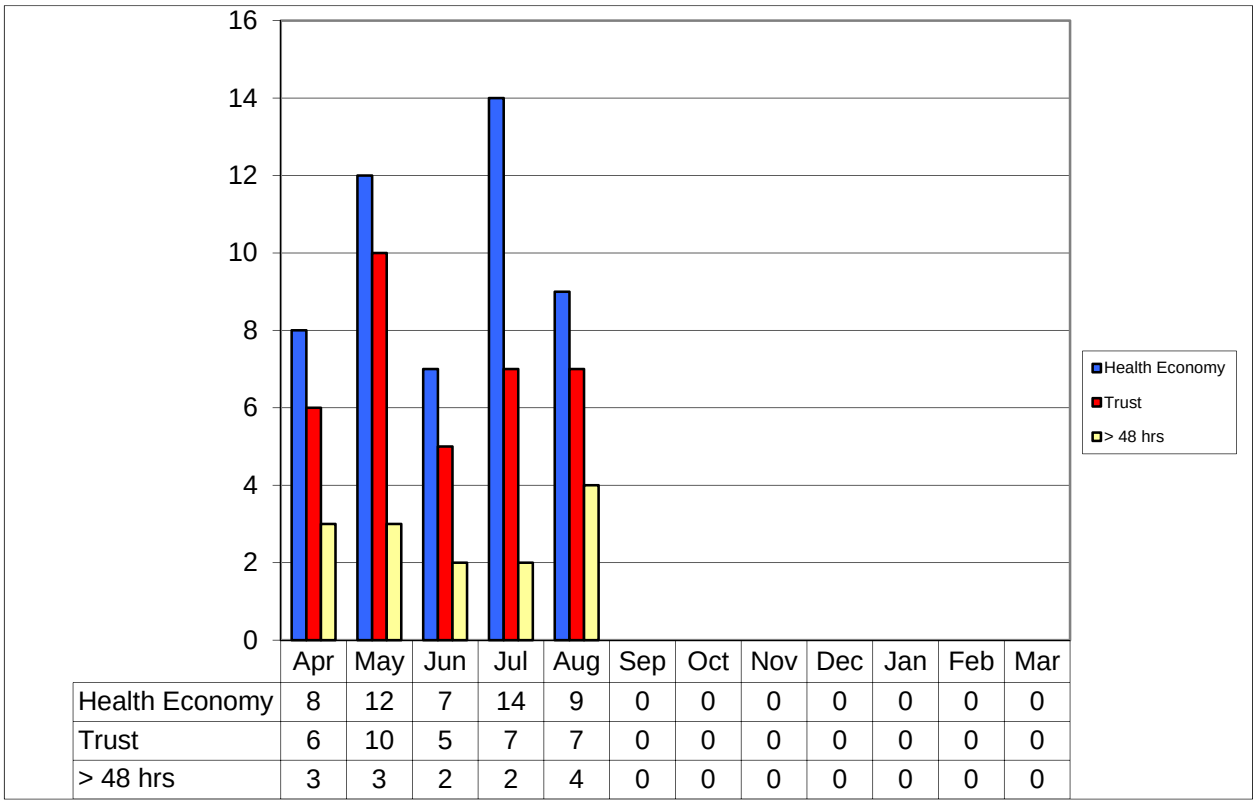
Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD: To receive the report and note the contents.

Summary:

Clostridium Difficile – The target for 2015/16 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. At the time of writing (26.8.15) we have 4 post 48 hour cases recorded in August 2015 and 2 cases recorded in July.

C. DIFFICILE CASES 2015/16



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	12	7	14	9	0	0	0	0	0	0	0
Trust	6	10	5	7	7	0	0	0	0	0	0	0
> 48 hrs	3	3	2	2	4	0	0	0	0	0	0	0

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], continues. Of the 14 post 48 hour cases identified since 1st April 2015, 7 cases have so far been reviewed by the apportionment panel and 6 of these were deemed as avoidable. The main themes identified are: delay in sending sample, delay in isolation, poor documentation and incomplete stool charts.

MRSA bacteraemia (Post 48 hrs) – There have been no post 48 hour MRSA bacteraemia cases identified so far this year.

Norovirus - no further cases.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation, Public Health England.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd September 2015

TITLE:	**Monthly Nurse/Midwife Staffing Position – June and July 2015**		
AUTHOR:	Derek Eaves, Professional Lead for Quality Yvonne O'Connor, Deputy Chief Nurse	**PRESENTER:**	Dawn Wardell, Chief Nurse

CORPORATE OBJECTIVE:

SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation

SGO2: Patient Experience - To provide the best possible patient experience

SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude

SUMMARY OF KEY ISSUES:

Attached is the latest monthly information on nurse/midwife staffing. As previously stated, there is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. It is worth noting that a new electronic system of collecting this data was commenced in June and to ensure consistency the same data is now used to source the monthly UNIFY return which results in the information on fill rates that is published on NHS Choices.

The paper indicates for the months of June and July 2015 when day and night shifts on all wards were staffed to planned levels (green) and were not staffed to the planned levels for both registered (amber) and unregistered staff (blue), with the day shift registered figures also taking into consideration the nationally recommended 1:8 nurse to patient ratio for general wards. It also indicates if planned levels were reached of registered (amber) and unregistered (blue) staff but the dependency or number of patients was such that the extra staff needed were not available and when levels were unsafe (red). The total number of shortfall shifts was 33 in June and 49 in July. The increased number of shortfall shifts in July, compared to previous months, was mainly due to the situation in the maternity service and so a detailed analysis of the situation there is provided.

The planned levels for each ward vary dependent on the types of patients and their medical specialities and national ratios apply to specialist areas such as intensive care, midwifery and paediatric areas. When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined and an assessment of any impact on key quality indicators has been undertaken.

IMPLICATIONS OF PAPER:

RISK	**Y** **Risk Register: Y**		**Risk Score and Description:** Nurse staffing levels are sub-optimal (20) Loss of experienced midwives (15)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** 13: Staffing
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance with the Risk Assessment Framework
	Equality Assured	**Y**	**Details:** Better Health Outcomes for all Improved patients access and experience
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To discuss and review the staffing situation and actions being taken and agree to the publication of the paper.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

June/July 2015

One of the requirements set out in the National Quality Board Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information.

The paper endeavours to give the Board a view of the frequency when Registered Nurse to patient ratios do not meet the recommended ratio on general wards of 1:8 on day shifts (there is no recommended ratio for night shifts) and also the number of occurrences when staffing levels have fallen below the planned levels for both registered and unregistered staff. It should be noted that these occurrences will not necessarily have a negative impact on patient care

The attached charts follow the same format as previously. They indicate for these two months when day and night shifts on all wards fell below the optimum, or when the 1:8 nurse to patient ratio for general wards on day shifts was not achieved.

In line with the recently published NICE (2014) guideline on safe staffing:

1) An establishment (an allocated number of registered and care support workers) is calculated for general wards based on a combination of the results of the six monthly Safer Nursing Care Tool exercise and senior nurse professional judgement both based on the number and types of patients on that ward (with the Board receiving a six monthly paper on this). For areas such as midwifery, critical care and paediatrics other specialist tools are used. The establishment forms a planned number of registered and care support workers each shift.
2) Each six weeks the Lead Nurse/Midwife draws up a duty rota aimed at achieving those planned numbers.
3) Each shift the nurse/midwife in charge assesses if the staff available meet the patients' nursing/midwifery needs.

If, at anytime, there is a shortfall between the planned for that shift and the staff available a clear escalation process is in place.

Starting in June 2015, following each shift, the nurse/midwife in charge now completes a spreadsheet indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed, for the patients on that shift. Each month the completed spreadsheet is checked by the Matron then staff in the Nursing Division analyse the data and the attached charts are compiled. In addition, for consistency purposes the data from the spreadsheet is now used for the UNIFY return from which the fill rates are published on NHS Choices.

It can be seen from the accompanying charts that the number of shifts identified as amber (shortfall of registered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available), blue (shortfall of unregistered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available) or red (unsafe staffing levels) are 33 in June and 49 in July. These figures can be compared with previous months (see Table 1) and correlate with an increase in vacancies for registered nurses and midwives. While the numbers of shortfalls in June is comparable to previous months, there has been a further increase in July. The latter arises from the significant increase in Maternity shortfalls (21 of the 49 shortfalls are within that area).

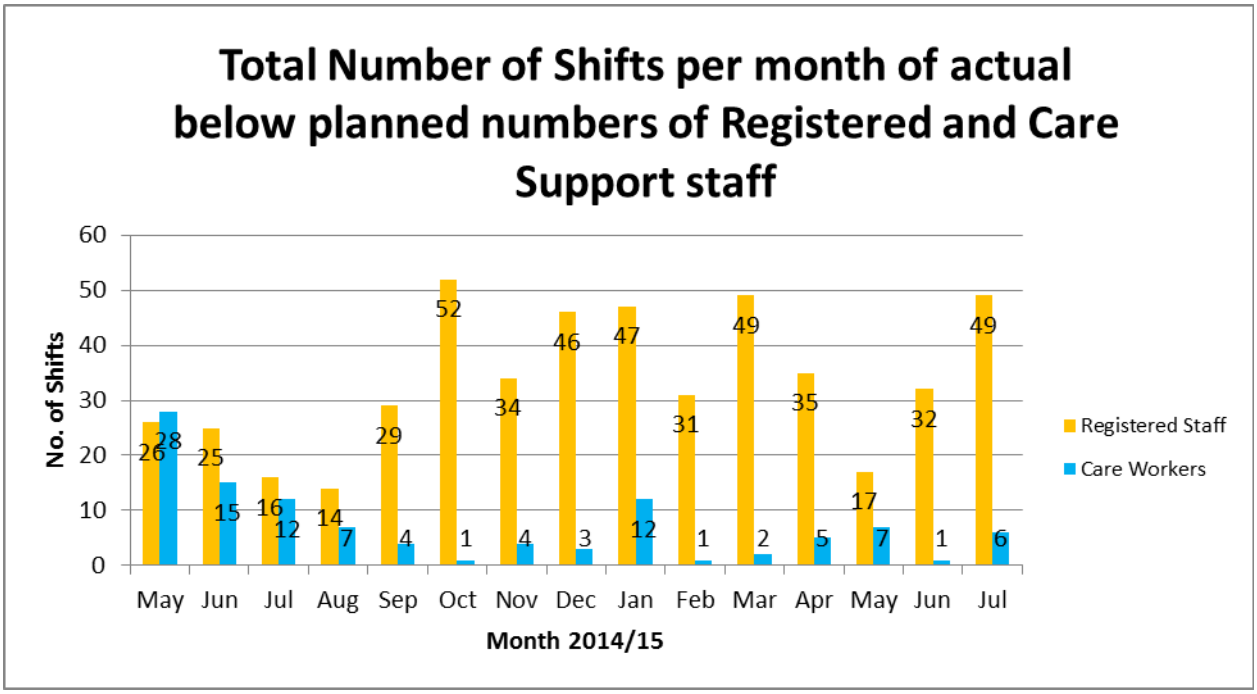
July saw a considerable increase in the maternity workload with 436 births (compared to a monthly average of 380-400 births). The shortfalls have occurred primarily due to vacancies, maternity leave and this increased workload. A recent recruitment drive means that vacancies should reduce considerably in the short term with two midwives having already started and twelve more all with start dates in September and early October. Increased use of support from registered nurses, extra support workers and the use of specialist and community midwives should also add to a reduction in shortfalls in the near future. It is also worth noting that a thorough investigation into the unit looking at all aspects of safety, including incidents, has not found any trends or significant safety concerns.

Returning to the complete Trust picture, overall the staffing available met the patients' nursing needs in the majority of cases but, in a number of instances, despite attempts through the use of redeployment of staff or the use of bank/agency staff, the optimum number of staff for the patients on that shift were not reached. In all instances of shortfalls, the planned and actual numbers are indicated.

When shortfalls in the 1:8 RN to patient ratio for day shifts on general wards or when shifts have been identified as below optimum; the reasons for the gaps and the actions being taken to address these in the future are outlined below.

An assessment of any impact on key quality indicators is undertaken each month. From as far as possible as it is to ascertain, these shortfalls have not affected the results of any of the nursing care indicator measures or other quality measures such as the number of infections. In addition, there is no evidence that they have affected patient feedback in terms of the answers to the real time surveys or in the number of concerns or complaints received.

Table 1



Nice (2014) Safe Staffing for nursing in adult in-patient wards in acute hospitals (London: July 2014)

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS JUNE 2015

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A3	2	RN	Vacancy x2	Bank and agency did not fill with one shift the bank nurse did not attend. On both shifts due to patient additional CSWs assisted. Safety was maintained.
A4	1	RN	Staff member moved to other ward	Staff member had to move to other ward to assist and so acute nurse stroke bleep holder helped the ward instead. For a short time, the bleep holder was called away. Safety was maintained although skin bundles were delayed but were completed.
B2H	3 1	RN CSW	Short term sickness Vacancy x2	Bank unable to fill. On one occasion hip practitioner assisted and on two the lead nurse assisted. Assessed as safe by Lead Nurse.
B2T	1	RN	Emergency care leave	With the number and dependency of patients on the ward no safety issues occurred.
B3	2	RN	Sickness and Maternity Leave	Bed occupancy was reduced and assistance given from B2 and so safety maintained.
B4	2	RN	Compassionate Leave x1 Special Leave x1	Bank unable to fill, safety maintained with a ratio of 1:9.6
B5	1	RN	Vacancy	The bank staff member cancelled but dependency was such that patients remained safe.
B6	1	RN	Sickness	Bank unable to fill, safety maintained with a ratio of 1:8.5
C1	5	RN	Vacancy x4 Sickness x1	On one occasion lead nurse worked clinically. Staff allocated appropriately with support from students. Bank unable to fill. On the unsafe staffing shift, two nurses booked through the agency did not turn up for work. A nurse was transferred from EAU and a CSW transferred from another ward. Safety was maintained and no incidents occurred.
C3	5	RN	Vacancy x5	Bank and agency were unable to fill. Patient safety maintained.
C5	1	RN	Training x1	One nurse on clinical study. Safety maintained.
C8	4	RN	Vacancy x4	Patient acuity was such that safety maintained
Maternity	4	RM	Vacancy High maternity leave x4	Bank unable to fill. Escalation process enacted. Staff moved to provide care to the areas of need. No patient safety issues occurred. On one occasion there was a delayed induction of labour.

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS JULY 2015

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A3	3	RN	Vacancy x2 Sickness x1	Bank and agency were unable to fill with one bank nurse cancelling and one agency nurse not attending. On all occasions with the patient caseload, safety maintained.
B1	1	CSW	-	On the red shift, CSWs were moved to other wards to assist as empty beds but then six patients admitted for major surgery. Some delays in care then followed. (This situation was not escalated correctly to the site co-ordinator)
B2H	1	RN	Vacancy	The allocated bank nurse cancelled. The ward was assessed as safe by Lead Nurse.
B3	1	RN	Vacancy	Agency nurse cancelled. Escalation to on-call director. Patients remained safe.
B4	2 4	RN CSW	Maternity Leave x2 Sickness x4	On both RN shortfall occasions bank unable to fill, safety maintained with a ratio of 1:9.6. The CSW shortfalls occurred when specialling was required. Specialling occurred as required by reducing the ratios of CSWs for the rest of the patients but safety levels were still maintained
B5	1	RN	Vacancy	Both one station and GAU were closed due to painting. Patients remained safe.
C1	5	RN	Vacancy x3 Sickness x2	Either lead nurse of nurse in charge assessed workload and redistributed it amongst staff more appropriately. Patient safety maintained.
C3	4	RN	Vacancy x3 Sickness x1	Bank and agency were unable to fill. Patient safety maintained with caseload on the ward.
C6	2	RN	-	On both occasions staff moved to other wards. On one occasion the ward had an admission which meant the ratio of staff to patients was slightly above the recommendation. On the other occasion, there was an unsafe staffing level but there were two students on the ward who were able to assist, if necessary and no incidents occurred. Safety was maintained.
C7	1 1	RN CSW	Vacancy Sickness	Bank unable to fill RN shift. Although bank provided a CSW two staff went off sick. Safety maintained.
C8	1	RN	-	Staff member moved to other ward which reduced the ratio to less than 1:8 although the dependency of the patients was such that safety was maintained.
MHDU	1	RN	Sickness	Nurse who was called in to assist was then unable to attend due to sick child. Bank, agency and other high dependency areas unable to help. CSW from a general ward assisted.
CCU/ PCCU	6	RN	Vacancy x3 Sickness x3	Both bank and own staff with extra shifts unable to fill. The CAT team assisted to ensure safe cover.
Maternity	21	RM	Vacancy and Maternity leave x 21 Sickness x 9	Bank unable to fill. Escalation process enacted reaching Level 3 on five shifts and Level 4 on six shifts. Staff moved to provide care to the areas of need. No patient safety issues occurred. On five occasions community and specialist midwives assisted and on one occasion nurse help occurred.

Jun-15		SHIFT																																																												
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WARD	**STAFF**	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
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Key

Unsafe staffing

Registered nurse/midwife shortfall

Care Support Worker shortfall

* Critical Care has 6 ITU beds and 8 HDU beds

** Neonatal Unit has 3 ITU cots, 2 HDU cots and 18 Special care cots. Ratios reflect BAPM guidance and include a single figure for registered and non registered staff

*** Children's ward accommodates children needing direct supervision care, HDU care 2 beds, under 2 years of age care and general paediatric care. There are no designated beds for these categories, other than HDU and the beds are utilised for whatever category of patient requires care.

**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the 'Birthrate +' staffing assessment

Any coloured shifts without numbers indicate that the planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available

Jul-15

SHIFT

WARD	STAFF	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16	
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WARD	STAFF	17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
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CCU/PCCU	Reg			7/5																											
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CRITICAL CARE*	Reg																														
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MATERNITY ****	Reg	19/17	18/13		18/13		18/12		18/14		18/14	19/15	18/14		18/12		18/13	18/15	18/13							19/16				19/16	
	Unreg																														

Key — Unsafe staffing (red); Registered nurse/midwife shortfall (amber); Care Support Worker shortfall (blue)

* Critical Care has 6 ITU beds and 8 HDU beds

** Neonatal Unit has 3 ITU cots, 2 HDU cots and 18 Special care cots. Ratios reflect BAPM guidance and include a single figure for registered and non registered staf

*** Children’s ward accommodates children needing direct supervision care, HDU care 2 beds, under 2 years of age care and general paediatric care. There are no designated beds for these categories, other than HDU and the beds are utilised for whatever category of patient requires car

**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the ‘Birthrate +’ staffing assessment

Any coloured shifts without numbers indicate that the planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 3 September 2015

TITLE:	**28 July 2015 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	David Badger – acting Committee Chair

CORPORATE OBJECTIVES

SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services

SUMMARY OF KEY ISSUES:

The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee and the decisions taken in accordance with the Committee's terms of reference.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
			yes	no
Clinical Quality, Safety and Patient Experience Committee	28 July 2015	D Badger	Yes	

Declarations of Interest Made

None

Assurances received

Positive assurances

- Operational Management assurance was received in respect of Stoke Swallowing Screening in respect of a revised performance figure of 85% which showed a sustained improvement in performance against this target;
- Operational Management assurance was provided over the performance of the Trust in respect of key quality indicators. This assurance recognized that the maternity indicators performance in respect of breast feeding continues to perform just below the target but others show continued achievement (subject to the late adjustment of the Stroke Swallowing Screening performance);
- Operational Management assurance was received in respect of the Trust's deliver of the Quality Priorities within the first quarter of the year, recognizing that some areas are more challenging that others; and
- Executive Management assurance was provided over compliance with the Trust's contractual requirements for dealing with Sis, but the Committee were informed that the Trust failed on 3 occasions to register Sis on STEIS within the 2 day requirement (but the action to address each of the incidents had not been delayed).

Decisions Made / Items Approved

- Approval of 3 Policies and 7 procedures / guidelines considered by Policy Group in July 2015;
- Approval to close 20 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced;
- Approved that, subject to the suggested additional wording on how learning intends to be cascaded within the Trust the learning report is shared with the CCG Clinical Quality Review Meeting in September;
- The Committee asked that the learning contained within the aggregated learning report be shared as widely as possible within the Trust; and
- The Committee supported the planned review of the Quality and Safety

Group's terms of reference to enable this reporting group better support the Committee.
Actions to come back to Committee (items the Committee is keeping an eye on)
• In respect of a group of maternity Serious Incidents the outcome of the established task and finish group will report back to this Committee; • The feedback of the results of the National Emergency Laparotomy - national clinical audit will come back once digested (only released today); • The progress in respect of Speech and Language staffing will be considered as future performance reports on Stroke Screening are received at this Committee; and • The updated terms of reference for the Quality and Safety Group will come back to the Committee for final approval.
Items referred to the Board for decision or action
None.

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 3 September 2015

TITLE:	**25 August 2015 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES

SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services

SUMMARY OF KEY ISSUES:

The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee and the decisions taken in accordance with the Committee's terms of reference.

The Board is also asked by the Committee to note and recognize the Trust's service for women with FGM was awarded "runner up" within the Excellence in Maternity Care category of the 2015 RCM National Awards.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
			yes	no
Clinical Quality, Safety and Patient Experience Committee	25 August 2015	D Wulff	Yes	

Declarations of Interest Made

None

Assurances received

Positive assurances

- Assurance was received via the Patient Experience Group over the delivery of the National Inpatient Survey action plan. This closes an action from a previous Committee meeting;
- Executive Management assurance was provided in respect of the work of the Maternity Task and Finish Group that no common causal link has been identified in respect of the Maternity related incidents. Assurance was provided that a full report on the work and any opportunities for improvement / enhancement to our processes would come to a future meeting of the Committee.
- Executive Management assurance was received in respect of the progress made against the Trust's Nursing Strategy action plan.
- Executive Management assurance was received over the attendance at the Transfusion Group. The most recent meeting was well attended and quorate which closes an action from a previous committee meeting earlier in the year; and
- Executive Management assurance was provided over compliance with the Trust's contractual requirements for dealing with SIs, but the Committee were informed that the Trust failed on 1 further occasion to register an SI on STEIS within the 2 day requirement (the delay was by just one day but action has been taken by the Patient Safety Team to better monitor where extra meetings are put into the process to ensure the 48hr registration still occurs)

Decisions Made / Items Approved

- Approval of 5 Policies and 10 procedures / guidelines considered by Policy Group in August 2015;
- Approval to close 27 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced; and
- Approval of Quality and Safety Group terms of reference which follows through an

action from the last meeting. These were revised to ensure they reflected a broader membership to ensure that the Group was able to deal with the breadth of issues and also that the Infection Control and Prevention Group report into Quality and Safety rather than direct to the Board Committee.

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

- The Committee will keep under review via the Quality and Safety Group having infection control report directly to it the Trust's actions for improving its performance in area to ensure the Trust can deliver the demanding targets;
- In respect of a group of maternity Serious Incidents the outcome of the established task and finish group will formally report back to this Committee as well as the Board;
- That within the future SI report the learning regarding the cluster of VTE incidents would be reported upon; and
- The Committee will continue to monitor the Trust's contractual registration of SIs on the system within 2 days.

Items referred to the Board for decision or action

The Board is asked to note and recognize the Trust's service for women with FGM was awarded "runner up" within the Excellence in Maternity Care category of the 2015 RCM National Awards.

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board on 3rd September 2015

TITLE:	**Workforce and Staff Engagement Committee Exception Report**		
AUTHOR:	**Julie Bacon; Chief HR Advisor**	**PRESENTER**	**Ann Becke; Non-Executive Director**
CORPORATE OBJECTIVE: SO4: Be the place people choose to work			

SUMMARY OF KEY ISSUES:

The Workforce and Staff Engagement Committee met on 25th August 2015 and discussed a number of matters including:

Staff Health & Wellbeing Service
This service had an accreditation assessment on 15th July for the Safe, Effective, Quality Occupational Health Service standard (SEQOHS). Although feedback was positive, accreditation was deferred to allow time for a small number of required actions to be addressed. A reassessment of these points will take place in three months.

Staff Friends and Family Test
In the staff, Friends and Family Report for the first quarter of 2015/16, the number of staff who would recommend the Trust as a place to work fell to 47% compared with 74% at the same time the previous year. The response rate has also decreased with only 73 staff responding in the latest report, which may have affected the results.

These results correlate with information obtained from the recent Chief Executive staff briefings where some staff have reported feeling undervalued. Ways to improve internal communication, with a focus on the positive aspects of the Trust and its successes were discussed. Actions will also be taken to increase the response rate.

Recruitment & Retention Initiatives
The Matron from Coronary Care attended to talk about the challenges of attracting and retaining band 5 nurses and the actions that they are taking to improve the situation.

Workforce KPI Report
A new KPI report was discussed which follows the format of the People Plans seven work streams and is designed to provide assurance using a range of workforce indicators

Health and safety
The Health and safety group's terms of reference were approved, together with a report on health and safety compliance within the Trust.

Trust Apprenticeship Programme
The Committee received a report on apprenticeships within the Trust. Although the implementation of apprenticeships had been patchy for the first three years, the Trust is now on course to meet its 2015/16 target of 50 apprentices.

Local Education and Training Group
The notes and action plan of the July LETG meeting were received. It was noted that there is a medical workforce planning group being arranged within the Trust to

Policies to be Ratified
Ten policies were ratified at the meeting.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:** Mandatory Training links with CQC outcomes: SAFE & WELL LED
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OFTRUST BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE TRUST BOARD

It is recommended that the Trust Board note the report

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3 September 2015

TITLE:	**Audit Committee Exception Report – 21 July 2015**		
AUTHOR:	**Richard Miner Chair – Audit Committee**	**PRESENTER**	**Richard Miner Chair – Audit Committee**

CORPORATE OBJECTIVE: S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary of issues received and discussed at the Audit Committee meeting that took place on 21 July 2015.

IMPLICATIONS OF PAPER: ***(Please complete risk and compliance details below)***

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details: Well Led**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD

To note the contents of the report.

The Dudley Group NHS
NHS Foundation Trust

CORPORATE OBJECTIVES : *(Please select for inclusion on front sheet)*

SO1:	**Deliver a great patient experience**
SO2:	**Safe and Caring Services**
SO3:	**Drive service improvements, innovation and transformation**
SO4:	**Be the place people choose to work**
SO5:	**Make the best use of what we have**
SO6:	**Plan for a viable future**

CARE QUALITY COMMISSION CQC) : *(Please select for inclusion on front sheet)*	
Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves food outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and that people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

Committee / Group highlights report to Board / Committee

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	21/7/2015	Richard Miner	yes	no
			Y	

Declarations of Interest Made

None

Assurances Received

The LCFS Annual Report for 2014/15 was presented by Baker Tilly and it was confirmed that the planned work had all been delivered on time and within budget.

An unmodified audit report on the Trust's Charitable Funds accounts for 2014/15 was proposed by Deliottes.

Internal audit work for 2015/16 has commenced and positive assurance had been received on the actions taken by management in respect of previous recommendations.

The new external auditors, PwC, have commenced their preparatory work including discussions with directors and stakeholders and will be liaising with their predecessors.

Decisions Made / Items Approved

Charitable Funds Representation Letter – approved

Charitable Funds Accounts 2014/15 – approved under delegated authority

Audit Plan 2015/16 – changes to the plan have been approved

Clinical Audit Plan 2015/16 – 7 additional clinical audits were approved for inclusion in the plan and four local obstetric clinical audits and one national clinical audit be removed from the Clinical Audit Plan

That the risk be assessed in respect of the impact on R&D income of recruitment numbers being lower than that budgeted.

Actions to come back to Committee / Group (Items Committee / Group keeping an eye on)

Research and Development and the plan to address the shortfall in recruitment to R & D studies will be reported back to a future meeting.

An improved format for the reporting of the corporate risk register and board assurance framework is being developed and better reporting to the Audit Committee will be considered at the next meeting.

The method of reporting losses on overseas visitor debts is changing and is likely to see

some future increase, this will be kept under review by the Committee.

Items referred to the Board / Parent Committee for decision or action

Standing Financial Instructions – the Committee has recommended approval of the detailed changes to the Board of Directors.

The Audit Committee Annual Report 2014/15 was approved and is ther efore referred to the Board for approval – this is separate item on the September Board agenda.

DUDLEY GROUP NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS ANNUAL REVIEW – JULY 2015

Introduction

The Standing Financial Instructions (SFI's) and Scheme of Delegation (SoD) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government Policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. It is recommended good practice that the SFI's and SoD are reviewed annually to take account of the changing control environment and additional financial governance arrangements.

July 2015 Review

The changes made to the SFI's are summarised in the table below.

Change	Reason	Section Numbers
Role of Internal Audit	To update to include reference to the latest internal audit standards	2.3.6
External Audit	To update to include the requirement to present the annual opinion to the Council of Governors	2.4.2
Fraud & Corruption	To update to include compliance with the NHS Standard Contract	3.1
Processing of Payroll	To update to bring the SFI's in line with the Trust's expenses policy in relation to the time limit on expense claims.	9.4.3
Losses & Special Payments	To include reference to the Local Security Specialist Manager in relation to theft.	14.2.2
Casual Gifts	To clarify the reporting requirements on the receipt of gifts.	18.5.1
Interests of Officers in Contracts	To clarify the reporting requirements of interests.	18.7.1
Declaration of Gifts, Hospitality and Interests	To clarify the use of the declarations register and the Trust's Standards of Business Conduct Policy.	18.18
Schedule of authorised limits	Update of the EU threshold for goods and most services.	Appendix

	Addition of the Deputy Director of Finance (FS) to authorise write offs up to the value of £10k. Addition of the Deputy Director of Finance (FS) to authorise PFI variations and capital expenditure up to the value of £125k. Update of various job titles.	

A full set of Standing Financial Instructions is available on request.

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
on 3 September 2015

TITLE:	**Audit Committee Annual Report 2014/15**		
AUTHOR:	**Richard Miner** **Chair – Audit Committee**	**PRESENTER**	**Richard Miner** **Chair – Audit Committee**
CORPORATE OBJECTIVE: **S06 Plan for a viable future**			

SUMMARY OF KEY ISSUES:

The Audit Committee Annual Report 2014/15 details the activity of the Committee and the assurances it has received.

The report is shared with the Board for information, so they are able to note the assurances received and actions taken by the Committee.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details: well led board**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD

To note the contents of the report.

The Dudley Group NHS
NHS Foundation Trust

ANNUAL REPORT OF THE AUDIT COMMITTEE FOR THE YEAR 2014/15

1. Introduction

The Audit Committee was established to provide assurance to the Board that there is an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives and that this system is established and maintained.

The purpose of this report is for the Audit Committee to account to the Trust Board of Directors on its activities relating to the financial year 2014/15. In practice this covers the period up to the approval and sign off of the Trust's Annual Report and Accounts, which took place on 12th May 2015. The Board gave delegated powers to t he Audit Committee to approve these documents.

After each of its meetings during the year, the Audit Committee provides a written report to the Trust Board that details the matters discussed, key issues identified and any items requiring referral to Trust Board. This annual report does not set out to reprodu ce that detailed reporting but draws from the information contained in these regular reports.

The Committee's chief functions are to support the Trust Board by critically reviewing:

a) the governance, risk management and assurance processes on which the Trust Board places reliance, including the risk and performance management systems and the Board Assurance Framework; and

b) all risk and control related disclosure statements, including the Annual Report and Accounts, Quality Report and Annual Governance Statement, underlying assurance processes and policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; and

c) the findings, implications and management responses to the work of the External Auditors, together with ensuring that there is an effective Internal Audit function and that the organisation has adequate arrangements in place for countering fraud.

Although financial scrutiny remains vitally important, Audit Committees have increasingly recognised that there is a widening range of activities which require comprehensive and effective controls and which should therefore fall within the remit of the Audit Committee. For NHS organisations, this typically includes clinical governance issues, such as the collection and reporting of performance and quality data, the preparation of annual clinical audit plans and processes and the measures taken to combat fraud.

In order to discharge its key functions, the Audit Committee prepares an Annual Report for the Trust Board and the Chief Executive as Accounting Officer of the Trust and expresses its considered opinion based upon the evidence placed before it.

2. Audit Committee's Responsibilities

During the year, the Audit Committee operated in accordance with its responsibilities as set out in its Terms of Reference, which are:

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

b) To ensure that there is an effective Internal Audit function that meets Government Internal Audit Standards and that provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board;

c) To review the work and findings of the External Auditors and consider the implications of and management's responses to their work;

d) To review the findings of other significant assurance functions, both internal and external to the Trust and including in particular local and national clinical audit activity and outcomes and consider the implications for the governance of the organisation;

e) To satisfy itself that the organisation has adequate arrangements in place for countering fraud and to review the outcomes of counter fraud work;

f) To receive and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee also requests specific reports from individual functions within the organisation (for example, clinical audit) where these are appropriate to the overall arrangements;

g) To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance;

h) To ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review in order to establish the completeness and accuracy of the information provided to the Trust Board;

i) To review the Annual Report, Quality Report and financial statements before submission to the Trust Board focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in and compliance with accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements and significant judgments used in the preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of management representations
- Qualitative aspects of financial reporting
- Contents of the Quality Report

3. Audit Committee Membership

The Audit Committee is constituted as a sub-committee of the Trust Board with approved terms of reference that are aligned with the *Audit Committee Handbook 2005* published by the HFMA and Department of Health. The required quorum for meetings is two Non-Executive Directors.

It is recommended that the Chair of the committee is a suitably (CCAB) qualified accountant. Jonathan Fellows served as Chair until 31 December 2014 and is a Fellow of the Association of Chartered Certified Accountants. With Jonathan becoming Deputy Chair of the Trust Board and Senior Independent Director, Richard Miner succeeded him with effect from 1 January 2015. Richard is an Associate of the Institute of Chartered Accountants in England and Wales and a Fellow of the Association of Chartered Certified Accountants.

Certain individuals were required to attend Audit Committee meetings. These included the Trust Director of Finance & Information, senior representatives of the External Auditors of the Trust, senior representatives of the Internal Auditors of the Trust and the Local Counter Fraud Specialist (LCFS).

The table below records attendance at each meeting during the 2014/15 cycle:

Date of Meeting	Audit Chair	Other NEDs	Finance Director*	External Auditors	Internal Auditors	LCFS
22 July 2014	Yes	2	Yes	Yes	Yes	Yes
21 October 2014	Yes	2	Yes	Yes	Yes	Yes
20 January 2015	Yes #	1	Yes	Yes	Yes	Yes
12 May 2015	Yes #	2	Yes	Yes	Yes	Yes

* 2 meetings attended by Paul Assinder and 2 by Paul Taylor

meetings chaired by Richard Miner

Other individuals from the Trust are invited to attend meetings including the Chief Executive, Director of Nursing, and the Associate Director for Governance.

The Committee is able to draw on the independent advice of the Trust's auditors and any other officers or outside agencies it considers necessary. The Committee also met with both the External and Internal auditors in private during the year in order to ensure that they had the freedom to raise any issues of concern. These meetings centered primarily on the auditors assessment of business risks and the management of these; transparency and openness of working relationships with management; and confirmation that management had not attempted to place any restrictions on the scope of their audit work. There were no matters to report as a result of these meetings.

The Terms of Reference for the Audit Committee are reviewed annually and the most recent update was approved at the October meeting. Whilst all Non-Executive Directors can attend meetings of the Audit Committee should they wish to do so, two specific Non- Executive Directors have been appointed to serve on the Audit Committee, in addition to the Chair of the Committee. The selection process is designed to provide the Audit Committee with a skill set that includes understanding of the organisation's objectives, structure, culture and governance; experience in organisations of similar size or complexity, or operating in the same environment; and knowledge of accounting, risk management and technical specialist areas pertinent to the organisation including Information Technology. Non-executive membership is also designed to provide "linkage" with other relevant committees of the Trust.

4. Internal Audit

Internal Audit services for the 2014/15 year were provided by Baker Tilly. Internal Audit supports the work of the Audit Committee in two key areas:

a) by providing an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's strategic objectives; and

b) by providing an independent and objective service to help improve risk management, control and governance.

As is normal, a risk based approach was taken to establish the internal audit plan for 2014/15. This took account of the strategic and operational risks relating to quality and safety issues; service delivery standards and targets; workforce; finance and business, as identified by both management and the Committee, as well as the need to review key financial systems to ensure that External Audit could continue to place reliance on the work of Internal Audit.

Internal Audit issues assurance ratings for audits as follows:

GREEN	the Trust Board can take significant assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective
AMBER	the Trust Board can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective
RED	the Trust Board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective

There were some areas of concern highlighted during the year:

- The Information Governance Toolkit and improvements necessary particularly to training and the need to follow through action plans.
- IT Business Continuity and Emergency Planning (including electricity and water testing) which was initially considered to be amber rated in October 2014. Immediate actions were taken and by January 2015 a follow up had indicated good progress.

- The mortality audit rated as Red/Amber although due to control rather than clinical issues.
- Capital development business cases where improvements needed to be made around demonstrating benefit realisation.
- Compliance with safeguarding children (Amber/Red) mainly due to use of fax machines and DNA letters.

All issued are tracked and followed up until satisfactory resolution.

Other areas reviewed and either rated or reviewed in an advisory capacity included:

- Asset management (Green rated)
- General ledger (Green)
- Cash receipting and treasury management (Green)
- Creditor payments and single tender waivers (Green)
- Data Quality (C Diff) (Green)
- Payroll (Green)
- Health and safety audits (good progress)
- Bed capacity management
- Delayed transfers of care
- Financial turnaround

The Audit Committee received progress reports from the Internal Auditors throughout the year and a final report in May 2015. In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion on the overall adequacy and effectiveness of the organisations risk management, control and governance processes (i.e. the system of internal control). This opinion is based on:

a) an assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

b) an assessment of the range of individual opinions arising from the risk based audit assignments reported throughout the year. This assessment takes account of the relative materiality of these areas and management's progress in addressing control weaknesses;

c) an assessment of any reliance placed upon third party assurances.

Based on the work undertaken in 2014/15, the HoIA was able to provide significant assurance that there was a generally sound system of internal control, designed to meet the organisation's objectives and that controls were generally being applied consistently.

Internal Audit also undertook a significant piece of work looking at the "lessons learned" from an aborted Electronic Patient Record (EPR) procurement known as "Project Fusion" which had proved costly in terms of finances and time. The report's conclusions, accepted in full, were of better project management and corporate governance procedures in the future as the Board considers other options for EPR. This is already seeing a strengthened IT Steering Group and greater direct accountability to the Board.

Following an open tender process, Baker Tilly were reappointed to provide Internal Audit services and Local Counter Fraud Services for a further 5 years.

The Audit Committee considers that:

- **The strategy for Internal Audit covers the Trusts key risks as recognised by the Committee**
- **A detailed plan for 2015/16 reflects the areas that the Committee believes should be covered as priority**
- **Sufficient assurances are being received by the Trust to monitor the Trust's risk profile effectively**
- **The level of audit resource is agreed as appropriate**

Accordingly the Audit Committee recommended to the Trust Board that the Internal Audit Plan for 2015/16 be adopted by the Trust Board and this took place at the Trust Board meeting in June 2015.

5. Clinical Governance

The core business of every NHS organisation is healthcare and consequently it is appropriate and necessary for the Audit Committee to consider the clinical objectives and risks in the Assurance Framework and report to the Trust Board on the controls and assurances relating to these. The Director of Nursing, from June this prost beca me known as the Chief Nurse, regularly attends the Audit Committee to report on risk and governance issues. The Audit Committee also receives regular updates on progress against the clinical audit plan from the Trust Clinical Audit Lead, Clinical Audit Team Leader and Clinical Audit Officers as well as a research and developmen t report which considers serious and adverse events as a consequence of clinical trials.

Changes are proposed and agreed to the clinical audit throughout the year.

The Committee received an annual report on the Clinical Audit Activity and how that provides assurance over sections of the Trust's Quality Report/

The Audit Committee considers that the Clinical Audit plan for 2015/16 includes the appropriate national and mandatory audits, meets the needs of the Trust and addresses specific risks. Accordingly the Audit Committee recommended to the Trust Board that the Clinical Audit plan for 2015/16 be adopted by the Trust Board and this took place at the Trust Board meeting in June 2015. The Audit Commmittee received the Clinical Audit Annual Report and the assurance it provided in respect of work referred to within the Trust's Quality Report.

6. Counter Fraud Services

Local Counter Fraud Services (LCFS) are also provided by Baker Tilly. Its activities flow from a number of initiatives:

- Pro- active awareness sessions to all staff; making them aware of where fraud can occur.
- Following up referrals

Typically, investigation of referrals might include examination of agency timesheets for evidence of fraud. A large piece of work was also brought to a conclusion during 2015 in respect of tendering procedures involving the PFI contract and was subsequently followed through with Summit.

The future is likely to see increasing focus on cyber-crime.

The LCFS presented its annual report in July 2015 and the work plan for 2015/16 was agreed in May 2015.

Reference is made above to Baker Tilly's re-appointment for a further 5 years.

The Audit Committee considers that the LCFS workplan for 2015/16 meets the needs of the Trust and addresses the Trust's specific fraud risks. Accordingly the Audit Committee recommended to the Trust Board that the LCFS workplan for 2015/16 be adopted by the Trust Board and this took place at the Trust Board meeting in June 2015.

7. External Audit

The Trust's continued deteriorating operating and financial performance into t he first half of 2014/15 set the tone for the year with the Tru st's External Auditors, Deloitte, reviewing waiting time performance, the CQC inspection report and the turnaround plan and considering the implications of these. By October 2014 Deloitte were voicing concerns about the future financial standing and the need to do sufficien t work to provide assurance before the accounts cou ld be signed off. They raised issues around the wording and style of their audit reporting.

In January 2015, Deloitte had were clear that the B oard and t he Audit C ommittee needed to be assured about the Trust's financial sustainability; they were.

Deloitte presented their report on the 2014/15 audit to the Audit Committee in May 2015, reporting that they would be issuing an unmodified audit opinion on the Trust Annual Accounts for 2014/15 and that the Annual Governance Statement complied with the guidance issued by Monitor. They issued a qualified opinion in respect of the value for money/use of reso urces work; t his principally stemmed from th e Trust's b reach of license triggered by concerns over financial sustainability. The Trust is required to have arrangements for "securing the economy, efficiency and effectiveness for the use of resources."

The above issues should not detract from an audit process that, once again, went smoothly, with all deadlines achieved.

The audited accounts include the consolidation of subsidiary Dudley Clinical Services Limited as well as the Charitable Funds accounts.

Also presented to the Audit Committee in May 2015 were the findings and recommendations from the Deloitte external assurance review of the 2014/15 Quality Report. This review covered two aspects:

a) firstly, an examination of the content of the Quality Report to ensure that it complied with Monitor's published guidance as set out in the Monitor's Annual Reporting Manual (ARM) and to ensure that it was not inconsistent with other specified information; and

b) secondly, a programme of work to test selected performance indicators.

Deloitte confirmed they would be issuing a non-qualified opinion on the Quality Report.

The Audit Committee is also required to consider the effectiveness of External Audit and also the independence of the external auditor in the light of any additional non-audit work undertaken during the year.

In assessing the effectiveness of the external audit process the Audit Committee takes account of the lead audit engagement partner, the audit team, planning and scope of the audit and identification of areas of audit risk, execution of the audit, communications by the auditor with the Audit Committee, the support provided by the auditor to the work of the Committee, how the auditor contributes insights and adds value and the independence and objectivity of the audit firm and quality of the formal report.

Independence and objectivity of the External Audit function is safeguarded by limiting the nature of non-audit services and only approving any additional non-audit service on the basis that it does not compromise independence, is a natural extension of the audit and that there are business and/or efficiency reasons that make the external auditors most suited to provide the service. The External Audit function is also subject to an open tender process every 5 years. As a consequence of this exercise in 2014, Deloitte were not selected for the next 5 year term and will be replaced by PwC. The decision, which is the responsibility of the Council of Governors, was not as a result of any shortcomings by Deloitte or any disagreement with Deloitte by the Trust but the application of a strict selection matrix by the tender group which scored each tendering firm based on both financial (cost of the service) and other non-financial competence based criteria. The Audit Committee wishes to record its thanks to Deloitte for their support and guidance over the last 5 years.

The Trust Annual Accounts, Annual Report, Annual Governance Statement, Quality Report and Letter of Management Representations were each considered in detail by the Audit Committee and it was agreed to recommend that they all be approved.

The Committee did not find any issues with the independence and objectivity of the External Audit partner and his team.

8. Conclusion and Audit Committee Opinion 2013/14

The Committee once again wishes to express its sincere gratitude and appreciation to everyone who has supported the work of the Audit Committee during the year and contributed to the effective functioning of the Audit Committee.

The Audit Committee considers it has obtained adequate assurance that the key controls and processes within the Trust to ensure corporate and financial governance continue to operate effectively and that this conclusion is supported by the reports of the Internal and External Auditors received by the Committee during the year.

As a result, the Audit Committee is able to provide reasonable assurance to the Trust Board that there are no major weaknesses in the Trust's risk management, control and governance processes. The Trust Board should however recognise that assurance given can never be absolute.

The opinion of the Audit Committee, based on the evidence placed before it during the year, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Trust Board, although work must continue to ensure that these are embedded throughout the whole organisation. In addition, there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Richard Miner ACA FCCA
Chair of Audit Committee
July 2015

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

3 September 2015

TITLE:	Complaints and Claims Q1 report (1 April to 30 June 2015)		
AUTHOR:	Maria Smith (Complaints & litigation manager)	**PRESENTER:**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVE: SO1 – Deliver a great patient experience			

SUMMARY OF KEY ISSUES:

Complaints report for Q1 ending 30 June 2015

100% of complaints received during year were acknowledged within 3 working days
44% of complaints received and closed during year were answered within 30 working days
34% of complaints closed during year were upheld/partially upheld during Q1
9% of complainants expressed dissatisfaction with their response (received and investigated during Q1
19 meetings were held with complainants during Q1
4 Inquests held during Q1
1 rule 28 (formerly rule 4 3) - reports on 'Action to Prevent F uture Deaths' received from Senio r Coroner during Q1

Claims for Q1

6 claims were closed
15 new claims were opened

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Domains** **Safe, effective and caring**
	Monitor	**Y**	**Details: supports effective governance**
	Other **Ombudsman**	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309** **0 complaints accepted for investigation by Ombudsman during the quarter**

ACTION REQUIRED OF COUNCIL:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS:

To note details of complaints and claims activity during the quarter ending 30 June 2015.

Key Facts – Complaints, Inquests & Ombudsman

Key facts	Qtr 1 ending 30/06/14	Qtr 2 ending 30/09/14	Qtr 3 ending 31/12/14	Qtr 4 ending 31/03/15	Year ending 31 March 2015	Qtr 1 ending 30/06/15
Total number of complaints received during Qs 1	**63** 2 - high 34- mod 27 - low	**92** 4 - high 58 - mod 30 - low	**64** 2 – high 39 – mod 23 - low	**94** 4 - high 48 - mod 42 - low	**313** 12 – high 179 – mod 122 - low	**70** 5– high 32 – mod 33 - low
% Complaints acknowledged within 3 working days	100%	100%	100%	100%	100%	100%
% Complaints received and answered within 30 working days	80%	50%	68%	45%	61% (incl complaints C/fwd from yr ending 31/3/14	44%
Number of upheld/partially upheld complaints received & answered during Q1	**20** during qtr	**33** during qtr	**15** during qtr	**20** during qtr	**143* (46%)** (*includes C/fwd from yr ending 31/3/14)	34 During qtr
Complaints accepted for investigation by Ombudsman during Q1	3	3	1	2	9	0
Privacy/dignity included as a concern in complaint	1	1	0	4	6	0
Complaints referring to shared accommodation	0	0	0	0	0	0
Complaints including safeguarding concern	0	1	0	0	1	0
Number of meetings held with complainants during Qs 1	14	23	19	15	71 (23% of complaints rec'd)	19 (27% of complaints rec'd)
Total number of dissatisfied complaints received in Q 1	5	6	3	6	20 (6% of complaints rec'd)	6
Total CCG/CSU led complaints received in Q1	2	2	1	3	8	3
New Coroner's cases opened during Q 1	2	3	1	1	7	7
Coroner's Inquests held/closed during Q1	5	7	4	2	18	4
Coroner's Rule 28 (was rule 43) received in during Q 1	1	0	0	0	1	1

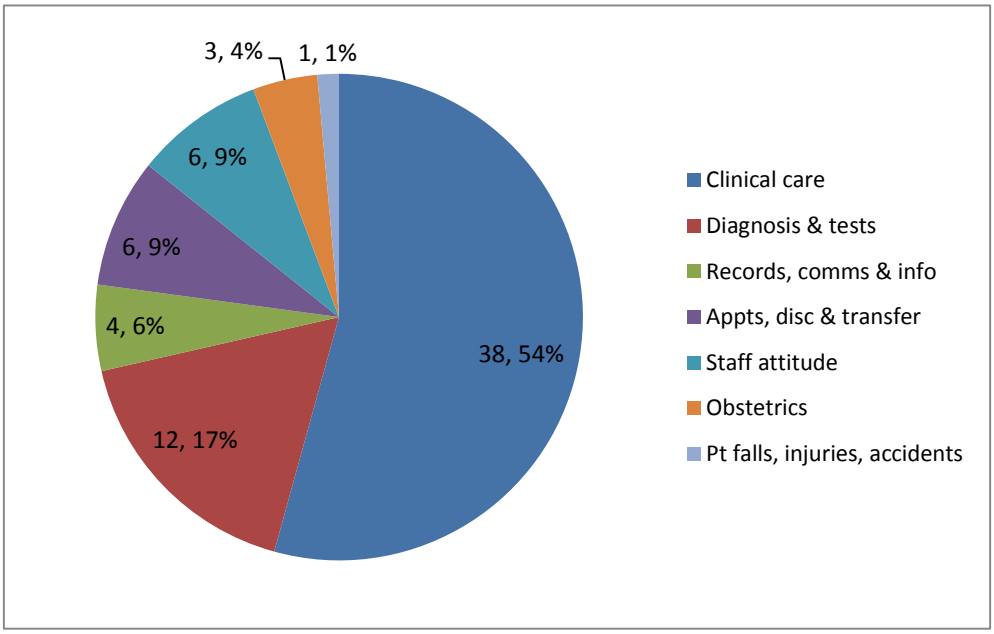
Category **	Qtr 1 Ending 30/06/14	Qtr 2 Ending 30/9/14	Q3 Ending 31/12/14	Qtr 4 Ending 31/3/15	Year ending 31/03/15	Qtr 1 Ending 30/06/15
Clinical Care (Assessment/Monitoring)	30 (47%)	34 (37%)	20 (31%)	50 (53%)	**134 (43%)**	38 (54%)
Diagnosis & Tests	3 (4%)	25 (27%)	8 (13%)	20 (22%)	**56 (18%)**	12 (17%)
Records, Communication & Information	7 (11%)	3 (3%)	6 (9%)	1 (1%)	**17 (5%)**	4 (6%)
Appointments, discharge & Transfers	8 (13%)	9 (10%)	10 (16%)	6 (6%)	**33 (11%)**	6 (9%)
Staff attitude, (previously included in Records, communication & info)	3 (4%)	8 (9%)	3 (5%)	6 (6%)	**20 (6%)**	6 (9%)
Obstetrics	3 (4%)	3 (3%)	4 (6%)	2 (2%)	**12 (4%)**	3 (4%)
Nursing care (District Nurses)	2 (3%)	0	0	0	**2 1%)**	0
Medication	1 (2%)	5 (6%)	6 (10%)	1 (1%)	**13 (4%)**	0
Patient Falls, Injuries or Accidents	0	1 (1%)	2 (3%)	2 (2%)	**5 (1%)**	1 (1%)
Equipment	1 (2%)	1 (1%)	2 (3%)	0	**4 (1%)**	0
Safeguarding	0	1 (1%)	0	0	**1 (1%)**	0
Theatres	1 (2%)	0	2 (3%)	1 (1%)	**4 (1%)**	0
Privacy & dignity	1 (2%)	1 (1%)	0	4 (5%)	**6 (1%)**	0
Pressure Sore	1 (2%)	1 (1%)	0	0	**2 (1%)**	0
Violence, aggression	1 (2%)	0	0	1 (1%)	**2 (1%)**	0
Other (security, workforce)	1 (2%)	0	1 (1%)	0	**2 (1%)**	0
Total:	**63** (100%)	**92 (100%)**	**64 (100%**	**94 (100%)**	**313 (100%)**	**70 (100%)**

*** Note complaints are allocated to the main category of the issue being raised*

Although fewer complaints have be en received during Q1 than in the last quarter of the previous year, they continue to b e complex and contain several issue s of con cern that need responding too. Complainants are being encouraged to attend a meeting with senior staff as th is enables th em to receive explanations and personal apologies for shortfalls in care identified.

The complaints team ha ve been faced with a nu mber of hostile and aggressive complainants du ring this quarter and the Vexatious complainants' policy had to be invoked in the case of two complainants and others reminded of the Trust's zero tolerance policy.

Analysis of complaints received by category
Q1 - ending 30 June 2015



% of complaints received against total hospital activity

5ACTIVITY	Total Qtr 1 ending 30/06/14	Total Qtr 2 ending 30/09/14	Total Qtr 3 ending 31/12/14	Total Qtr 4 Ending 31/03/15	TOTAL Year ending 31/03/15	Total Qtr 1 Ending 30/06/15
Total patient activity	181,132	187,117	184,687	183574	736,510	189260
% Complaints against activity	0.03%	0.05%	0.03%	0.05%	0.04%	0.03%

Note that during this period the Trust received 1% of compliments as measured against our activity

Senior Coroner – Inquest conclusions during Q1

During Q1

4 Inquests were held and concluded during the quarter and verdicts were –

1 – death by hanging (this took place at a location unrelated to the hospital)
2 – natural causes
1 – narrative and rule 28 (formerly rule 43) – 'Preventing Future Deaths' received (see overleaf).

Rule 28 (formerly rule 43)
'Preventing Future Deaths'

The coroner has asked for a report on the procedures undertaken by the Trust during handover from WMAS in the case of a spinal cord injury. Our response was required within 56 days and this was achieved with the response being provided by 29 July 2015.

Parliamentary & Health Service Ombudsman (PHSO)

New cases being considered / taken for investigation during Q1:

No new cases have been accepted by the Ombudsman during Q1.

CLAIMS

During the quarter, 6 claims were closed –

	Specialty
1	Gynacology
2	Surgery
1	Maternity
1	ED
1	Trauma and Orthopaedics

It should be noted that for two claims the value of damages paid was Nil.

During the quarter, 15 new claims were opened –

	Specialty
2	Medicine
1	Respiratory
3	Trauma & orthopaedic
1	Gynaecology
1	Plastic surgery
1	Obstretrics
1	ED

5 Employer's liability claims

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd September 2015

TITLE:	**Integrated Performance Report**		
AUTHOR:	**Anne Baines, Director of Strategy and Performance Stuart Nugent, Assistant Director of Finance**	**PRESENTER**	**Anne Baines, Director of Strategy and Performance**

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have

SUMMARY OF KEY ISSUES:

Attached is the Integrated Performance Report until July 2015.

Overall performance has been good, particularly with regard to the Emergency Access target (4 hours) where we consistently perform amongst the best organisations in the country. We are also performing well against the national 18 wek standard for Referral to Treatment Times although changes to this indicator will impact on future levels of performance

The main area of risk is the future performance against the cancer targets. Continued escalation of performance management has been instigated with weekly meetings for the Division with the Director of Strategy and Performance and Chief Operating Officer.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:** ***(Please select from the list on the reverse of sheet)***
	Monitor	**Y**	**Details:** Poor performance would result in the Trust being in breach of licence
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
x		x	

RECOMMENDATIONS FOR THE BOARD

Board of Director is asked to note the contents of the Integrated Performance Report for July 2015

Trust Board of Directors 3rd September 2015

Integrated Performance Report - July 2015

1. Introduction

This paper aims to present to the Board of Directors performance against the key areas, highlighting areas of good performance and identifying areas of exception together with the actions in place to address them.

2. Integrated Performance Report

The report for the period April 2015 to July 2015 is enclosed for consideration at Appendix 1.

Overall the Trust is continues to perform extremely well against the majority of key indicators. Areas to highlight include

- The target percentage of people recommending services using the Friends and Family Test on ward areas and in maternity services has improved
- Delivery of the emergency access target (4hrs) where the Trust is consistently performing amongst the top organisations in the country
- Achievement of all three Referral to Treatment (RTT) 18 week targets
- Delivery of Clostridium Difficile (C-Diff) target (9 cases against expected 9 patients) and no MRSA cases this year
- Achievement of income and expenditure for the year to date although income is less than planned for July
- Stable performance against mandatory training rates & appraisal rates
- Levels of sickness have reduced in July and is below target for the first time in 2015/16

Those areas requiring further attention include

- The Friends & Family measure of how many responses are collected (the footfall) on wards has been extended to include the day case unit. This department has significant numbers of patients (more than 4,000 in July) but currently a low response rate (6%). The proposed solution to this is to consider the introduction of a two way texting system.

- Outpatient activity - marginally under performed in outpatients in total for the year to date, but particularly in July. The plan has been set on working days however the actual activity will be affected by annual leave of key staff. Within outpatient activity for procedures is below plan particularly in Ophthalmology and Orthodontics, the latter due to having a substantive medical vacancy. Interviews are planned in September 2015.

- Community activity continues to be below target due to vacant community nursing posts. Recruitment into these posts continues although is not expected that this will recover the under-performance by the year end.

- Performance on Stroke Swallowing Assessment has reduced in June 2015. There is no pattern to performance (target achieved in April and May 2015 & for 7 months out of 12 last year). The Division have been asked to review the pathway to determine what additional training and actions can be taken to ensure consistency delivery.

3. Cancer

The Board have previously been updated on concerns about achieving the following 2 cancer targets

- 62 day treatment following national screening referral
- 62 day urgent GP referral to treatment

Data for these indicators is confirmed a month late with the Trust currently reporting June data. It is possible to report an interim forecast for July based on the internal assessment. Breached to target times are based on the pathway of patients which include treatment begun in Russells Hall Hospital and completed in New Cross Hospital. Many of these are complex pathways.

Despite initial concerns, the performance for these 2 indicators was above target for Quarter 1April to June 2015 (90.2% and 85.2% respectively)

The performance of this target continues to be raised with the Division through direct management lines, weekly escalation meeting with the Directors and the Divisional Performance Review meetings. In addition the Finance and Performance Committee have received separate updates.

4. 18 Week Targets

The Referral to Treatment (RTT) target for Incomplete Waits has previously included elective admissions and out-patients. From August a further group of patients those with open pathways, i.e. who have chosen to delay their treatment will be added. It is projected that this will affect the performance from the current 95.6% to approximately 94% which is still above the 92% target.

5. Recommendation

Trust Board of Directors is asked to:

a. Note the contents of the report

Anne Baines
Director of Strategy and Performance

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Dashboard 2015/16

Quality And Risk

Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Friends & Family – Community – Footfall	0%	0%	1%	1%	-	-	-	-	-	-	-	-	1%	%
Friends & Family – Community – Recommended %	97%	98%	96%	96%	-	-	-	-	-	-	-	-	96%	%
Friends & Family – ED – Footfall	8%	15%	12%	7%	-	-	-	-	-	-	-	-	11%	15%
Friends & Family – ED – Recommended %	90%	90%	92%	90%	-	-	-	-	-	-	-	-	91%	95%
Friends & Family – Maternity – Footfall	23%	22%	21%	20%	-	-	-	-	-	-	-	-	21%	15%
Friends & Family – Maternity – Recommended %	99%	99%	99%	97%	-	-	-	-	-	-	-	-	98%	84%
Friends & Family – Outpatients – Recommended %	84%	82%	82%	88%	-	-	-	-	-	-	-	-	83%	%
Friends & Family – Ward – Footfall	16%	16%	14%	15%	-	-	-	-	-	-	-	-	15%	25%
Friends & Family – Ward – Recommended %	96%	97%	98%	97%	-	-	-	-	-	-	-	-	97%	95%
Incidents - Patient Falls, Injuries or Accidents	127	116	116	103	-	-	-	-	-	-	-	-	462	
Incidents - Pressure Ulcer	187	163	182	150	-	-	-	-	-	-	-	-	682	
Never Events	0	0	0	0	-	-	-	-	-	-	-	-	0	0
Rates of Clostridium Difficile	3	3	2	1	-	-	-	-	-	-	-	-	9	9
Serious Incidents - Action Plan overdue	46	31	37	24	-	-	-	-	-	-	-	-	138	
Serious Incidents – Not Pressure Ulcer	6	9	9	10	-	-	-	-	-	-	-	-	34	
Serious Incidents - Pressure Ulcer	21	20	21	17	-	-	-	-	-	-	-	-	79	
Stroke - Suspected TIA Scanned < 24hrs of Presentation	95%	100%	91.3%	-	-	-	-	-	-	-	-	-	95.71%	60%
Stroke Admissions : Swallowing Assessment	81.25%	83.33%	72.09%	-	-	-	-	-	-	-	-	-	78.74%	80%
Stroke Admissions to Thrombolysis Time	69.23%	61.54%	42.86%	-	-	-	-	-	-	-	-	-	42.86%	%
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	94.23%	92%	92.86%	-	-	-	-	-	-	-	-	-	93.06%	80%
Zero Tolerance MRSA	0	0	0	0	-	-	-	-	-	-	-	-	0	0

Finance

Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Budgetary Performance	£279k	£535k	£70k	£135k	-	-	-	-	-	-	-	-	£1,018k	£0k
Capital v Forecast	100%	98.6%	99.7%	93.7%	-	-	-	-	-	-	-	-	93.7%	95%
Cash v Forecast	97.9%	104.9%	108.1%	87%	-	-	-	-	-	-	-	-	87%	95%
Debt Service Cover	0.72	0.93	1.05	1.13	-	-	-	-	-	-	-	-	1.13	2.5
EBITDA	£1,138k	£1,885k	£2,079k	£2,137k	-	-	-	-	-	-	-	-	£7,239k	£5,682k
I&E (After Financing)	(£783)k	(£123)k	£183k	£201k	-	-	-	-	-	-	-	-	(£522)k	(£2,050)k
Liquidity	6.1	5.76	5.41	6.28	-	-	-	-	-	-	-	-	6.28	0
SLA Performance	£1,105k	£612k	£657k	(£820)k	-	-	-	-	-	-	-	-	£1,554k	£0k
SLR Performance	(£782)k	(£123)k	£184k	£201k	-	-	-	-	-	-	-	-	(£521)k	£0k

The Dudley Group NHS
NHS Foundation Trust

Dudley Group NHS Foundation Trust
Integrated Performance Dashboard 2015/16

Performance

Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
A&E - A&E Attendances Seen Within 4 Hours (%)	98.6%	98.8%	99.1%	99.3%	-	-	-	-	-	-	-	-	99%	95%
Activity - A&E Attendances	7,895	7,940	8,137	8,052	-	-	-	-	-	-	-	-	32,024	26,222
Activity - Community Attendances	34,405	33,071	35,042	34,401	-	-	-	-	-	-	-	-	136,919	146,116
Activity - Elective Day Case Spells	3,620	3,418	4,012	3,958	-	-	-	-	-	-	-	-	15,008	14,543
Activity - Elective Inpatients Spells	482	525	581	581	-	-	-	-	-	-	-	-	2,169	2,393
Activity - Emergency Inpatient Spells	4,424	4,280	4,181	4,240	-	-	-	-	-	-	-	-	17,125	16,062
Activity - Outpatient First Attendances	10,672	10,106	12,331	12,472	-	-	-	-	-	-	-	-	45,581	40,836
Activity - Outpatient Follow Up Attendances	26,300	24,530	28,307	27,851	-	-	-	-	-	-	-	-	106,988	109,351
Activity - Outpatient Procedure Attendances	4,308	3,957	4,745	3,928	-	-	-	-	-	-	-	-	16,938	19,431
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	97.7%	96.4%	95.5%	-	-	-	-	-	-	-	-	-	96.5%	93%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	100%	98.7%	100%	-	-	-	-	-	-	-	-	-	99.6%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	100%	100%	100%	-	-	-	-	-	-	-	-	-	100%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	-	-	-	-	-	-	-	-	-	100%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	100%	100%	100%	-	-	-	-	-	-	-	-	-	100%	94%
Cancer - 62 day - From Referral for Treatment following national screening referral	82.4%	91.3%	95.2%	-	-	-	-	-	-	-	-	-	90.2%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	83.6%	81.9%	88.5%	-	-	-	-	-	-	-	-	-	85.3%	85%
RTT - Admitted Pathways within 18 weeks %	95.2%	95.3%	96.1%	95.6%	-	-	-	-	-	-	-	-	95.6%	90%
RTT - Incomplete Waits within 18 weeks %	95%	95.2%	95.2%	95.6%	-	-	-	-	-	-	-	-	95.3%	92%
RTT - Non-Admitted Pathways within 18 weeks %	97.7%	97%	98%	98.3%	-	-	-	-	-	-	-	-	97.8%	95%

Staff/HR

Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Appraisals	88%	80.6%	81.5%	80.8%	-	-	-	-	-	-	-	-	80.8%	90%
Mandatory Training (Substantive)	81.53%	82.13%	82.8%	82.35%	-	-	-	-	-	-	-	-	82.35%	90%
Sickness Rate (Performance Dashboard)	3.52%	3.70%	3.68%	3.44%	-	-	-	-	-	-	-	-	3.58%	3.50%
Staff In Post (Contracted WTE)	4,095.77	4,077.64	4,050.2	4,024.21	-	-	-	-	-	-	-	-	4,024.21	

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the meeting of the Board of Directors
Thursday 3rd September 2015

TITLE:	**Trust Constitution Annual Review**		
AUTHOR:	**Mrs Helen Board, Patient and Governor Engagement Lead**	**PRESENTER**	**Mr Glen Palethorpe, Director of Governance / Board Secretary**
CORPORATE OBJECTIVE: SO 5 Make the best of what we have			

SUMMARY OF KEY ISSUES:

Each year the Trust Constitution is subject to review and is updated to reflect any changes required. Changes to the Trust's Constitution can only take effect when amendments are approved by more than half of the voting members of the Trust Board of Directors and more than half of the Council of Governors.

As part of this year's review there are a small number of proposed changes are set out in the table below. It should be noted that these changes are not material to the operation of the Trust but do take into account regulation or guidance changes such as the introduction of the Fit and Proper Person Requirement placed on all NHS Directors or align the constitution to more efficient processes for example the review of the Scheme of Delegation to be undertaken at the same time as happens for the Trust. Once approved these will go forward to the Council of Governors meeting tonight for their consideration and approval.

Constitution Review 2015

Item number	Page number	Existing Text	Proposed text	Reason for change
23. Board of Directors – Appointment and removal of the chief executive and other non-executive directors	10	None	23.5 a person deemed to be fit and proper as set out in the CQC Fit and Proper Persons requirements except with the approval in writing of Monitor. Removal may be triggered by a person who fails to meet the fit and proper person requirements (FPPR).	Appointment can only be made if the person meets the fit and proper person requirement set out by the CQC regulations.
25. Board of Directors - removal	10	None	25.4 Removal may be triggered by a person who fails to meet the fit and proper person requirements (FPPR).	The Director must maintain an on-going ability to if the person meets the fit and proper person requirement set out by the CQC regulations. Failure to do so may trigger their removal.
28. Board of Director – remuneration and terms of office	11	None	28.3 the terms of office shall be reflective of guidance issued by Monitor.	This has been added to bring greater clarity. We have always reflected such guidance.
35. Annual report and forward plans and non-NHS work	13	None	35.8 For statutory transaction more than half the members of the Council of Governors must approve any application by the Trust to: - merge with or acquire another trust - separate the Trust into two or	This has been added to take account of the latest Monitor Guidance issued in March 2015.

			more new NHS foundation trusts - be dissolved NOTE as in previous years other significant transactions would be consulted with the Full Council of Governors	
59. (2) a	41	A statement submitted by the candidate of no more than 100 words, and …	A statement submitted by the candidate of no more than 200 words, and…	Based on feedback from prior elections candidates have felt that 100 words is too restrictive. This has been increased to 200 as a limit is felt to be beneficial and focuses candidates on being concise in their statement.
Annex 6, item 14	44	they are a member of the Local Involvement Networks (LINKs) /Healthwatch relating to this Foundation Trust;	they are a member of the Healthwatch relating to this Foundation Trust;	Update as LINKs no longer exist.
Annex 8 Standing orders – Board of Directors	66			Reviewed with no changes required
9.2 Review of Standing orders	85	**CoG** 9.2.1 Standing Orders shall be reviewed every two years. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders	9.2.1 Standing Orders shall be reviewed annually. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.	This change aligns the review with that undertaken by the Board of Directors

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**No**	**Details:**
	Monitor	**Yes**	**Details: compliance with Code of Governance Framework**
	Other	**No**	**Details:**

ACTION REQUIRED OF COUNCIL OF GOVERNORS

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

To approve the amendments to the Trust Constitution

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 3rd September 2015

TITLE:	**Operational Plan 2015/16 Q1 progress against the annual goals**		
AUTHOR:	Karen Morrey	**PRESENTER**	Anne Baines Director of Strategy & Performance

CORPORATE OBJECTIVE: All

SUMMARY OF KEY ISSUES:

The attached table identifies the progress against the annual goals identified in this year's Operational Plan.

Strategic Objective	RAG rating		
	Red	Amber	Green
Deliver a Great patient experience			4
Deliver safe and caring services		3	11
Drive service improvement, innovation and transformation		3	4
Be the place people choose to work		2	3
Make the best use of what we have		2	3
Plan for a viable future	1	2	2
Total	**1**	**12**	**27**

Where there is slippage identified the lead Executive has outlined the mitigating actions being undertaken.

A further review will be carried out at the end of Q2.

IMPLICATIONS OF PAPER: ***(Please complete risk and compliance details below)***

RISK			**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** All
	Monitor	**Y**	**Details:** Operational Plan is submitted to & approved by Monitor

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	x	**x**	

RECOMMENDATIONS FOR THE BOARD:

- The progress against each of the goals is noted
- Assurance that remedial actions are being taken

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2015/16 Q1 Progress against the Annual Goals

Annual Goal	Measures of Achievement	Timescale	Lead	Q1 Performance	RAG	Remedial Action
Deliver a great patient experience						
➢ Achieve good FFT results/patients survey	✓ Monthly scores equal or better than national average	Monthly	Chief Executive	Achieved better than average for in-patients & community. Out patients not yet published nationally	G	
➢ Ensure patients, carers and public fully engaged and involved	✓ Improved National Patient Survey results ✓ Demonstrate engagement through feedback	Annual Ongoing	Chief Executive	The 2015 survey will sample 1250 patients who were inpatients during July 2015. Task and Finish Group established and developed detailed action plan to improve those areas where we scored less than the national average. Circulated to staff responsible for delivery of actions to themes identified from improvement relating to communication, environment and process. All actions monitored by Patient Experience Group. Provisional survey results for 2015 survey work expected late 2015. The Trust is employing a range of communication and engagement mechanisms to inform staff and patients of feedback received from survey sources including national and local surveys. Developed enhanced analysis tool and modified report submitted quarterly to the Patient Experience Group, displaying the 'you said, we did' in wards and clinic areas, publishing results of survey feedback to Trust website and in the Your Trust magazine	G G	
➢ Achieve key performance	✓ 95% emergency access standard	Monthly	Chief Operating Officer	Achieved	G	

standards	✓ 18 weeks RTT ✓ Cancer treatment standards	Monthly Monthly		Achieved Achieved		
Deliver safe and caring services						
➢ Deliver quality improvements	✓ Achievement of nursing care indicators ✓ Zero avoidable stage 4 pressure ulcers ✓ Reduction in stage 3 pressure ulcers from 14/15 ✓ Zero post 48 hour MRSA cases ✓ No more than 29 post 48 hour clostridium difficile ✓ Achievement of improvement trajectory in nutritional audit ending year in all wards green (93%)	Quarterly Monthly March 2016 March 2016 March2016 Monthly/March 2016	Chief Nurse	Review of the NCI process identified suboptimal assessment and escalation process No stage 4 pressure ulcers identified On track to achieve, but time lag in assessment impacts on ability to predict numbers accurately No post 48 hour MRSA cases Quarter trajectory exceeded by 1 case; should have been 7 but 8 cases recorded. Annual limit of 29 cases remains significant challenge The overall Trust score is 97% for the target is presently being met some not yet at green but on target to achieve.	A G G G A G	Review of audit tool and escalation Improve process of review Increase Focus for teams Review of areas in escalation
➢ Deliver agreed CQUIN requirements	✓ Deliver CQUINs schemes	Ongoing	Director of Strategy & Performance	On track. Q1 delivered in all	G	
➢ Maintain good mortality performance	✓ SHMI/HSMR within expected range ✓ 85% of in hospital deaths have multidisciplinary review within 12 weeks	Ongoing Ongoing	Medical Director	The latest SHMI published for the period January – December 2014 is 1.038. The 15/16 target is 90% of deaths, where applicable, within 12 weeks. Q1 data is not available in full until 12 weeks after the end of q1 which would be 30/09/2015 but a calculation to date shows 91.5%.	G G	
➢ Improved risk management	✓ Reconfiguration of DATIX system	March 2016	Director of Governance	Datix are working with the Corporate Governance and IT Teams to build a stable version of Datix. This work commences on the 1st September. September training on Datix (the latest version) will be provided to the Divisions / Directorates working	G	No additional action required

				towards. A launch of Datix version 14 by the end of October. Once the new system is launched then the improved reporting will be delivered thus allowing the Divisions and the Corporate Governance Team to focus on the "learning" from incidents rather than mechanically on the reporting.		
➢ Deliver requirements from key quality inspections	✓ Deliver CQC action plan ✓ Deliver WMQRS action plans	See action plan See action plans	Chief Executive	An update report was taken to the Board in June providing assurance over the progress with the key actions from the previous inspection. Due to service changes after the inspection 2 areas were deemed to be open to ensure that actions completed following the service redesign did not cut across the CQC initial actions. A further update on these will be presented later in the year. As WMQRS reviews are undertaken action plans are developed to address any findings. The action plan in relation to the Day Theatres review was presented to CQSPE and has been shared with the CCG as part of the regular CQR meetings. Progress against the completion of the final actions where the due dates were after the CQSPE and CQR mtg will be reported to subsequent CQSPE meetings.	G G	None identified at this stage None identified at this stage
➢ Safe staffing levels	✓ Deliver safe staffing levels	Monthly	Chief Nurse	1:8 ratios in place (day) escalation of red areas on capacity brief. New starters due September intake – 41 staff. Midwifery 15 vacancies now filled due to start Sept/Oct	G A	Recruitment continues Mitigation plans in place
Drive service improvement, innovation & transformation						
➢ Develop integrated services and redesigned community provision	✓ Integrated services across acute and community in place ✓ Redesigned community services in line with Vanguard proposals	Dec 2015 March 2016	Director of Strategy and Performance/ Chief Operating Officer	Proposal developed for New Divisional structure including Integrated Pathways Re-design of community nursing structure developed to support Vanguard	G G	
➢ Increase access to 7 day services	✓ 7 day services in place in diagnostics	TBA	Chief Operating Officer	Status report to Board Workshop. Self assessment to be submitted 4th September	A	

➢ Continued improvement in key services	✓ Improvements in service performance delivered stroke/renal/care of the elderly	Review quarterly	Chief Operating Officer	Stroke – achieves on most performance targets. Further work underway to reduce variations Renal – external MSH appointed. CIP continues to make some process Care of the Elderly – improvement in LOS, results in closure of A1. Further work to support Vanguard frail elderly pathway	G A G	
➢ Expand Research & Development / Academic Health Sciences Network role	✓ Demonstrate greater involvement and engagement	Ongoing	Medical Director	Participated in Innovation Adoption benchmarking process. Trust representation on AHSN advisory groups	A	
Be the place people choose to work						
➢ Continued implementation of Listening into action	✓ Regular events in place	June 2015	Chief Executive	Support, guidance and publicity continues to be provided to teams wishing to use the LiA format to improve services. Events held in Q1 included PALS and Community Transformation.	G	
➢ Enhance colleague engagement	✓ Improved scores in National staff Survey ✓ Wider engagement developed	Annually Ongoing	Chief Executive Chief Executive	Plans are being developed to improve the score for National Staff Survey. Engagement activities continue, including CE face-to-face briefings, Long Service Awards and launch of Committed to Excellence. Trust's Facebook site launched in Q1 and we are about to launch 'Team of the Week' on Facebook to highlight the work of teams across the Trust and promote their services. Twitter followers steadily increasing (now stands at 1533 followers). Staff Discounts page on the Hub grows in popularity and positive feedback received.	G	
➢ Improve workforce performance in sickness, mandatory training, appraisal	✓ Sickness a target 3.5% ✓ Mandatory training and appraisal target of 90%	Monthly	Chief Executive	Trust absence rate for June 2015 was 3.77% Mandatory training compliance for July 2015 was 82.8% against a 90% target Appraisal compliance in June 2015 was 81.5% across the Trust	A A	
➢ Leadership development/OD	✓ To develop the measure in year	Quarterly	Chief Executive	As at end July 2015, 56 staff are enrolled on the Trusts leadership course. The	G	

				completion rate is 80%.		
Make the best use of what we have						
➢ Develop IT Strategy /EPR	✓ Strategy and plan in place	December 2015	Chief Executive	The Trust has engaged Cymbio, (part of Capita Health), to carry out a process review across the hospital to measure the effectiveness of Clinical IT. This work started in August 2015 and will complete in October. This output will enable the development of and detailed output Based Specification for upgrade/replacement of clinical systems. An outline Business case will be submitted to the December 2015 Board.	G	
➢ Match capacity to demand	✓ Initial improvement achieved	Quarterly	Chief Operating Officer	Further work on capacity and demand to meet access targets in diagnostics & cancer services	A	
➢ Deliver financial (recovery) plan	✓ Effective plans in place and monitored ✓ Financial plans delivered in line with plans	Monthly	Director Finance and IT	FRP currently forecast to save £16.7m in 2015-16. Monthly monitoring through TEC and F&P	G	
➢ Delivery Monitor financial requirements	✓ Deliver plan i.e. Deficit of £4.2m, rating of 2	Monthly	Director of Finance and IT	Forecast out-turn £3.1m at month 4 and forecast COS rating of 3. Monthly monitoring through F&P and TME.	G	Bringing forward 2016-17 schemes if monthly run rate shows sign of deterioration
➢ Deliver the CIP	✓ Deliver CIP and financial target	Monthly	Director Strategy and Performance	Introduced new governance approach. £4.299m delivered against a target of £5.188m Developing proposals for 2016/17	A	
Plan for a viable future						
➢ Revise the current 5 year plan	✓ Revised plans in place	June 2015	Director of Strategy and Performance	Completed & submitted to Monitor.	G	Discussion with Monitor on FRP may result in further amendment
➢ Review the Clinical Strategy	✓ Revised plans in place	June 2015	Director of Strategy and Performance	The work on the Transformation plan has led to delays in this commencing	R	Discussions underway with Execs to agree the process

➢ Develop an economy wide plan with CCG and other providers in Dudley	✓ Play a full part in this work	July 2015	CEO/ Director of Strategy and Performance	Initial discussions taken place with other organisations in Dudley. Focus is on the Vanguard proposal currently	A	Discussion took place at the Board workshop
➢ Play a part in the development of the Black Country Alliance	✓ Plan and Programme in place across alliance	July 2015	CEO	Launched. 1st Board in September. Workstreams are in place. Trust deliverables not yet identified	G	
➢ Dudley Partnership	✓ Vanguard	TBA	CEO/DSP	Vanguard proposal developed. Partnership meeting in place. Process in place. Trust deliverables not yet identified	A	Discussion on the way forward took place at the Board workshop

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 3 September 2015

TITLE	**Performance Report June (Month 3) and July (Month 4)**		
AUTHOR	**Paul Taylor** **Director of Finance and Information**	**PRESENTER**	**Jonathan Fellows** **F & P Committee Chairman**
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: **Summary reports from the Finance and Performance Committee meetings held on 30 July 2015 and 27 August 2015.**			

RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year**
COMPLIANCE	**CQC**	**Y**	**Details:** **CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.**
	NHSLA	**N**	
	Monitor	**Y**	**The Trust remains on monthly monitoring by Monitor.** **Monitor has confirmed that the Trust is in breach of its authorisation conditions regarding future financial sustainability. Undertakings have been signed by Trust to resolve this position**
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners**

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
			X
RECOMMENDATIONS FOR THE BOARD: **The Board is asked to note the contents of the report.**			

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance & Performance Committee	30 July 2015	Jonathan Fellows	yes	

Declarations of Interest Made

None

Assurances Received

- The Committee noted that the EPR consultancy contract had been awarded to Cymbio
- The Committee will received regular updates on the IT Infrastructure upgrade project
- JAC electronic messages had been switched back on and performance was good
- The Medical Division confirmed that the 62 day cancer target was achieved for Q1
- Community services had moved forward over the last 12 months and integration with acute services has been positive
- The rapid response team was now up and running
- I & E performance was better than planned with a year to date deficit of £723,000 which is £2.119m ahead of plan
- The balance sheet and cash position was ahead of plan after 3 months
- The Trust continues to be a high performer against the national ED 4 hour target with a performance of 99.3% against the 90% target
- The Trust's performance against all other national and local key performance targets was good
- The Committee received Workforce key performance indicators
- CIP savings made were currently slightly ahead of plan at £4.29m. There is slippage against some schemes and work is taking to identify additional schemes to secure the planned level of saving

Decisions Made / Items Approved

- The Committee considered and approved the Monitor Q1 return and associated declarations
- The Committee ratified the Patient Access Referral to Treatment (RTT) policy

Actions to come back to Committee

- A report will be presented to the Committee following review of two recently published cancer documents, detailing any impact the on the Trust
- An update on performance against cancer targets will be presented to the August F & P Committee

Items referred to the Board for decision or action
• **There were no items for referrals to the Board of Directors**

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance & Performance Committee	27 August 15	Jonathan Fellows	yes	

Declarations of Interest Made

None

Assurances Received

- Feedback on the progress on the EPR business case work, and received assurances that meetings would be planned to enable maximum participation by clinical and other staff, together with the chance for staff from the Transformation team to attend
- Dawn Wardell (CNO) gave details of the steps being taken to arrest the rise in spending on bank and agency qualified nurses which had risen in June and July 2015
- Progress being made to meet the 62 day Cancer target, and the implications of a number of "long waiters" being treated at our tertiary centre
- The current financial projection for 2015-16 after 4 months remains at £3.133m deficit although spending in July 2015 was higher than expected and income lower. A number of risks and mitigations were discussed including a change of approach to contract management from commissioners.
- Major performance indicators were all performing to the agreed standards
- The Financial Recovery Plan 2015-16 was forecast to out-turn at £16.7m, in line with the plan in aggregate

Decisions Made / Items Approved

- The Financial Recovery Plan 2016-17 was agreed, and would be recommended to Board

Actions to come back to Committee

- CNO and Finance team to work to produce a forward look of qualified nurses in post, and estimated bank and agency for each month of the rest of 2015-16, or in order to monitor progress

Items referred to the Board for decision or action

- The Financial Recovery Plan 2016-17, and the submission to Monitor of 21st August 2015 regarding financial sustainability