The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 4 June, 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**		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 7 May 2015	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 7 May 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	Y O'Connor	To Note & Discuss	10.00
	7.2 Nursing Staffing Report	Enclosure 5	Y O'Connor	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 Trust response to the Lampard Report	Enclosure 7	G Palethorpe	To Note	10.30
	7.5 Annual Report – Doctors Appraisal & Revalidation	Enclosure 8	P Harrison	To Note	10.40
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 9	J Fellows	To Note & Discuss	10.50
	8.2 Audit Committee Exception Report	Enclosure 10	R Miner	To Note & discuss	11.00
	8.3 Charitable Funds Exception report	Enclosure 11	D Bland	To Note	11.10
9.	**Compliance**				
	9.1 Monitor Certifications	Enclosure 12	G Palethorpe	To Note	11.15
10.	**Any other Business**				
	10.1 CQC Inspection Action Plan	Enclosure 12a	G Palethorpe	To note	11.20

11.	**Date of Next Board of Directors Meeting** 9.30am 2 July 2015, Clinical Education Centre		D Badger		11.20
12.	**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		11.20

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 7th May, 2015 at 9:30am in the Clinical Education Centre.

Present:

David Badger, Chairman
Richard Miner, Non Executive Director
Jonathan Fellows, Non Executive Director
Denise McMahon, Nursing Director
Paul Taylor, Director of Finance and Information
Ann Becke, Non Executive Director
Doug Wulff, Non Executive Director
David Bland, Non Executive Director
Paula Clark, Chief Executive

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Anne Baines, Director of Strategy and Performance
Jon Scott, Chief Operating Advisor
Julie Bacon, Chief HR Advisor
Glen Palethorpe, Director of Governance/Board Secretary
Yvonne O'Connor, Deputy Director of Nursing
Raj Paw, Organ Donation Committee Representative
Terry Whalley, Programme Director, Black Country Alliance

15/045 Note of Apologies and Welcome

Apologies were received from Paul Harrison. The Chairman welcomed Terry Whalley, Programme Director for the Black Country Alliance to the meeting.

15/046 Declarations of Interest

There were no declarations of interest.

15/047 Announcements

The Chairman announced that this was the Chief Operating Advisor and Director of Nursing's last meeting. The Chairman thanked the Nursing Director on behalf of the Board for her hard work over her many years working at the Trust and wished her well for the future, he also thanked the Chief Operating Advisor for the legacy he was leaving at the Trust and wished him well for the future.

15/048 Minutes of the previous Board meeting held on 2nd April, 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.

15/049 Action Sheet, 2nd April, 2015 (Enclosure 2)

15/049.1 Nurse Staffing Report (Items 15/027.2, 15/038.1, 15/030.2)

Item 15/027.2 and 15/038.1: Representations had been made through the normal channels and a letter was not now required.

Item 15/030.2: to be discussed further with the Nursing Director.

Item 15/030.2 regarding nurse staffing reporting to be discussed further with the Nursing Director.

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.

15/050 Patient Story

Liz Abbiss, Head of Communications and Patient Experience presented the patient story. The story related to a patient receiving care on Ward C8. A transcript of the story was provided to Board members.

The Chairman noted that there were both some worrying and encouraging comments. The Nursing Director stated that there were some communication issues around the patient's discharge but confirmed that learning issues are being addressed with the relevant staff. Mrs Becke, Non Executive Director, asked that the positive comments were also fed back to the cleaners on the ward.

The Chairman noted the patient story.

15/051 Chief Executive's Overview Report (Enclosure 3)

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

- **Friends and Family Test Performance:** The Trust continued to perform well in April with an increase to 98% against the national position of 95%. There had been a dip reported in ED and this was as a result of reduced footfall in relation to the Urgent Care Centre. The Trust was on or above the targets for Maternity Services.

- **Operational Performance:** The Trust appeared in the number one position nationally for the second time in April for ED. The Emergency Care Intensive Support Team had visited the Trust that week and there had been positive outputs from the event. Challenges were noted around Cancer and Diagnostics, and measures had been put in place to resolve the position. The Chairman asked if the Finance and Performance Committee could revisit Diagnostic performance. Mr Fellows, Chair of the Finance and Performance Committee confirmed that the Committee is monitoring performance and the Trust should recover the position by June.

- **National Staff Survey 2014:** The Trust has performed well and was in the top 20% in the country for a number of measures.

The Chairman noted the report and the positive response to the National Staff Survey.

15/052 Patient Safety and Quality

15/052.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Nursing Director 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: Finished the year with 38 cases against the target of 48 for the year. The Trust is on target for the year with 3 cases against the target of 29 cases for the year.

Norovirus: Continued good performance.

The Chairman noted the positive report and confirmed that the continued good performance on infection control was a testament to the hard work of the Nursing Director.

15/052.2 Nurse Staffing Report (Enclosure 5)

The Nursing Director presented the Nurse Staffing report given as Enclosure 5.

The Board noted that there had been 51 shifts below plan, which was a slight rise on last month. The Nursing Director confirmed that the new graduate pool has commenced.

No red alerts had been identified on the staffing sheet.

The Chairman noted the positive report.

15/052.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)

The Medical Non Executive Director presented the Clinical Quality Safety Patient Experience Committee Exception Report, given as Enclosure 6. The Board noted the new style report and noted the following key areas:

- Positive assurances were received around the Saving Lives Audit Tool, Quality Performance Dashboard, Quality Accounts, Nursing Strategy and Learning Disability Strategy, KPIs and the Lampard (Saville) recommendations.

- Negative assurances were received around the TAL target and would be reported back to the 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.

- One item was referred to the Board for decision and this was to seek the Board's approval to ask the Vanguard Partnership Board members and in particular their Clinical Strategy Group to work on developing cross local economy strategies for End of Life and Palliative Care, Learning Disabilities, Dementia, Falls and DNACPR. The Board approved this approach.

The Board confirmed that they liked the new exception reporting style.

The Chairman noted the report and the Board's support for the referral to the Partnership Board.

15/052.4 Organ Donation Report (Enclosure 7)

Raj Paw, Organ Donation Committee Lead, presented the Organ Donation Report, given as Enclosure 7, the following key issues were noted:

- Key Achievements for 2014/15: 6 organs had been donated for transplant. The Donation after Brain Death and Donation after Cardiac Death Policy had been ratified and is now available on the Hub. Agreement had been reached that a datix form would be submitted if elements of the donation pathway were not adhered to. An Annual Plan had been devised for 2014-17, the Donor Recognition Project was completed and Mr Bland, Non Executive Director, was appointed as NED Lead on the Committee.

- Organ Donation Data: Large increase in donations nationally, particularly after cardiac death.

- Issues arising and actions planned: Maintain data collection and review quarterly performance via the Organ Donation Committee.

The Board noted the reduced input by the Organ Donation Specialist Nurse following maternity leave.

The Director of Strategy and Performance asked how we extend the role into the Community. Mr Paw confirmed that most Community patients would not be suitable for donation but this is an element that could be considered in the future. Dr Wulff, Non Executive Director, stated that taking the message into the Community would improve awareness. Mr Bland, Non Executive Director, commented that families can override a patient's wishes following death.

The Chairman noted the report and the work of the Organ Donation Committee and recorded the Board's thanks to the Committee and to the work of Steve Waltho, Committee Chair.

15/052.5 Nurse and Midwife Revalidation (Enclosure 8)

The Nursing Director presented the Nurse and Midwife Revalidation Report, given as Enclosure 8.

The Nursing Director confirmed that a page had been established for nurses on the Hub relating to revalidation.

An outline of revalidation requirements were included in the report at Appendix 1.

The Board noted that Derek Eaves is the lead for revalidation at the Trust. The Nursing Director confirmed that the work on revalidation will drive appraisal rates.

The Terms of Reference for the Nurse/Midwife Appraisal and Revalidation Group were presented at Appendix 2 of the papers. The Chief Operating Advisor commented that in the quoracy element it should be either the Chair or the Vice Chair to attend and not both. The Nursing Director noted the amendment.

The Nursing Director confirmed that revalidation is a huge piece of work for the Trust but work is well advanced in preparation.

Mrs Becke, Non Executive Director, confirmed that she had attended an event earlier in the week for International Midwives' Day and the staff at the event appeared calm about revalidation.

The Chairman noted the report and positive approach taken, noted the plan of action detailed in the report and the Terms of Reference along with the suggested amendment made by the Chief Operating Advisor.

The Chairman asked about the reporting arrangements for the Group. The Nursing Director confirmed that this would be to the Matrons' Group and then to the Clinical Quality, Safety, Patient Experience Committee.

15/053 Finance

15/053.1 Finance and Performance Report (Enclosure 9)

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Report, given as Enclosure 9.

The Board noted that performance in March had been affected by year end accounting adjustments. For the year end the Trust had achieved a final position better than plan and a better cash position than budget at £26.2m

Non financial performance continued to be strong with the exception of Diagnostic waits which had been discussed earlier in the meeting.

The Draft Plan for 2015/16 will be circulated shortly and shows a return to balance by 2016/17.

The Board gave approval to delegate authority to the Audit Committee to approve the Annual Accounts.

The Chairman noted the positive report for the year end despite the Trust facing massive challenges. The Board approved the delegation to the Audit Committee.

15/054 Any Other Business

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

15/055 Date of Next Meeting

The next Board meeting will be held on Thursday, 4th June, 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 7 May 2015

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
15/019.3	Estates Report on Emergency Planning and Business Continuity	Risk Committee to investigate assurance around Emergency Planning and Business Continuity in more detail.	JS	16/6/15	To June Risk Committee Meeting
15/049.1	Nursing Staffing	Item 15/030.2 regarding nurse staffing reporting to be discussed further with the Nursing Director	DM/C	4/6/15	
15/008.9	Research and Development Report	The hidden benefits of Research and Development, particularly around drug costs, to be included in future Research and Development Reports to Board. Dr Neilson to consider presenting an update on the Trust's Research and Development activities to Dudley CCG.	PH JN	2/7/15 2/7/15	

ENCLOSURE 3

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Public Board Meeting – 4th June 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
- Junior Doctors' supervision – top ranking
- NHS England visit to Vanguard programme
- 7 Day service update

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
NHS Foundation Trust

Chief Executive's Report – Public Board – June 2015

Friends and Family: Update June 2015 Board

Community (01.05.15 – 17.05.15 provisional)

In April 2015 97% of respondents indicated they would be extremely likely or likely to recommend the service they had used to friends and family. Work is on-going with local managers to improve the response rates. National benchmarking data is not available at this time.

Community Services April 2015	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Community Nursing Services – percentage recommended	90%	91%	97%	100%	100%
No of responses	12	23	30	5	3
Rehab and Therapy services – percentage recommended	87%	100%	91%	100%	100%
No of responses	31	7	22	9	1
Specialist Services – percentage recommended	90%	100%	95%	95%	100%
No of responses	10	1	59	22	2
Combined score – percentage recommended	89%	93%	95%	97%	*
Total responses	53	31	111	36	*

**less than 5 responses are not reported nationally*

Inpatient FFT (01.05.15 – 17.05.15 provisional)

The percentage of friends and family who would recommend the Trust's inpatient services has been maintained at 98% (during the period 1st -17th May. The latest published NHS England figures are for March 2015 and show The Dudley Group scored 98% against the national average of 95%. This makes us the top performer when compared to neighbouring trusts (Sandwell and West Birmingham, Walsall, Royal Wolverhampton) which we have held since April 2014.

We have also implemented FFT in day case and our children's inpatient areas with the first data submitted to NHS England in May 2015 included as part of the inpatient report. The provisional inpatient response rate for May (01.05.15 – 17.05.15) shows a small increase to 35% (compared to 34% for April 2015).

	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015 Provisional
Date range	01.01.15	01.02.15	01.03.15	01.04.15	01.05.15
	31.01.15	28.02.15	31.03.15	19.04.15	17.05.15
Number of eligible inpatients	1901	1717	1912	1368	1228
Number of respondents	596	742	909	471	428
Ward FFT recommended percentage	97%	98%	98%	98%	96%
Ward footfall	31%	43%	48%	34%	35%

A&E FFT (01.05.15 – 17.05.15 provisional)

The percentage of friends and family who would recommend the Trust's A&E has increased during the period 1st – 17th May to 91% compared to 90% for April. The latest published NHS England figures are for March 2015 show The Dudley Group scored 92% against the national average of 87% which put us in the top 20% of trusts. Locally, this puts us second to Worcester Acute at 95%.

The provisional response rate for May (01.05.15 – 17.05.15) shows a slight increase to 10% compared to 5% for April 2015. The A&E information does not include the Urgent Care Centre; this will be reported separately by Malling to NHS England.

The Dudley Group NHS
NHS Foundation Trust

Date range	Jan 2015	Feb 2015	March 2015	April 2015	May 2015 provisional
	01.01.15	01.02.15	01.03.15	01.04.15	01.05.15
	31.01.15	28.02.15	31.03.15	19.04.15	17.05.15
Number of eligible A&E patients	4023	3622	3804	3858	1944
Number of respondents	587	1045	1011	421	191
A&E FFT recommended percentage	95%	98%	92%	90%*	91%
A&E footfall)	15%	29%	27%	8%*	10%

**note different to reported figure in April due to UCC figures being removed.*

Inpatient FFT Score	*97+*	*A&E FFT Score*	*95+*
	96		*94*
	<95		*<94*

Response rate A&E	*<15 %*	*15-20%*	*20%+*	
Response rate Inpatients	*<25 %*	*25-30%*	*30-40% +*	*40%+ ★*

FFT Scores key	*Top 20% of Trusts (based on December 14 scores)*
	Top 30% of Trusts (based on December 14 scores)
	Below top 30% of Trusts (based on December 14 scores)

Maternity FFT (01.05.15 – 17.05.15 is 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	Jan 2015	Feb 2015	Mar 2015	Apr 2015	1-17 May 2015 Provisional
Antenatal Score, percentage recommended	98%	99%	100%	95%	98%
Response rate	19%	33%	30%	30%	30%
Birth, Percentage recommended	99%	97%	99%	100%	100%
Response rate	18%	38%	31%	26%	20%
Postnatal ward, Percentage recommended	99%	99%	99%	100%	100%
Response rate	18%	38%	31%	26%	20%
Postnatal community, Percentage recommended	100%	100%	100%	100%	100%
Response rate	13%	11%	100%	8%	16%

Key

% 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 key	*Top 20% of Trusts (based on March 14 scores)*
	Top 30% of Trusts (based on March 14 scores)
	Below top 30% of Trusts (based on March 14 scores)

Outpatients

The first data for April has been submitted to NHS England. There is no national benchmarking available at this time. NHS England does not require the submission to include eligible population figures.

FFT Outpatients Services	Apr-15	May-15 Provisional
	01.04.15	01.05.15
	30.04.15	17.05.15
Number of respondents	49	55
Outpatients recommended percentage	84%	78%

Junior Doctors' supervision:
The Trust has been identified nationally as a top performing Trust for supervising newly qualified doctors in the workplace for two successive years by the national General Medical Council's annual survey of trainees.

In recognition of this, Dr Whallett, Head of Medical Education has been invited to a forum in London to share some of the good practices that have been put in place in Dudley over recent years which have contributed to this coveted achievement. An example of is the intensive training in safe medicines prescribing in Russells Hall for new doctors and pharmacy trainees that won another national award as part of Health Education England's 'Better Training, Better Care' initiative in 2012.

NHS England visit to Vanguard programme:
The New Models of Care team from NHS England who are heading up the Vanguard programme visited the Dudley health and social care economy teams over two days last month. The visiting teams were shown progress on the Vanguard programme in Dudley and were taken to some showcase sites. As a health and social care economy we were able to demonstrate the joint working between organisations and also to talk about the support we would like from NHSE to progress our plans faster.

7 Day Services – update on progress and schedule:
We are currently undertaking a readiness assessment on our progress and status for 7 day services. An update paper will be presented to Board in July.

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors 4th June 2015 - PUBLIC

TITLE:	Infection Prevention and Control Exception Report		
AUTHOR:	Denise McMahon – Director of Nursing Dr Elizabeth Rees - Consultant Microbiologist/Infection Control Doctor/ Director of Infection Prevention and Control	**PRESENTER:**	Yvonne O'Connor Deputy Nursing Director

CORPORATE OBJECTIVE:
SG01: 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.

SUMMARY OF KEY ISSUES:
The Board of Directors are asked to note Trust Performance against C. Difficile and MRSA targets and the other notable infections.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Infection Prevention and Control	
	Risk Register: Y		**Risk Score:**	IC010 – Score: 16
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**	Outcome 8 – Cleanliness and Infection Control
	NHSLA	**N**	**Details:**	
	Monitor	**Y**	**Details:**	Compliance Framework
	Equality Assured	**Y/N**	**Details:**	
	Other	**Y/N**	**Details:**	

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

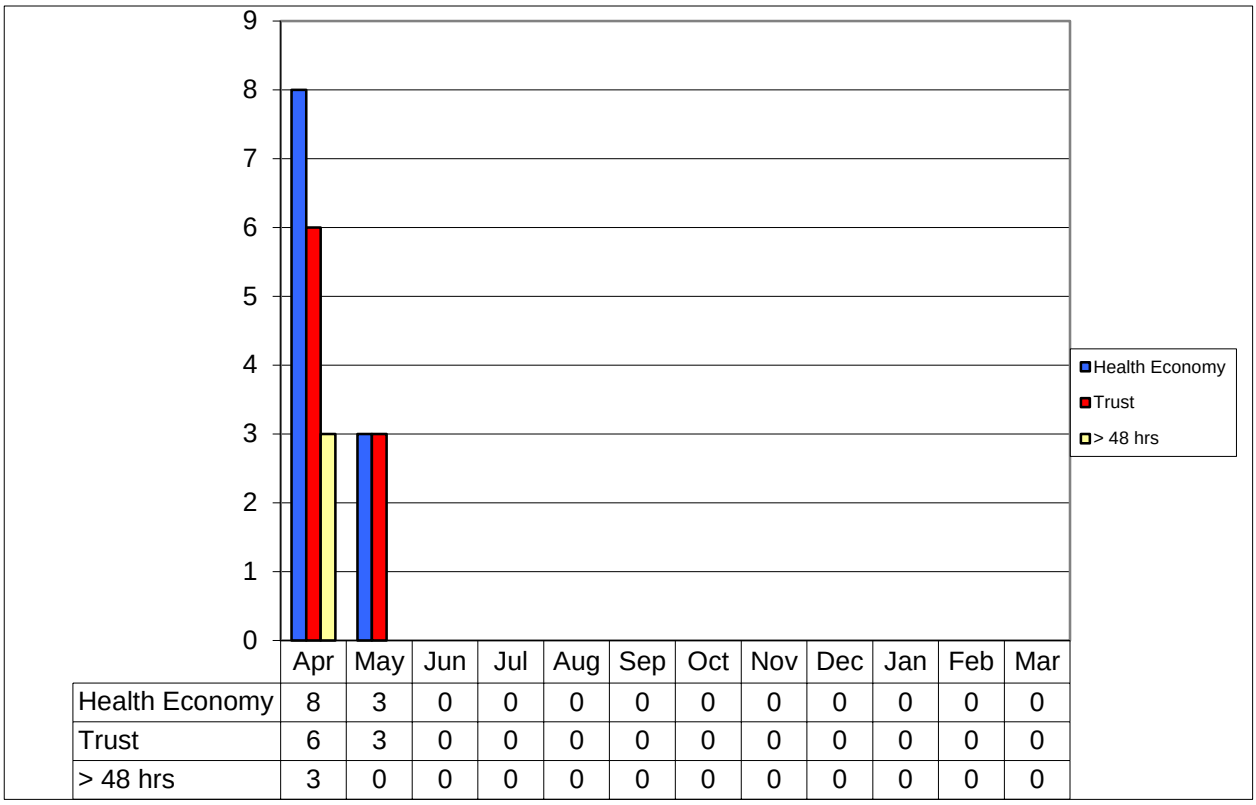
RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

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 (21/5/15) we have 0 post 48 hour cases recorded in May 2015.

C. DIFFICILE CASES 2015/16



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	3	0	0	0	0	0	0	0	0	0	0
Trust	6	3	0	0	0	0	0	0	0	0	0	0
> 48 hrs	3	0	0	0	0	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], has commenced. Of the 38 post 48 hour cases in 2014/15 financial year all cases have now been reviewed with the CCG of which 30 were determined as being associated with lapses in care. The main themes identified are: poor documentation, issues related to antibiotic prescribing, delayed sample collection and poor environmental scores.

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.

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 4th June 2015

TITLE:	**1. Results of Six Monthly 'Safer Nursing Tool' exercise** **2. Monthly Nurse/Midwife Staffing Position (April 2015) and Review of all staffing shortfalls since commencement of data collection in June 2014**		
AUTHOR:	Derek Eaves, Professional Lead for Quality Yvonne O'Connor, Deputy Chief Nurse	**PRESENTER:**	Yvonne O'Connor, Deputy 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:

PART 1: This is the third six monthly detailed review of nurse staffing levels using as a basis the Safer Nursing Care Tool (SNCT), comparing the results with the two previous exercises and the present establishments which are generally based on the Ward Review undertaken in 2014, unless wards have changed their speciality or bed numbers since then. Both methods are described in the paper and the results of each are provided and compared with a number of caveats. In addition, Nursing Sensitive Indicators are provided for each ward. Where appropriate, actions already being undertaken or further actions are suggested.

PART 2: This part of the paper contains 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.

The paper indicates for the month of April 2015 when day and night shifts on all wards were (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 1:8 nurse to patient ratio for general wards. It also indicates when 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 these shifts is 40 which is a reduction from last month. 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.

In addition, last month it was suggested that an overview was made of all of the shortfalls occurring over the months since these reports was commenced. The figures are provided. As all of the data is collected manually on four or five sheets per ward per month, it is difficult to undertake in depth analysis of the information, however, a discussion on the four areas with the highest shortfalls is made.

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	**CQC**	**Y**	**Details:** 13: Staffing
	NHSLA	**N**	**Details:**

LEGAL REQUIREMENTS	**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

PART 1 Nurse Staffing Review

Introduction

This paper provides an overview of the nurse staffing situation at the Trust. It is the third six monthly paper following the recommendations of the national publications 'How to ensure the right people, with the right skills, are in the right place at the right time' and 'Hard Truths' authored by Jane Cummings, Chief Nursing Office for England and Mike Richards, Chief Hospital Inspector at the Care Quality Commission. It contains data from both the initial two exercises (February and September 2014) and the more recent exercise (March 2015) using the Safer Nursing Care Tool (SNCT) for all wards in the Trust for which the tool is applicable. It also contains present establishment data for comparison purposes which generally came from the internal extensive Ward Review process undertaken in January/February 2014 although a number or ward changes, and their associated establishments have changed since that time. From the first paper in early 2014, the Trust Board decided to adopt the figures from the Ward Review and agreed an extra £3million funding to increase the nurse establishment. The paper also contains a number of quality indicators for each ward (or Nurse Sensitive Indicators (NSIs) as the SCNT designates them).

In Part 2, the paper provides the now monthly information for the month of April 2015 on actual staffing levels at the Trust in relation to planned registered and unregistered staff. It also contains a brief analysis of the shortfalls that have occurred since the monthly reports commenced in June 2014.

A. Safer Nursing Care Tool (SNCT)

1. Introduction/Background

The AUKUH (Association of UK University Hospitals) staffing tool was formally launched at the CNO Summit on 1 November 2007. Further development work was then carried out by the NHS Institute and later, The Shelford Group. Following an extensive review of the tool, its definitions and multipliers, commissioned by the Shelford Group's Chief Nurses' Sub-Group, it was relaunched as The Safer Nursing Care Tool in mid 2013.

It can be seen there have been a number of organisations involved in this tool and a number of changes to it.

2. The Trust and the Safer Nursing Care Tool

The Trust has now three sets of data from this tool. The six monthly exercise requires staff on all wards to assess every patient's dependency (and categorising every patient into 1 of 5 care groups) over a twenty day period (Monday to Friday over four weeks). As the descriptions of each category are open to interpretation, it can be seen that it contains a professional judgement of which group every patient falls into. There therefore needs to be consistency of assessment.

3. Specialties the tool covers

It is worth noting that the originators of the tool indicate that this is an 'adult, generic' tool. It states that the tool is being further developed to better reflect the complexities of caring for older people in acute care wards. It stated in July 2013 that this latter version 'is almost ready for use', although this has not been published to date. It also states a tool is being developed for Accident and Emergency Departments.

4. Second Element of the Tool

As well as determining the level of acuity/dependency of all patients and calculating the nurse staffing required per ward based on the actual needs of those patients, the second element of the tool describes Nurse Sensitive Indicators (NSIs) such as care undertaken, patient feedback, complaints, pressure ulcers and falls. It is recommended that these should be monitored to ensure that the staffing levels determined in Element 1 are enabling the delivery of expected patient outcomes.

Links between patient dependency, workload, staffing and quality have been established in recent years. Evidence in the literature links low staffing levels and skill mix ratios to adverse patient outcomes. Monitoring Nurse Sensitive Indicators is therefore recommended to ensure that staffing levels, deliver the patient outcomes that we aim to achieve. However, even with optimum staffing establishments poor patient outcomes may result due to other reasons such as high turnover, sickness, leave or unfilled vacancies.

The initial six monthly report did not include this element with the Board regularly receiving separate reports on quality data such as complaints, nursing care indicators, incidents, safety thermometer results, healthcare associated infections and patient and staff experience data. However, this and the last paper attempt to cover this element by including some of the relevant data that is produced for the Trust's monthly 'Ward Performance Reports'. Some of that data consists of the Trust's own Nursing Care Indicators (NCIs) but due to changes in some of the criteria of this system in September 2014 it is not possible to make historical comparisons on all criteria. In addition, due to issues with the Datix system at the time, it was not possible to provide incident data by ward for November. Also, for this paper a number of other indicators, such as the Friends and Family Test results, have been introduced to hopefully give a wider view on quality.

5. Overview of SNCT Data

There are some fixed parameters with the SNCT e.g. the times allocated to each patient category. With regards to the parameters that are within the power of the Trust, it has been decided to use an average 23% time out/headroom for annual leave etc (only one value for all staff can be used and the tool suppliers suggest between 22-25%) while the accompanying Ward Review (see Section B below) data used 23.2% for permanent RN staff and 22.46% for permanent unqualified staff. In addition, within the SNCT it was decided to use the same RN to unqualified split throughout (60:40 split RN to unqualified staff) unlike the Ward Review, which has used differing figures for each ward. The SNCT default 68:32 has not been used.

It also needs to be pointed out that the SNCT calculation does not take into consideration the national at least 1:8 RN/patient ratio directive for day shifts while this forms the basis of

the RN calculations in the Ward Review. This therefore means that when comparing the two calculations (SNCT/Ward Review) only the total WTE should be looked at.

The tool also provides 'benchmarks' of the average percentage of each category of patient per speciality from the wards that took part in research on which the tool is based.

B. Ward Review

Matrons, the Director of Nursing and her Deputy discussed and debated the nurse requirements of each area, ensuring consistency with the recent national guideline of the at least 1:8 registered nurse to patient ratio for day shifts. This method therefore consists of experienced nurses considering a range of issues associated with a ward, from its layout, the range of associated support staff such as ward clerks etc, the types of patient and their dependencies, skill mix within the team, the specialties of medical staff using the ward and such issues as the throughput and turnover of patients, any associated ward attenders etc. The system looked at the staffing and grade mix needs for each of the seven days of the week both for the day and night shifts for both RN and unqualified staff. The resultant figures went through a number of iterations, ensuring that there was consistency between similar wards etc. With expert help from the Finance Department this resulted in detailed data for each ward from which an establishment and associated cost was calculated. The whole process was validated by Mr S Davies, who was the Interim Turnaround Director at the time and checked by Price Waterhouse Cooper.

C. Data

Section 6 below contains the summaries of key data from both the three SNCT data collections and the Ward Review (or present establishment, if the ward and establishment has changed since the review) for each ward as well as the available Nurse Sensitive Indicators (NSIs), as described above.

In summary, with regards to the comparison between the ward review and SNCT figures, this needs to be interpreted with caution for the following reasons:

- For some of the wards there have been changes to the bed numbers and specialities
- It also needs to be remembered that the SNCT figures below do not take into account the workload associated with the numbers of admissions, discharges, transfers, escorts or deaths that occur on a ward and all of these activities take nursing time. Each ward will be different in this respect with some wards having a stable population of patients while others having possibly more than one person in a bed space during a twenty four hour period.
- In addition, the SNCT tool is based purely on the patient types and numbers in the 20 day study periods which do not include weekends.
- There are different percentages added in for relief/time-out/headroom
- Most importantly, the 1:8 RN/patient ratio for day shifts is not built into the SNCT.

6. SNCT and Comparative FTE Data

Ward A1

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Med
1	60	76	32	40
2	5	0	0	10
3	34	24	68	48
4	1	0	0	1
5	0	0	0	2
Beds	14 +4flex	14+4 flex	23	
Av Pat	18	17	21.9	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	13.7	11.9	19.6	12.27/16.56*
HCAs required	9.2	8.0	13.1	8.22/21.95*
Total FTE required	**22.9**	**19.9**	**32.6**	**20.49/38.51***

***Latter figures are for March 2015 as the patient numbers and speciality of the ward changed after September 2014.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	100	100	98	99
Manual Handling	100	98	93	100
Falls Assessment			100	96
Tissue Viability Assessment	100	100	100	100
Nutritional Assessment	95	93	94	100
Fluid Balance Management	85	93	88	98
Medication Assessment	99	100	100	100
Nutrition (Total)				97
SL – Hand Hygiene				100
SL – Commode Audits				93
Friends and Family Test Score				100
Incidents				
Minor Incidents	8	7	-	0
Moderate Incidents	0	0	-	1
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	1	0

Commentary: After the September 2014 study the ward was changed from a rheumatology ward to care of the elderly (in November 2014), hence the change in establishment. Since March 2015 this ward has closed.

Conclusion: No action required.

Ward A2

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Med
1	17	20	80	32
2	0	0	3	2
3	83	80	17	66
4	0	0	0	0
5	0	0	0	0
Beds	42	42	42	
Av Pat	41.8	41.3	41.5	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	40.2	39.3	28.3	34.35/38.64*
HCAs required	26.8	26.2	18.9	32.88/38.41*
Total FTE required	**67.0**	**65.6**	**47.2**	**67.23/77.05***

**Latter figures are for March 2015 as the patient speciality of the ward changed after September 2014.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	97	100	100	86
Manual Handling	100	95	100	100
Falls Assessment			97	-
Tissue Viability Assessment	89	97	100	100
Nutritional Assessment	100	100	100	93
Fluid Balance Management	98	100	95	97
Medication Assessment	100	98	100	100
Nutrition (Total)				99
SL – Hand Hygiene				97
SL – Commode Audits				94
Friends and Family Test Score				96
Incidents				
Minor Incidents	10	6	-	8
Moderate Incidents	1	1	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	0	1

Commentary: After the September 2014 study the ward was changed to a short stay area, hence the establishment change. The Acute Medical Society indicates that such areas require 1:6 qualified nurse to patient ratio hence the increase in establishment. The high turnover area means there can be more that 30 transfers of patients a day while the study only looks at the situation at one time-point in the day. The usefulness of the tool in such circumstances is therefore questionable (just like it is not suitable for the Emergency Department). NSIs are good and generally 'green'.

Conclusion: No action required.

Ward A3

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Rehab
1	19	29	25	38
2	0	0	0	7
3	80	71	75	52
4	0	0	0	4
5	0	0	0	0
Beds	28	28	28	
Av Pat	27.9	28	25.3	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	26.6	25.5	23.6	18.58/25.84*
HCAs required	17.7	17	15.7	21.92/19.20*
Total FTE required	**44.4**	**42.6**	**39.3**	**40.50/45.04***

**Latter figures are for March 2015 as the patient speciality of the ward changed after September 2014.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	98	96	96	100
Manual Handling	100	100	100	100
Falls Assessment			98	94
Tissue Viability Assessment	100	100	98	100
Nutritional Assessment	98	98	100	100
Fluid Balance Management	95	100	99	100
Medication Assessment	100	100	100	100
Nutrition (Total)				99
SL – Hand Hygiene				93
SL – Commode Audits				90
Friends and Family Test Score				90
Incidents				
Minor Incidents	12	5	-	6
Moderate Incidents	0	0	-	1
Major/Tragic Incidents	0	0	-	0
Complaints	0	2	0	1

Commentary: Occupancy remains high. After September 2014, the ward changed from Stoke Rehabilitation to care of the elderly, although the dependency of patients remains similar. The ward and establishment also includes FESU (Frail Elderly Short Stay Unit), which has not opened yet. As the ward has 28 beds decreasing the day RN staff would result in a ratio of 1:9.3. NSIs are good.

Conclusion: No action required.

Ward A4

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Stroke
1	35	65	24	21
2	14	20	40	7
3	47	11	35	67
4	4	4	1	6
5	0	0	0	0
Beds	12	12	12	
Av Pat	11.2	11.8	11.4	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	9.7	8.5	9.7	10.2
HCAs required	6.4	5.6	6.5	5.48
Total FTE required	**16.1**	**14.1**	**16.2**	**15.68**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	90	98	96	100
Manual Handling	93	100	100	100
Falls Assessment			100	96
Tissue Viability Assessment	100	100	100	100
Nutritional Assessment	100	92	100	100
Fluid Balance Management	100	100	100	100
Medication Assessment	100	100	100	100
Nutrition (Total)				97
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				100
Incidents				
Minor Incidents	0	2	-	3
Moderate Incidents	0	0	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	0	0

Commentary: Patient dependency has increased. Occupancy remains high. NSIs are good. All three SNCT studies and the ward review have had similar results. As there are 12 beds on the ward, reducing day RN staff would result in a ratio of 1:12.

Conclusion: No action required.

Ward B1

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Surgery
1	81	79	80	62
2	18	3	1	15
3	0	18	18	22
4	0	0	0	1
5	0	0	0	0
Beds	26	26	26	
Av Pat	18	17	23.2	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	15.4	16.6	15.8	18.35
HCAs required	10.3	11.1	10.5	11.04
Total FTE required	**25.7**	**27.7**	**26.3**	**29.39**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	94	100	99	98
Manual Handling	68	86	75	81
Falls Assessment			100	100
Tissue Viability Assessment	88	98	93	100
Nutritional Assessment	26	96	97	100
Fluid Balance Management	90	93	86	91
Medication Assessment	100	86	82	89
Nutrition (Total)				97
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				99
Incidents				
Minor Incidents	0	3	-	2
Moderate Incidents	0	0	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	0	0

Commentary: Dependency remains similar to the last study while occupancy has increased slightly. NSIs have improved from January 2014. In May 2015, NSIs remain RAG rated green with the exception of manual handling which is Amber rated. The SNCT study results and the present establishment are similar, although the present establishment has a slightly higher FTE which is probably accountable by the fact, as previously stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges. With 26 beds, reducing day RN staff would result in a ratio of 1:8.7

Conclusion: No action required except there needs to be continued close monitoring of the NSIs.

Ward B2 Trauma

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Trauma
1	65	68	58	34
2	16	13	2	5
3	19	19	40	57
4	0	0	0	2
5	0	0	0	3
Beds	24	24	24	
Av Pat	23.2	23	23.2	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	16.8	16.4	18.1	13.80
HCAs required	11.2	11	12.1	17.81
Total FTE required	**27.9**	**27.4**	**30.2**	**31.61**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	95	97	96	96
Manual Handling	98	100	75	83
Falls Assessment			100	98
Tissue Viability Assessment	97	98	100	96
Nutritional Assessment	100	100	78	100
Fluid Balance Management	100	100	86	100
Medication Assessment	98	100	100	94
Nutrition (Total)				99
SL – Hand Hygiene				100
SL – Commode Audits				98
Friends and Family Test Score				97
Incidents				
Minor Incidents	9	6	-	2
Moderate Incidents	3	3	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	1	1

Commentary: Occupancy remains high and dependency has increased. Incident numbers have improved. Both the SNCT study outcomes and the present establishment are similar, although the latter has a slightly higher FTE which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges. NSI results are good. In May 2015, NSIs show the ward was at escalation level 1 in April but this is now showing an improvement.

Conclusion: No action required except there needs to be continued close monitoring of the NSIs.

Ward B2 Hip

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Ortho
1	62	68	43	42
2	19	3	7	22
3	19	29	50	34
4	0	0	0	1
5	0	0	0	0
Beds	30	30	30	
Av Pat	28.4	28.7	29.2	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	20.6	21.1	24.4	18.79
HCAs required	13.8	14	16.2	30.14
Total FTE required	**34.4**	**35.1**	**40.6**	**48.93**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	98	92	98	99
Manual Handling	97	98	100	100
Falls Assessment			100	100
Tissue Viability Assessment	90	95	100	100
Nutritional Assessment	89	89	100	100
Fluid Balance Management	98	93	86	98
Medication Assessment	100	100	100	100
Nutrition (Total)				99
SL – Hand Hygiene				100
SL – Commode Audits				98
Friends and Family Test Score				97
Incidents				
Minor Incidents	9	6	-	4
Moderate Incidents	3	2	-	0
Major/Tragic Incidents	0	2	-	0
Complaints	0	6	0	0

Commentary: Dependency has increased and occupancy remains high. The majority of patients on this ward have a dementia diagnosis, are elderly and frail. Due to the nature of patients on the ward, almost all require two staff members to deliver care on a two hourly basis, hence the number of Clinical Support Worker staff to support this. Complaints are showing a downward trend since August. Recent NSIs and those from May 2015 show an excellent improvement in quality indicators, with green RAG ratings across the indicators. The model used to review this ward is now being rolled out across other wards within surgery by the Head of Nursing to ensure standards are also reviewed in depth.

As there are 30 beds on the ward, decreasing the day RN staff would result in a ratio of 1:10. NSIs have improved in November.

Conclusion: No action required.

Ward B3

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Surgery
1	54*	43	28	62
2	12*	11	29	15
3	34*	46	31	22
4	0	0	3	1
5	0	0	0	0
Beds	28+10SAU	38+4HDU	38+4HDU	
Av Pat	35	29.2	38.9	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	27.6	24.2	32.9	24.84
HCAs required	18.4	16.2	21.9	16.44
Total FTE required	**46.0**	**40.4**	**54.8**	**41.28**

*Not including SAU

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	94	96	96	87
Manual Handling	94	84	53	44
Falls Assessment			97	98
Tissue Viability Assessment	100	87	96	97
Nutritional Assessment	98	**72**	**77**	**78**
Fluid Balance Management	100	92	93	12
Medication Assessment	100	99	100	100
Nutrition (Total)				67
SL – Hand Hygiene				96
SL – Commode Audits				100
Friends and Family Test Score				96
Minor Incidents	4	5	-	3
Moderate Incidents	1	0	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	1	0	0

Commentary: In the light of a number of issues including the poor NSIs and apparent recent radical change in the dependency of patients, B3 is currently undergoing a review process, similar to that carried out on B2Hip to ensure all aspects of the ward are evaluated and action plans created to address any issue that may become apparent as a result of the review. It is intended to undertake this type of review on all of the Surgery Nursing Division over the next 6 months, and repeat on an annual basis thereafter. A new Lead Nurse will be in post from 1st June 2015 and will be in a position to know exactly where the issues are in her new ward that will require her immediate attention.

As indicated, dependency of patients in March data has noticeably increased. This needs to be rechecked to ensure this an ongoing trend for the ward. A further assessment will be undertaken commencing 1st June 2015 by an external (to the ward) assessor who will work with the new Lead Nurse to train her in the assessment methods.

Conclusion: NSIs need to be continued to be closely monitored. Full review report awaited.

Ward B4

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Surgery
1	81	71	84	62
2	5	5	7	15
3	14	25	9	22
4	1	0	0	1
5	0	0	0	0
Beds	48	48	48	
Av Pat	45.1	43.1	47.3	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	30.4	30.9	31.0	30.36
HCAs required	20.3	20.6	20.7	24.66
Total FTE required	**50.7**	**51.6**	**51.7**	**55.02**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	97	92	99	97
Manual Handling	86	74	78	80
Falls Assessment			79	100
Tissue Viability Assessment	93	67	93	100
Nutritional Assessment	97	32	100	100
Fluid Balance Management	97	83	98	100
Medication Assessment	99	100	100	100
Nutrition (Total)				100
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				100
Minor Incidents	5	7	-	6
Moderate Incidents	1	2	-	1
Major/Tragic Incidents	0	0	-	0
Complaints	1	1	0	0

Commentary: Dependency has decreased slightly. NSIs considerably deteriorated in August but have improved since and have improved again in May 2016. The SNCT study outcomes suggest smaller FTE than the establishment, which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges.

Conclusion: No action required.

Ward B5

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Surgery
1	87	97	95	62
2	9	2	3	15
3	5	1	3	22
4	0	0	0	1
5	0	0	0	0
Beds	22	30+4GAU	30+4GAU	
Av Pat	21.9	33.3	33.1	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	14.0 (23.2)	20.2	20.4	18.93
HCAs required	9.3 (15.4)	13.4	13.6	16.44
Total FTE required	**23.3** (**38.6**)	**33.6**	**34.0**	**35.37**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	100	100	98	98
Manual Handling	100	100	100	67
Falls Assessment			80	100
Tissue Viability Assessment	100	100	100	100
Nutritional Assessment	88	50	100	90
Fluid Balance Management	98	100	97	96
Medication Assessment	97	100	100	100
Nutrition (Total)				94
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				93
Minor Incidents	5	1	-	0
Moderate Incidents	2	2	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	1	2

Commentary: There were 22 beds on B5 for the initial SNCT study but now there are 20 beds + SAU (10 beds) and Gynaecology Assessment Unit (GAU) (4 beds). The figures in brackets on the first study include the SNCT figures for SAU and GAU to assist with any comparison. As there are 30 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:10. Occupancy remains constant as does dependency. NSIs are variable although are all green in May 2015. The latest SNCT study suggests a smaller FTE than the ward review, which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges, which is a significant issue for this ward with the two assessment units.

Conclusion: No action required other than continue closely monitoring NSIs.

Ward B6

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % ENT
1	88	87	92	73
2	2	2	3	12
3	10	11	5	7
4	0	0	0	3
5	0	0	0	6
Beds	29	17	17	
Av Pat	28.2	16.4	16.5	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	18.3	10.7	10.3	13.06
HCAs required	12.2	7.1	6.9	8.22
Total FTE required	**30.4**	**17.8**	**17.2**	**21.28**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	94	100	100	100
Manual Handling	89	100	100	38
Falls Assessment			100	100
Tissue Viability Assessment	98	100	100	100
Nutritional Assessment	98	90	100	86
Fluid Balance Management	91	93	100	96
Medication Assessment	100	100	100	100
Nutrition (Total)				99
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				98
Minor Incidents	9	1	-	2
Moderate Incidents	1	1	-	0
Major/Tragic Incidents	0	0	-	1
Complaints	1	1	0	2

Commentary: B6 had 29 beds during the first study but then lost 12 beds. Decreasing the day RN staff would only leave one nurse on duty. Dependency remains similar despite the change in number of beds. NSIs have seen an improvement in time but with a recent slight deterioration. The latest SNCT study suggests a smaller FTE than the ward review, which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges.

Conclusion: No action required other than continue closely monitoring NSIs.

Ward C1

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Med
1	39	24	46	40
2	14	29	1	10
3	47	47	53	48
4	0	0	0	1
5	0	0	0	2
Beds	48	48	48	
Av Pat	47.9	47.9	47.9	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	40.3	42.0	39.9	31.59
HCAs required	26.9	28.0	26.6	32.88
Total FTE required	**67.2**	**70.0**	**66.5**	**64.47**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	92	94	91	80
Manual Handling	100	99	97	30
Falls Assessment			100	61
Tissue Viability Assessment	100	100	100	98
Nutritional Assessment	81	90	72	24
Fluid Balance Management	89	92	89	92
Medication Assessment	100	100	100	100
Nutrition (Total)				94
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				100
Minor Incidents	8	5	-	4
Moderate Incidents	0	0	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	0	0

Commentary: As there are 48 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:9.6. Occupancy remains high with dependency decreasing in the last study. NSIs have deteriorated and the ward is on escalation with an action plan in place although latest recent results in May 2015 show that the NSIs have now improved and are now in green. All three SNCT studies and the ward review have had similar results. At present, a 'deep dive' review is being undertaken into all aspects of this ward similar to the approach taken on C7 (see below).

Conclusion: This ward is undergoing a review of its management.

Ward C3A/B (C3)

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Med Eld
1	12	23/30	34	32
2	7	0/0	1	2
3	81	77/70	65	66
4	0	0/0	0	0
5	0	0/0	0	0
Beds	52	24/28	52	
Av Pat	48.1	24/27.8	49.2	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)*
RNs required	46.7	22.5/25.2	43.7	(17.79) (18.58) /34.86
HCAs required	31.1	15/16.8	29.1	(16.44) (21.92) /38.41
Total FTE required	**77.8**	**37.5/42.0**	**72.8**	**(34.23) (40.50) /73.27**

**Figures in brackets are the separate establishments of the two separate wards while the other larger figures the present establishments.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	80	96	100	93
Manual Handling	86	100	100	100
Falls Assessment			100	100
Tissue Viability Assessment	92	100	100	100
Nutritional Assessment	97	94	100	97
Fluid Balance Management	100	98	100	93
Medication Assessment	100	100	100	100
Nutrition (Total)				98
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				94
Minor Incidents	16	9	-	8
Moderate Incidents	0	5	-	4
Major/Tragic Incidents	0	0	-	0
Complaints	0	1	0	1

Commentary: At the initial SNCT study this ward had 52 beds. The ward was then split into two (C3A[24 beds]/C3B[28beds]) but has now been unified again under one lead nurse. The latest SNCT study and the ward review have had similar results. NSIs are good.

Conclusion: No action required.

Ward C5

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Med
1	53	53	54	40
2	12	3	4	10
3	27	36	39	48
4	8	8	4	1
5	0	0	0	2
Beds	48	48	48	
Av Pat	47.7	47.4	48	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	37.9	38.5	38.4	31.59
HCAs required	25.3	25.7	25.6	32.88
Total FTE required	**63.1**	**64.2**	**64.0**	**64.47**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	96	100	97	98
Manual Handling	86	77	100	100
Falls Assessment			100	100
Tissue Viability Assessment	78	90	100	98
Nutritional Assessment	74	96	100	97
Fluid Balance Management	98	97	100	71
Medication Assessment	100	99	100	82
Nutrition (Total)				86
SL – Hand Hygiene				100
SL – Commode Audits				97
Friends and Family Test Score				100
Minor Incidents	10	3	-	10
Moderate Incidents	2	2	-	1
Major/Tragic Incidents	0	0	-	0
Complaints	0	1	2	1

Commentary: Occupancy remains high and dependency has increased. NSIs have fluctuated and are kept under review. All three SNCT studies and the ward review have had similar results.

Conclusion: No action required.

Ward C6

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Surgery
1	89	88	88	62
2	4	2	0	15
3	7	10	12	22
4	0	0	0	1
5	0	0	0	0
Beds	20	20	20	
Av Pat	19.1	17.2	17.3	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	12.2	11.1	11.2	15.82
HCAs required	8.1	7.4	7.5	10.96
Total FTE required	**20.3**	**18.5**	**18.7**	**26.78**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	92	100	89	98
Manual Handling	100	100	61	27
Falls Assessment			100	100
Tissue Viability Assessment	100	100	100	100
Nutritional Assessment	100	98	75	85
Fluid Balance Management	100	100	100	100
Medication Assessment	89	100	90	100
Nutrition (Total)				98
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				98
Minor Incidents	6	4	-	4
Moderate Incidents	0	0	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	0	0

Commentary: Dependency remains similar with a slight drop in occupancy. With 20 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:10. NSIs have deteriorated slightly although there has been an improvement following implementation of action plans to rectify issues. The establishment is a slightly higher FTE that the SCNT results which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges.

Conclusion: No action required other than continue closely monitoring NSIs.

Ward C7

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Med
1	68	64	57	40
2	2	1	4	10
3	30	35	39	48
4	0	0	0	1
5	0	0	0	2
Beds	36	36	36	
Av Pat	35.7	35	35.7	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	26.2	26.5	27.8	26.86
HCAs required	17.5	17.7	18.6	21.92
Total FTE required	**43.7**	**44.1**	**46.4**	**48.78**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	94	97	89	82
Manual Handling	87	89	61	90
Falls Assessment			100	100
Tissue Viability Assessment	98	100	100	96
Nutritional Assessment	56	94	75	100
Fluid Balance Management	75	89	100	90
Medication Assessment	99	98	90	100
Nutrition (Total)				94
SL – Hand Hygiene				96
SL – Commode Audits				88
Friends and Family Test Score				100
Minor Incidents	10	7	-	5
Moderate Incidents	3	2	-	1
Major/Tragic Incidents	0	1	-	1
Complaints	0	0	0	1

Commentary: Occupancy remains high and dependency has increased slightly. NSIs remain variable and have deteriorated recently since August and so the ward remains on escalation with an action plan in place. As there are 36 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:9. FTEs from the SNCT and the ward review are similar.

Following discussions between the lead nurse and senior staff, active management of the ward overall has taken place, resulting in changes to the skill mix. This also included reviewing the quality indicators such as patient feedback and the Nursing Care Indicators. Some of the results of this were seen to be associated with staffing shortfalls.

Conclusion: No action required other than continue closely monitoring the NSIs.

Ward C8

	Feb 14	Sep 14	Mar 15	
Patient Level	% of patients	% of patients	% of patients	Benchmark % Med
1	69	83	34	40
2	2	2	4	10
3	29	15	62	48
4	0	0	0	1
5	0	0	0	2
Beds	36+4 flex	36+4flex	36	
Av Pat	40.1	39.4	36	
Required Staff	SNCT	SNCT	SNCT	Establishment (WTE)*
RNs required	36.7	33.4	31.8	39.87/20.55*
HCAs required	24.5	22.2	21.2	27.4/39.42*
Total FTE required	**61.1**	**55.6**	**52.9**	**67.27/59.97***

**Latter figures are for March 2015 as the patient numbers and speciality of the ward changed after September 2014.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14	Mar 15
Nursing Care Indicators				
Patient Observations	98	96	100	96
Manual Handling	100	92	50	100
Falls Assessment			100	100
Tissue Viability Assessment	100	82	100	100
Nutritional Assessment	100	97	100	100
Fluid Balance Management	93	79	94	95
Medication Assessment	100	99	96	100
Nutrition (Total)				98
SL – Hand Hygiene				100
SL – Commode Audits				100
Friends and Family Test Score				100
Minor Incidents	8	4	-	5
Moderate Incidents	0	1	-	0
Major/Tragic Incidents	0	0	-	0
Complaints	0	0	0	0

Commentary: The ward has recently changed from short stay to a rehabilitation ward, hence the reduction in establishment. Occupancy is high. Dependency is higher than previously which would be expected with the change in specialty. NSIs are good. As this is a rehabilitation ward, it was agreed that there is no need for the 60/40 qualified/unqualified split that is set into the SNCT calculation.

Conclusion: No action required

7. Conclusion

It can be seen that even with the difficulties in comparing different methods of formulating how many staff are required on a ward that not too dissimilar results occur. From the analysis that can be undertaken on both the results of the establishment calculations and on the Nursing Sensitive Indicators, it would seem that the situation as it stands is reasonable across all areas, although some areas for action have been noted. While the present establishments seem to conform with the requirements of an 'objective' measure, it is still necessary to monitor what occurs on a day to day basis with such variables as staff sickness and vacancies affecting the staff available. The latest results of this monitoring for April 2015 follows in Part 2 below.

With regards to the quality indicators, as already stated, due to changes in some of the criteria of the NCIs in September 2014 it has not been possible to make full historical comparisons on all criteria after this date. In addition, further changes to these indicators have had to be made in this report. As time progresses, it is hoped that the quality measures that can be used will remain static so that they will be more easily interpretable. It also needs to be noted that due to the changes in ward specialities and bed numbers that occurred late last year and again early this year and any future similar changes will also make it difficult to make clear historical staffing comparisons in the future.

PART 2

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

April 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 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 chart follows the same format as last month. It indicates for this month 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 each ward 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). The establishment forms a planned number of registered and care support workers each shift.
2) Each six weeks the Lead Nurse draws up a duty rota aimed at achieving those planned numbers.
3) Each shift the nurse in charge assesses if the staff available meet the patients' nursing needs.

Following a shift, the nurse in charge completes a monthly form 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 day. Each month the completed form for every ward is sent to the Nursing Directorate where they are analysed and the attached chart compiled.

It can be seen from the accompanying spreadsheet 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) are 40. This compares to 51 in March, 34 in February, 59 in January, 49 in December 2014, 38 in November 2014, 53 in October 2014 and 33 in September 2014. The number has decreased this month. Again, the number is small in terms of the overall shifts. This month no shift was assessed as red/unsafe. 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 deployment 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.

Last month it was suggested that an overview was made of all of the shortfalls occurring over the months since these reports was commenced. The figures are provided in the table below. As all of the data is collected manually on four or five sheets per ward per month, it is difficult to undertake in depth analysis of the information, however it can be seen that the following four areas have the most qualified staff shortfalls: Wards B4, C1, C7 and Maternity. Considering each area separately:

B4: With regards to the surgical area B4 due to the nature of the patients treated on the ward there are many occasions when the ward has empty beds. Initially when collecting the staffing data, the actual number of the patients on the ward each day was not collected. After a review, it is realised that many of the apparent shortfalls on this ward are against the bed numbers rather than the actual patients. This data error is now rectified. In addition, a routine in-depth review of this ward is being undertaken in June.

C7: It can be seen that the shortfall numbers on C7 have been decreasing considerably over the time period being looked at. Following discussions between the lead nurse and senior staff active management of the ward overall has taken place, resulting in changes to the skill mix, but also reviewing the quality indicators such as patient feedback and the Nursing Care Indicators. Some of the results of this can be seen to be associated with staffing shortfalls

C1: Ward C1 is reliant on temporary staffing, which is not always available, having at present five qualified staff vacancies. These vacancies have been advertised three times. Unfortunately, no appointment was made. At present, a ‘deep dive’ review is being undertaken into all aspects of this ward similar to the approach taken on C7.

Maternity: Maternity services currently has a high level of maternity leave for Midwives i.e. 8.0 WTE and midwife vacancy. The service is actively recruiting midwives and held a very successful recruitment open day on 16 May 2015; more than 40 applications have been received and it is envisaged that from these applicants appointments will be made. However, plans are in places to address the coming month’s midwife shortfalls as staff recruited will not be expected to be in post and fully practicing until the Autumn, however, maintaining safe staffing levels through the summer period will be challenging.

The agreed maternity escalation policy is actively implemented as required and a DATIX incident form completed when staffing on the Maternity Unit is assessed as being compromised.

The Directorate are undertaking a review of midwife staffing which includes:

- Reassessment of midwifery staffing levels using the modified Birth rate plus (BR+) tool, table top exercise and a review of the NHSE Maternity Care pathway tool (2015)
- Benchmarking against NICE guidance (NG4): safe midwifery staffing for maternity settings (2015)
- Reviewing Safer Childbirth Table 6; maternity unit staffing
- Revisiting the risk assessment for maternity staffing to include the risk of recruiting a large number of new staff requiring induction and the support for inexperienced midwives.

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

		MONTHLY SHORTFALLS											
WARD	**STAFF**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
WARD A1	Reg				1	2	2	2	3	1		4	15
	Unreg			1			1		8				10
WARD A2	Reg					5	3		1				9
	Unreg						1						1
WARD A3	Reg			1	2		1	1	5	2	3	5	20
	Unreg		1	1									2
WARD A4	Reg				1			1		1			3
	Unreg		2										2
WARD B1	Reg	4			2	1	6	4	4	3	1		25
	Unreg	4											4
WARD B2 HIP	Reg		1	1								1	3
	Unreg												0
WARD B2 TRAUMA	Reg		1	2		2			2		4		11
	Unreg		3										3
WARD B3	Reg								3	7	8	2	20
	Unreg	1		1									2
WARD B4	Reg	5		1		14	8	9	8	6	4	6	**61**
	Unreg	6											6
WARD B5	Reg					1			1				2
	Unreg		1						1		1	4	7
WARD B6	Reg	1			2	2	1			1	1		8
	Unreg		2										2
WARD C1	Reg	2	5		7	2	3	9	4		10	5	**47**
	Unreg	1	1					1					3
WARD C2	Reg					1		1					2
	Unreg												0
WARD C3	Reg			1		1						1	3
	Unreg												0
WARD C4	Reg				1								1
	Unreg			4	4								8
WARD C5	Reg			4		4	1	2	1		1		13
	Unreg							1					1
WARD C6	Reg	1	1		2		3	1			2		10
	Unreg	3									1		4
WARD C7	Reg	11	9		4	5	3	3		1	1		**37**
	Unreg		2	1		1	2	1	1			1	9
WARD C8	Reg				1	1		7	7	2	5	6	29
	Unreg									1			1
CCU	Reg										1		1
	Unreg												0
PCCU	Reg												0
	Unreg												0
EAU	Reg					1					1		2
	Unreg												0
MHDU	Reg				1	1		1					3
	Unreg												0
CRITICAL CARE	Reg												0
	Unreg												0
NEONATAL	Reg					9							9
MATERNITY	Reg				3		3	5	8	7		5	**31**
	Unreg								2				2

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS APRIL 2015

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	4	RN	Vacancy x3 Sickness x1	Bank and agency requested, unable to fill. Substantive staff contacted. Patient dependency/safety maintained managed with this ratio of staff. Patient caseload split with nursing staff from A3 to maintain safety.
A3	5	RN	Vacancy x 5 Sickness x 1	As stated last month, due to the number of vacancies, the staff on A1 have been working closely alongside the staff on ward A3 to ensure the safe delivery of care on both wards. For these three shifts the bank and agency were unable to fill but safety was maintained.
B2T	1	RN	Special Leave	Bank unable to fill. Staff redeployed. Safe staffing maintained.
B3	2	RN	Sickness x1 Vacancy x1	Bank unable to fill. Ratio was 1:9:5 Safety maintained.
B4	6	RN	Vacancy x2 Maternity leave x4	Bank and agency were unable to fill and on one occasion bank nurse cancelled. With the patients present and on two occasions with empty beds the ward remained safe.
B5	4	CSW	Sickness x4	Bank was unable to fill and on one occasion the bank CSW cancelled. Patients remained safe.
C1	5	RN	Vacancy x5	Bank and agency were unable to fill. On all occasions, safety was maintained
C3	1	RN	Vacancy x1	Substantive staff contacted but unable to help. Patient safety maintained.
C7	1	CSW	Increased dependency	Extra CSW booked through bank but did not attend. High workload on ward meant that some care was delayed and routine night duties such as ensuring stocked supplies did not occur.
C8	6	RN	Vacancy x3 Sickness x3	Allocation to patients changed after patients dependency assessed and acuity such that safety maintained
Maternity	5	RM	High maternity leave and sickness absence	Bank unable to fill. Escalation process enacted. No patient safety issues occurred

Apr-15

SHIFT

WARD	STAFF	1 D	1 N	2 D	2 N	3 D	3 N	4 D	4 N	5 D	5 N	6 D	6 N	7 D	7 N	8 D	8 N	9 D	9 N	10 D	10 N	11 D	11 N	12 D	12 N	13 D	13 N	14 D	14 N	15 D	15 N	16 D	16 N
WARD A1	Reg																		2/1				2/1										
	Unreg																																
WARD A2	Reg																																
	Unreg																																
WARD A3	Reg																		3/2				3/2		3/1								
	Unreg																																
WARD A4	Reg																																
	Unreg																																
WARD B1	Reg																																
	Unreg																																
WARD B2 HIP	Reg																																
	Unreg																																
WARD B2 TRAUMA	Reg							3/2																									
	Unreg																																
WARD B3	Reg																																
	Unreg																																
WARD B4	Reg				5/3	6/3	5/3	6/5			5/3																						
	Unreg																																
WARD B5	Reg																																
	Unreg									4/2						4/2						4/2											
WARD B6	Reg																																
	Unreg																																
WARD C1	Reg									6/5												6/5	4/3							6/5			
	Unreg																																
WARD C2***	Reg																																
	Unreg																																
WARD C3	Reg											7/6																					
	Unreg																																
WARD C4	Reg																																
	Unreg																																
WARD C5	Reg																																
	Unreg																																
WARD C6	Reg																																
	Unreg																																
WARD C7	Reg																																
	Unreg																																
WARD C8	Reg							4/3		4/3										4/3		4/3											
	Unreg																																
CCU	Reg																																
	Unreg																																
PCCU	Reg																																
	Unreg																																
EAU	Reg																																
	Unreg																																
MHDU	Reg																																
	Unreg																																
CRITICAL CARE*	Reg																																
	Unreg																																
NEONATAL**	Reg																																
MATERNITY ****	Reg																								15/12								
	Unreg																																

WARD	STAFF	17 D	17 N	18 D	18 N	19 D	19 N	20 D	20 N	21 D	21 N	22 D	22 N	23 D	23 N	24 D	24 N	25 D	25 N	26 D	26 N	27 D	27 N	28 D	28 N	29 D	29 N	30 D	30 N	31 D	31 N
WARD A1	Reg						2/1						2/1																		
	Unreg																														
WARD A2	Reg																														
	Unreg																														
WARD A3	Reg						3/2						3/1																		
	Unreg																														
WARD A4	Reg																														
	Unreg																														
WARD B1	Reg																														
	Unreg																														
WARD B2 HIP	Reg																														
	Unreg																														
WARD B2 TRAUMA	Reg																														
	Unreg																														
WARD B3	Reg			6/4																6/4											
	Unreg																														
WARD B4	Reg					6/5																									
	Unreg																														
WARD B5	Reg																														
	Unreg			4/2																											
WARD B6	Reg																														
	Unreg																														
WARD C1	Reg									6/5																					
	Unreg																														
WARD C2***	Reg																														
	Unreg																														
WARD C3	Reg																														
	Unreg																														
WARD C4	Reg																														
	Unreg																														
WARD C5	Reg																														
	Unreg																														
WARD C6	Reg																														
	Unreg																														
WARD C7	Reg																														
	Unreg																														
WARD C8	Reg					4/3												4/3													
	Unreg																														
CCU	Reg																														
	Unreg																														
PCCU	Reg																														
	Unreg																														
EAU	Reg																														
	Unreg																														
MHDU	Reg																														
	Unreg																														
CRITICAL CARE*	Reg																														
	Unreg																														
NEONATAL**	Reg																														
MATERNITY ****	Reg												15/14																		
	Unreg																														

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

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 4 June 2015

TITLE:	**26 May 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 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	26 May 2015	D Wulff	Yes	

Declarations of Interest Made

None

Assurances received

Positive assurances

- Operational Management verbal assurance was received that the Saving Lives audit tool findings (High Impact Item 5: Prevention of Ventilator Aquired Pneumonia) were as discussed at the last meeting about documentation lapses and assurance provided that there were no patient safety risks (follow up of action from prior meeting);
- Operational Management verbal assurance was received in respect of the *C diff* performance at a Ward level, in that each case were there had been delays in isolation was known and the actions taken were planned and that patient care was managed appropriately (follow up of action from prior meeting);
- Operational Management verbal assurance was received in respect of the management of quality, safety risks and patient experience whilst the actions to improve the TAL ophthalmology performance are being taken (follow up of action from prior meeting). As actions are still to be fully delivered the Committee asked for further assurance after the planned actions have been implemented (see below items to be reported back to this Committee);
- Executive Management Assurance over compliance with the Trust's contractual requirements for reporting and dealing with SIs;
- Executive Management assurances were received on the Trust's positive position in respect the Kirkup recommendations (follow up of action from prior meeting); and
- *At the last meeting in April the Committee received a report in respect of the national patient survey which provided assurance in respect of improved performance and the Committee received assurance from management that action is planned to address those areas where the Trust was not performing well.*

Missing assurances

- The performance report identified a key area of continued poor performance

relating to Stoke - Swallowing Assessments for which assurance was not provided in respect to how patient care was being managed. This assurance was re-requested for the next meeting (see below items to be reported back to this Committee); and

- The poor data quality identified within the national COPD clinical audit report meant that the value of this assurance was very limited and was therefore considered by the Committee to be missing. Questions were raised as to the data quality processes surrounding this audit and the Committee requested a report to its next meeting on this issue (see below items to be reported back to this Committee).

Decisions Made / Items Approved

- Approval of Policies considered by Policy Group in May 2015;
- Approval to close 37 SIs following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced; and
- Approved that the report received in respect of the Trust's positive position regarding the Kirkup recommendations is shared with the CCG Clinical Quality Review Meeting.

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

- Assurance in respect to the quality of patient care and experience in respect of the Stoke - Swallowing Assessments performance of the Trust which continues to be below target (two consecutive months where the target has been missed);
- Further assurance to be provided that the actions taken in respect of improving the Trust's operational performance in respect the ophthalmology TAL have had no unintended consequences on patient care;
- A report on the processes being applied in respect of data quality when submitting data to national clinical audits, in particular the lessons that need to be learnt from the poor data quality supplied to the national COPD clinical audit submission;
- To review the assurances provided by the Quality and Safety Committee in respect to the closure of the concern over the quality and effectiveness of the Trust's Transformation Committee.

Items referred to the Board for decision or action

None.

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 4 June 2015

TITLE:	**Lampard Report – Trust response to recommendations**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary

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

SUMMARY OF KEY ISSUES:

The Trust has provided a number of updates to the Board via reports to the Clinical Quality, Safety and Patient Experience Committee on how the Trust has responded positively to the recommendations made within the Lampard Report.

The Trust is required to formally respond to Monitor by the 15th June confirming the actions planned and that taken in respect of the original recommendations. The Trust is also required to give an indication of when any actions in progress at the time submission will be completed.

The Trust's response to Monitor is that all recommendations have been considered and where any actions were required, that these actions have been complete or in two cases will be completed within a matter of months.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

That the Board approves the attached for submission to Monitor.

APPENDIX ONE

THE DUDLEY GROUP NHS FOUNDATION TRUST

Recommendation	Issue identified	Planned Action	Progress to date (29 May 2015)	Due for completion
R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all without exception.	On review, after receipt of the original DH letter (gateway ref 18350), the Trust identified a gap in respect of a need for a specific Policy governing this area.	Policy to be developed, ratified and implemented supported by a formal record off all visits and requests for visits.	Complete – the Policy was developed and approved in January 2014, with a formal log of all such visits now being maintained.	
R2 All NHS trusts should review their voluntary services arrangements and ensure that: - They are fit for purpose - Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision. - All voluntary services managers have development opportunities and are properly supported.	On review, after receipt of the original DH letter (gateway ref 18350), we identified no significant gap in these arrangements, but that a review of the Trust's Volunteer Policy would be undertaken.	Policy to be formally reviewed (acceleration of the Trust's formal cyclical review of this Policy) and updated if required.	The Policy was reviewed and updated with minor amendments in March 2014. The formal review confirmed that the Policy already covered all aspects of the Trust's volunteer arrangements and activities. Following the final release of the Lampard report the Policy was further reviewed.	Policy reviewed and awaiting formal ratification complete by August 2015.
R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.	The Trust has robust systems operating to address this recommendation. All staff and all volunteers receive mandatory training on Safeguarding. Both Satff and Volunteers are also	No action was required		

Recommendation	Issue identified	Planned Action	Progress to date (29 May 2015)	Due for completion
	subject to safeguarding refresher training. Compliance with these requirements is subject to formal review and follow up to ensure all staff and volunteers are up to date on this training.			
R5 All NHS trusts should undertake regular reviews of: - Their safeguarding resources, structures and processes (including their training programmes); and - The behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.	Trust structures meet RCPCH guidance with these being subject to an annual review with the outcome recorded in Annual Safeguarding Report. Training is reviewed to ensure that I remains fit for purpose and picks up any potential issues from reported incidents. The last review was undertaken in January 2015. In considering this recommendation the Trust felt that building in an assessment of behaviors would be built into annual safeguarding audits.	The scope of the Annual Safeguarding audits be extended to not only include an assessment of compliance with Trust policy but also to provide information on staff and management behaviours and attitudes.	Complete - the Audits are scheduled in across 2015/16 with their outcomes reported as part of the routine reporting to the Board via its Sub Committee focusing on Clinical Quality, Patient Safety and Experience.	
R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and	On receipt of the original DH letter (gateway ref 18350), the Trust's DBS Policy was updated.	A transparent process to report on the completion of checks using	Complete - the reporting of DBS checks undertaken and their satisfactory outcome is recorded and reported.	

Recommendation	Issue identified	Planned Action	Progress to date (29 May 2015)	Due for completion
volunteers every three years. The implementation of this recommendation should be supported by NHS employers (as set out in the Secretary of State's proposed recommendation).	As part of the Policy update it was determined that more transparent reporting of compliance with these checks could be put in place.	RAG rating was to be developed.		
R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary	The Trust does not currently facilitate patient access to wifi and thus the internet / email etc. The Trust is looking at enabling this and as that is progressed a policy regarding acceptable use will be developed as appropriate.	To develop an appropriate policy when required.	Patient Wi fi will be offered from June/ July 2015 and a reasonable use notice will be developed as part of the sign on process. However the Trust is only faclitiationg through a third party access to the wifi network and the Trust is not granting access to its systems or network.	
R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	The Trust following receipt of the original DH letter (gateway ref 18350) reviewed its arrangements for the recruitment, checking, general employment and training of contract and agency staff. This review identified robust processes aided by the use of the Trust's staff bank process which ensure such processes are applied. The review also confirmed that agencies are chosen from the framework which includes a requirement for	Stronger controls to be developed over the use of non framework agencies.	Service Level Agreements are in place with non-framework agencies stipulating the checks they must do as part of them supplying staff to the Trust. Greater challenge of non framework agency use has seen their use reduce dramatically. Further work is being done on providing HR oversight to areas using contractors and agency staff	HR business partner recruitment will be complete by July 2015

Recommendation	Issue identified	Planned Action	Progress to date (29 May 2015)	Due for completion
	all registered agencies to comply with these requirements. It was identified that better control over none framework agencies could be delivered reducing the risk in this area.			
R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director	Polices are in place and through HR business partners their consistent operation is supported. Oversight for HR rests with the Chief HR Advisor.	No further action was planned.		
R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.	The Trust's Charity does not have an association with any major donors or celebrities. However should the Charity be approached then it would apply the Trust's policies and procedures as the Board are the corporate Trustee for the Charity.	No further action was planned.		

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 4th June 2015

TITLE:	**Annual Report- Medical Appraisal & Revalidation**		
AUTHOR:	**Teekai Beach** **Directorate Manager**	**PRESENTER**	**Paul Harrison, Medical Director**

CORPORATE OBJECTIVE: **SO2; S04**

SUMMARY OF KEY ISSUES:

Revalidation for medical staff commenced in December 2012 and is required by all doctors to be given a licence to practice every five years. In order to be revalidated doctors require five satisfactory annual strengthened appraisals (although initial revalidation requires less). Revalidation arrangements have been in place within the Trust since December 2012. This report briefly outlines the progress made since implementation and highlights any issues.

The revised reporting format reflects the proposed national format which Responsible Officers will be required to submit to NHS England going forward.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: **N**		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** **SAFE; WELL LED**
	Monitor	**Y/N**	**Details:**
	Other **GMC** **NHSE**	**Y/N**	**Details:** The GMC (Licence to Practise and Revalidation) Regulations 2012 Medical Profession (Responsible Officers) Regulations 2010 Medical Profession (Responsible Officers) (Amendment) Regulations 2013 GMC Good Medical Practice The GMC Protocol for making Revalidation recommendations Framework for Appraisal and Revalidation.

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS FOR THE BOARD

To receive the report and note the actions.
Approve submission of a quarterly report to the Workforce and Engagement Committee

1. Executive Summary

This report briefly outlines the progress made by the Responsible Officer in meeting statutory duties with regards to Medical Appraisal and Revalidation for the year April 2014-April 2015.

- The Trust currently has an appraisal rate of 84% with generally positive feedback on the quality of appraisals.

- 149 doctors have been revalidated as of September 2013 with 24 doctors deferred compared to a 10% national average.

- The Trust has successfully transferred responsibility for medical appraisal from Medical Service Heads where applicable to a pool of appraisers.

- The Trust is performing well against the Core Standards for Medical Revalidation with only one non-mandatory domain rated red.

2. Purpose of the Paper

This report provides an update medical revalidation further to the paper presented to board in October 2014.

.

Medical revalidation is a legislative requirement governing the competence of doctors outlined in the Good Medical Practice Framework for Appraisal and Revalidation (GMC March 2011). The Responsible Officer's role was set out in The Medical Profession (Responsible Officers) Regulations 2010 The background to Revalidation was outlined in the previous paper presented to Board (July 2012).

This paper will outline the progress against plan for Medical Revalidation in the last year, against the issues set out in the previous reports.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

For revalidation purposes, the Trust is deemed to be the Designated Body for all medical staff who hold permanent, fixed term or long term locum posts (this excludes doctors in training).

In the opening round of revalidation, the cycles are shortened and initially for doctors revalidating in the first year to March 2013, only one strengthened medical appraisal was required. Only the responsible Officer, Trust Medical Director was revalidated in that period. For the year 2013/2014 20% of doctors were required to revalidate and a further 40% revalidated in 2014/2015; 2015/2016.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

4. Governance Arrangements

The Medical Director holds an informal Medical Appraisal Committee (DMAC) which is responsible for implementation and ongoing supervision of Medical Appraisal including systems and processes to support revalidation for consultants and non consultant career grade doctors within the Trust. It provides quality assurance by reviewing appraisal documentation and observing appraisals to ensure quality and consistency of the process and produces quarterly and annual reports for the Board on appraisal for revalidation outcomes. It will also act as an appeal mechanism for any doctor who has concerns over their appraisal. The committee comprises the Medical Director, who is also the Responsible Officer, Assistant Medical Director, and the Directorate Manager.

It is proposed going forward that detailed quarterly and annual reports are sent to the Workforce and Engagement Committee separate to the statutory requirement to report to the public board. This will ensure that there is sufficient oversight and scrutiny of the systems and processes for medical appraisal and revalidation.

The Assistant Medical Director is responsible for the implementation and day to day running of appraisal for revalidation, and is the first point of contact for doctors who have concerns over any aspect of the appraisal process, and is accountable to the responsible officer for providing leadership in respect of the medical appraisal process.

Management support is provided by the Directorate Manager. In September 2015 a Project Officer will be appointed from the NHS Graduate Management Training Scheme.

The committee will be aware that currently the Medical Director is also the Responsible Officer. The Medical Director's personal appraisal has highlighted as an action for his Personal Development Plan the development of a separate role of Responsible Officer. The board approved this proposal in June 2014. Since then the Deputy Medical Director has completed his training as a Responsible Officer. The formal separation will take place as soon as the Deputy Medical Director can be released from his clinical role. This has been delayed due to the need to prioritise operational requirements within the Surgical Division.

a. Policy and Guidance

The Trusts' Medical Appraisal Policy was ratified in June 2014 and drafted in line with the NHS England Medical Appraisal Policy. The NHS England Policy Version 2 was published in May 2015 with some minor process changes. Where those changes are applicable to this Trust then the Trust policy will be amended to reflect those changes.

Should the board accept the proposal to provide a quarterly report to the Workforce & Engagement Committee this will be reflected in the revised policy and ratified by that committee.

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

For the appraisal to year 31st March of the 242 medical staff who should have completed appraisals within that period. 154 have been appraised by the end of the period; 31st March 2015. 201 completed appraisals within 15 months of their last appriaisal date as specified by the GMC.

A small number of incomplete apprisals (4) are as a result of all a result of long term sickness, maternity leave and sabbatical leave approved by the Responsible Officer. No doctors have been referred to the GMC for non-engagement with appraisal as those falling outside of the 15 month window have responded to the internal escalation process. Almost all doctors are using the Trusts's electronic PReP appraisal system. 1 doctor acting within a primarily research role uses an external, Heath Education West Midlands approved system and 1 doctor purchased apprisal software prior to joining the trust have been allowed to use alternative electonic apprisal software provided the Revalidation Lead has access to their portfolios on request.

Feedback on appraisers was largely positive with minor negative comments confined to feedback on the electronic system rather than the appraiser.

Details of exceptions i.e. missed appraisals and reasons, incomplete appraisals etc. (See **Annual Report Template Appendix A;** Audit of all missed or incomplete appraisals audit)

b. Appraisers

There are a total of 35 Medical Appraisers across the Trust operating within the pool. A further 23 appraisers are undertaking training in June 2014, which will bring the total pool of Medical Appraisers to 58.

Training will be undertaken by an external provider and is competency based to meet the requirements of the Core Standards for Medical Revalidation

c. Quality Assurance

The Following Quality Assurance Processes are in place:

Each Appraisal Portfolio is reviewed for the purpose of revalidation:

- to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate -by whom and sign offs
- to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard -by whom and sign offs
- to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs -by whom and sign offs

For the organisation

- Audit of timelines of process of appraisal (by external auditors)
- System user feedback

The Trust will implement the following processes during 2015/2016:

For the individual appraiser

- An annual record of the appraiser's reflection on appropriate continuing professional development

- An annual record of the appraiser's participation in appraisal calibration events such as reflection on appraisal network meetings
- 360 feedback from doctors for each individual appraiser – how collected, reviewed, collated and fed back to the appraiser, how calibrated with the feedback for other appraiser.

d. Access, security and confidentiality

Information governance guidelines, storage and access to appraisal documentation is set out in the Medical Appraisal and Revalidation Policy.

There have been no incidents with regards to security and confidentiality in the last financial year with regards to appraisal documentation. There was 1 incident reported in the previous financial year when 1 doctor was incorrectly given access as a Clinical Director. The doctor reported the error immediately and the incident was reported via DATIX and managed appropriately via the Trust's incident management processes.

e. Clinical Governance

Doctors have access to their individual complaints and incidents via the Trust Governance team.

6. Revalidation Recommendations

For the period 2014-2015 149 doctors were revalidated. There were 24 deferrals, one of which has since been revalidated. There have been no referrals for non-enagement.

See **Annual Report Template Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

There is a local policy in place which ensures that the Medical Staffing Team receives the relevant information from all appointments including locum and fixed term contract doctors details on induction and advises them that they are subject to the Trust Revalidation Policy.

The external audit undertaken in September 2013 noted the correct usage of this policy but recommended that this is also reflected in the Medical Appraisal & Revalidation Policy, amendments were made in June 2014.

An audit of recruitment and engagement background checks will be undertaken in quarter 2 2015/2016, and reported to the board accordingly.

8. Monitoring Performance

Doctors are monitored both via appraisal and Trust policies for line management, as well as job planning by the medical service head.

9. Responding to Concerns and Remediation

The Trust has appropriate polices in place to respond to concerns regarding doctors.

The 'Procedure for the Initial Handling of Concerns about Doctors and Dentists and the Management of Exclusions' covers the process for dealing with serious concerns about a doctor's performance. It includes sections on Conduct, Capability and Health and is currently under review.

A Medical Staff Update is provided privately to the board to compliment this report.

10. Risk and Issues

There are no existing risks on the register associated with medical appraisal and revalidation.

11. Corrective Actions, Improvement Plan and Next Steps

Below is an update on the progress against 109 core standards for Medical Revalidation, highlighting progress against those areas reported Amber (partially achieved) or Red rated (not achieved) in the last Board report; October 2014.

The Standards highlighted in grey are non-mandatory and only recommended actions. As such All mandatory actions are achieved.

	Core Standard	October 2014	June 2015
2.2.6	The responsible officer ensures that medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers)		
2.2.8	The responsible officer ensures that the initial training programme is competency based and those who cannot demonstrate the competencies do not become/are not appointed as medical appraisers.		
2.2.9	The responsible officer ensures that there is an initial review of performance for appraisers covering the first three appraisals followed by an initial review.		
2.2.11	The responsible officer ensures that there is a written role description, person specification and terms of engagement for medical appraisers		
2.2.12	The responsible officer ensures that appraisers have access to regular appraiser assurance groups or networks, which will include agreement about expectations of attendance.		
3.1.28	The responsible officer co ordinates a quality assurance look back process of cases.		
3.1.29	The responsible officer ensures that there are mechanisms are in place to define the success criteria for interventions and processes and to demonstrate that the organisation learns from experience.		
3.2.4	The responsible officer ensures that individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (ref RST guidance)		
3.2.6	The responsible officer ensures that case investigators and case managers have a regular programme of updates and skills development.		
3.2.7	The responsible officer ensures that case investigators and case managers undertake quality assurance of their roles and receive feedback on their performance.		
3.2.8	The responsible officer ensures that case investigators and case managers participate in peer networks to learn and share good practice.		

12. Recommendations

The board is asked to accept this report and note it will be shared, with NHS England along with the annual audit.

Audit of all missed or incomplete appraisals audit 2014/2015

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window'	2
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 31 March 2015	
Recommendations completed on time (within the GMC recommendation window)	149
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	149
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0

Describe other	0
TOTAL [sum of (late) + (missed)]	0

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 4 June 2015

TITLE	**Performance Report April 2015**		
AUTHOR	**Paul Taylor Director of Finance and Information**	**PRESENTER**	**Jonathan Fellows F & P Committee Chairman**
CORPORATE OBJECTIVE: SG06 Enabling Objective			
SUMMARY OF KEY ISSUES: • **The budget for 2015-16 was agreed to be £3.718m deficit as submitted to Monitor on 14th May 2015** • **Annual Accounts and Annual Report 2015-16 received and approved** • **Key Performance Indictors which were available for April 2015 remain on track.** • **Transformation Programme incorporating the Financial Recovery Plan 2015-16 is up and running**			
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**	**Details: The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS) at Q4, but 3 for Finance for the forthcoming**

			12 months. The Trust remains on monthly monitoring by Monitor. **Monitor has notified the Trust that it is no longer investigating A&E performance in the Trust** **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 COUNCIL

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance & Performance Committee	21st May 2015	Jonathan Fellows	yes	

Declarations of Interest Made

none

Assurances Received

- The first month of 2015-16 budgetary position is better than planned by £686,000 – with both income and expenditure showing positive variances
- The Trust has a liquidity ratio of 6.1 days which is better than the planned position of 5.5 days
- All of the financial recovery plan schemes have been included in budgets for 2015-16
- Key performance indictors for A&E and Elective waiting times are above the prescribed standards
- Progress on recruitment of external support to define the Operating Requirements of a new clinical information systems are proceeding according to plan, and support to the proves from the Operations Directorate has been given
- The progress on designing and implementing the Transformation and Financial Recovery Plan 2015-16 and 2016-17 was given to the Committee
- The next steps to enable Monitor to withdraw their "breach of authorisation conditions" notification was discussed and progress and risks reviewed
- The progress being made in a number of areas by the Nursing Division in the last 12 months

Decisions Made / Items Approved

- Annual Report 2014-15 and Annual Accounts 2014-15 were approved
- The reduction of the planned deficit for 2015-16 was approved, as delegated by the Board of Directors at their meeting on 7th May 2015

Actions to come back to Committee
• **Monthly budgetary control information to ensure satisfactory performance is being achieved and appropriate remedial action taken** • **Similar monthly information on key performance targets** • **Progress on the Transformation and FRP programme – each month** • **A report to be prepared regarding the potential expansion of the centrally managed Allocate staff rostering software to other staff groups**
Items referred to the Board for decision or action
• **To note the revised 2015-16 planned deficit of £3.718m – and the planned Continuity of Service rating at the year-end of 3.**

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 4 June 2015

TITLE:	Audit Committee 12 May 2015 Exception Report		
AUTHOR:	Mr R Miner Non-Executive Director	**PRESENTER**	Mr R Miner Non-Executive Director

CORPORATE OBJECTIVE: **S05; S06**

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 for this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details: Compliance with Monitor Licence**
	Other	**Y**	**Details: Auditors requirements**

ACTION REQUIRED OF BOARD OF DIRECTORS:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

Audit Committee Highlights Report to Board of Directors
5 June 2015

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**12/5/2015**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

Glen Palethorpe – previously employed by Baker Tilly

Assurances Received

- Significant Assurance as reported in the Head of Internal Audit opinion (there were 4 areas requiring improvement but none significant).
- The Project Fusion Report from Baker Tilly which highlighted shortfalls in process and lessons learned and the need, in future, for this to be shared and owned by the Board.
- The Losses and Special payment report for the year ending 31 March 2015 which was not considered material.
- An Unmodified Opinion on the Trust Accounts, but a Qualified Opinion in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources of the Trust Accounts 2014/15. This was as a consequence of the Trust's breach of licence.
- An unqualified opinion on the Quality Accounts 2014/15 with some recommendations for the future (including training)
- The Annual Clinical Audit Report for 2014/15

Decisions Made / Items Approved

The Committee approved:

- The 2015/16 Internal Audit Strategy (Attached for information)
- The 2015/16 LSFS Workplan
- The 2015/15 Clinical Audit Plan
- The 2014/15 Trust Annual Report, which included the Annual Governance Statement under Board delegated authority
- The 2014/15 Trust Annual Accounts under Board delegated authority
- The Representation Letter and Ms Clark was to sign on behalf of the Trust
- The 2014/15 Trust Quality Account

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

The Audit Committee had noted their disappointment at the lack of co-operation from Summit and Interserve into certain tendering activities as well as a lack of action from outside parties in the LCFS investigation and this be highlighted to the Summit Board

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

Follow up of LCFS investigation with Summit Board.

The Dudley Group NHS Foundation Trust

Internal Audit Strategy 2015/2016 - 2017/2018

Presented at the Audit Committee meeting of: 12 May 2015

Contents

1 Introduction 2
2 Developing the internal audit strategy 3
3 Internal audit resources 8
4 Audit committee requirements 9
Appendix A: Internal Audit Plan 2015/2016 10
Appendix B: Internal audit strategy 15
Appendix C: Internal audit charter 20
Appendix D: Our approach to an internal audit assignment 25
Appendix E: Overview of internal audit assignment opinions 26
For further information contact 27

1 Introduction

Our approach to developing your internal audit plan is based on analysing your corporate objectives, risk profile and assurance framework as well as other, factors affecting The Dudley Group NHS Foundation Trust in the year ahead including changes within the sector.

1.1 Background

Based in the heart of the Black Country, The Dudley Group NHS Foundation Trust is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest.

The Trust was the first hospital in the area to be awarded coveted Foundation Trust status in 2008, and provides a wide range of medical, surgical and rehabilitation services.

Currently the Trust serves a population of around 450,000 people from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge.

1.2 Vision

The Trust's vision is 'Where People Matter'. This is supported by three new values: Care; Respect; and Responsibility.

1.3 Trust Developments

The following key priorities for the Trust have been taken into consideration when developing our Internal Audit Plan:

- Delivery of the £10.2 million Cost Improvement Programme;
- Maintaining safe staffing levels in line with NICE guidance;
- Following the transfer of IT services in house, we will provide support and advice to the Trust during the procurement stage to provide a replacement for the current clinical support systems; and
- The Trust is undertaking a two phase redundancy programme. Our work will ensure that there is robust process in place in terms of producing and challenging quality impact assessments to ensure that the redundancies do not have a detrimental impact on quality.

2 Developing the internal audit strategy

We use your objectives as the starting point in the development of your internal audit plan.

2.1 Risk management processes

We have used various sources of information (see Figure A below) and discussed priorities for internal audit coverage with the following people:

- The Executive Team;
- Chair of the Board; and
- Chair of the Audit Committee.

Based on our understanding of the organisation, and the information provided to us by the stakeholders above, we have developed an annual internal plan for the coming year, and a high level strategic plan **(see Appendix A and B for full details).**

Figure A: Sources considered then developing the Internal Audit Strategy.

2.2 How the plan links to your strategic objectives

Each of the reviews that we propose to undertake is detailed in the internal audit plan and strategy within Appendices A and B. In the table below we bring to your attention particular key audit areas and discuss the rationale for their inclusion or exclusion within the strategy.

Area	Reason for inclusion or exclusion in the audit plan/strategy	Link to strategic objective
Cost Improvement Programme (CIP) Delivery	The current Trust plan of a £6.7 million deficit is predicted on the delivery of a CIP Programme of £10.2 million. Our review will consider the processes in place for managing the delivery of the savings.	To delivery an infrastructure that supports delivery.
Cost Improvement Programme (CIP) – Quality Impact	The Trust is entering into a two phased redundancy plan to reduce 400 posts over the next two years across the Trust to save £14 million on its pay costs to achieve financial stability. Our review will focus on the robustness of the process and challenge in regards to the quality impact assessments during phase one in order to identify any lessons learned going into phase two.	To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation. To provide the best possible patient experience.
Safer Staffing Reporting	Following the release of the NICE Guidance in regards to safe staffing levels, our review will consider the processes put into place by the Trust to monitor and ensure that appropriate levels of staff are maintained and that action is taken where this is not deemed sufficient.	To delivery an infrastructure that supports delivery.
Fusion Project	Following on from our Project Fusion – Lessons Learned review in 2014/15, we will ensure that the recommendations made within this report have been implemented and we will provide support and advice during the implementation stages of the new system.	To delivery an infrastructure that supports delivery.
Discharge Management	Follow on from our work in 2014/15 which focussed on the arrangements in place with the Local Authority in regards to delayed transfer of care, our review in 2015/16 will focus on the discharge management arrangements within the Trust.	To provide the best possible patient experience.

As well as assignments designed to provide assurance or advisory input around specific risks, the strategy also includes: a contingency allocation, time for tracking the implementation of actions and an audit management allocation. Full details of these can be found in Appendices A and B.

Figure B details those strategic risks and objectives in which may warrant internal audit coverage, reflecting both the inherent and residual risk. This review of your risks allows us to ensure that the proposed plan will meet the organisation's assurance needs for the forthcoming and future years.

Strategic risk No.	Strategic risk	Strategic objective
BAF COR065	The current Trust plan of a £6.7m deficit is predicted on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to delivery this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years.	To deliver an infrastructure that supports delivery.
BAF COR076	The Registered Nursing (RN) staffing levels do not meet Safe Staffing for Nursing in Adult Patient Wards in Acute Hospitals NICE/Guidance.	To deliver an infrastructure that supports delivery.
BAF ST002	Delivery of the turnaround plan negatively impacting upon the patient experience, quality of care and patient safety.	To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.
COR068	The Referral to Treatment (RTT) standard is at risk if the level of emergency attendance or admission activity rises or the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or, the theatre capacity and productivity is insufficient to meet demands, resulting in cancelled elective patients, breaches to the RTT standard and reduced income. (COR076)	To provide the best possible patient experience.

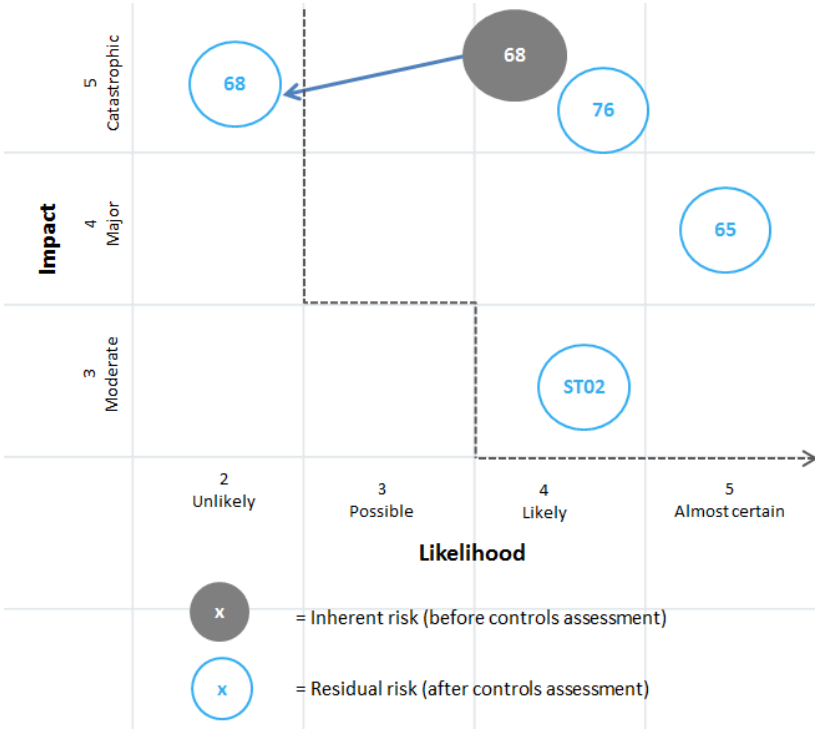


Figure B: Strategic risk matrix

Figure B is an extract from the 5x5 risk matrix for The Dudley Group NHS Foundation Trust focussing on those risks scoring 16 or above (inherent).
Where the residual risk remains unchanged from the inherent risk, only the inherent score has been shown in the extract.

2.3 Working with other assurance providers

The Audit Committee is reminded that internal audit is only one source of assurance and through the delivery of our plan we will not, and do not, seek to cover all risks and processes within the organisation.

We will however continue to work closely with other assurance provides, such as external audit and Local Counter Fraud Specialists to ensure that duplication is minimised and a suitable breadth of assurance obtained.

3 Internal audit resources

Your internal audit service is provided by Baker Tilly Risk Advisory Services LLP. The team will be led by Mike Gennard, supported by Alex Hire as your client manager.

3.1 Fees

Our anticipated fee to deliver the plan of 260 days is £ 88,400 (excluding VAT).

3.2 Conformance with internal auditing standards

Baker Tilly affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS). Further details of our responsibilities are set out in our internal audit charter within Appendix C.

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our Risk Advisory service line commissioned an external independent review of our internal audit services in 2011 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF) published by the Global Institute of Internal Auditors (IIA) on which PSIAS is based.

The external review concluded that “the design and implementation of systems for the delivery of internal audit provides substantial assurance that the standards established by the IIA in the IPPF will be delivered in an adequate and effective manner”.

3.3 Conflicts of Interest

We are not aware of any relationships that may affect the independence and objectivity of the team, and which are required to be disclosed under internal auditing standards.

4 Audit committee requirements

In approving the internal audit strategy, the committee is asked to consider the following:

- Is the Audit Committee satisfied that sufficient assurances are being received within our annual plan (as set out at Appendix A) to monitor the organisation's risk profile effectively?
- Does the strategy for internal audit (as set out at Appendix B) cover the organisation's key risks as they are recognised by the Audit Committee?
- Are the areas selected for coverage this coming year appropriate?
- Is the Audit Committee content that the standards within the charter in Appendix C are appropriate to monitor the performance of internal audit?

It may be necessary to update our plan in year, should your risk profile change and different risks emerge that could benefit from internal audit input. We will ensure that management and the audit committee approve such any amendments to this plan.

Appendix A: Internal Audit Plan 2015/2016

Audit Area (Executive Lead)	Scope for 2015/16	Audit days	Proposed timing	Estimated Audit Committee date
Risk based assurance				
Data Quality (Director of Finance and Information)	The review will consider how the Trust is ensuring the data they report is accurate and supported by appropriate documentation. We will review one key performance indicators included within the Trust's Performance Report; which will be agreed with management at the time of scoping the audit (18 weeks is likely to be first consideration).	10	July 2015	October 2015
Delivery of the Business Plan (Director of Strategy, Performance and Transformation)	To review the effectiveness of the delivery of the Two Year Integrated Business Plan and Five Year Strategy with an aim of providing advice for the development of future plans. This will include benchmarking the content of the Plan to those within similar organisations.	5	May 2015	July 2015
Cost Improvement Programme (CIP) Delivery (Director of Strategy, Performance and Transformation)	To review the Trust's systems for challenging the delivery of the Trust's CIP programme, the tracking of actions taken to manage variances and the further development of the revised CIP plan.	7	October 2015	January 2016
Cost Improvement Programme (CIP) – Quality Impact Assessment (Director of Nursing)	This review will focus specifically on the completion of the Quality Impact Assessment process in regards to the proposed redundancies. We shall consider the arrangements for assessing and monitoring the risk to quality throughout the life of the schemes, from the planning phase through to post implementation evaluation. This will be an advisory piece of work, considering any lessons learnt which can be taken forward by the Trust.	10	May 2015	July 2015

Audit Area (Executive Lead)	Scope for 2015/16	Audit days	Proposed timing	Estimated Audit Committee date
Safer Staffing Reporting (Director of Nursing)	Our review will consider the assurance process in place for informing the Board of ward staffing levels in comparison to the agreed ratios set by the Trust. We will also consider the migration actions in place where ward staff ratios are not being met and how this is documented and reported. Our review will take into consideration the Patient Safety Walk Around and how this information is triangulated with the staffing level ratios. The Trust is also in the process of rolling out Allocate templates to all wards from the Allocate system. Our review will consider any identified efficiency savings as a result of this.	14	June 2015	October 2015
NHS Friends and Family Test – Lessons Learnt (Director of Nursing)	To consider the methods used across the Trust for distributing the Friend and Family Test and also collating the responses. Our review will consider the best practice applied across the Trust. The review will also consider the framework in place to ensure that lessons learnt based on the test are captured, disseminated and followed up.	8	July 2015	October 2015
Doctor Revalidation (Medical Director)	To provide assurace over the Trust's developed systems for doctor revalidation.	8	November 2015	January 2016
Discharge Management (Director of Operations)	To consider the discharge management arrangements in place within the Trust.	12	May 2015	July 2015
Management Capacity (Chief Executive)	Our review will consider the Trust's processes for succession planning and staff development programme.	6	October 2015	January 2016
Safeguarding (Director of Nursing)	To follow up the recommendations made within our Compliance with Sections 5.1, 6.1 and 7.1 of the Trust's Safeguarding Children Policy audit (21.14/15)	5	July 2015	October 2015

Audit Area (Executive Lead)	Scope for 2015/16	Audit days	Proposed timing	Estimated Audit Committee date
Project Fusion (Director of Finance and Information)	To follow-up lesson learnt from the Project Fusion review undertaken in 2014/15.	5	Depending on the implementation stages of the project	To next Audit Committee following completion
Project Fusion (Director of Finance and Information)	To review the project management and governance arrangements around the replacement for Project Fusion.	10	Depending on the implementation stages of the project	To next Audit Committee following completion
Whistleblowing (Chief Executive)	A review of the compliance with the Whistleblowing Policy will be undertaken. Our review will consider benchmarking with other organisations in terms of recording informal cases and how the nature of whistleblowing cases received by the Trust is triangulated with other areas such as complaints, claims and incidents to ensure that lessons are learnt across the Trust. Our review will take into consideration the Patient Safety Walk Around and how this information is triangulated with whistleblowing cases.	12	September 2015	January 2016
Data Security (Director of Finance and Information)	To review the Trust's processes for data security across data stored within the main databases, portable storage and end user applications.	12	August 2015	October 2015
IT Disaster Recovery Plan (Director of Finance and Information)	To consider the IT Disaster Recovery Plans in place within the Trust following the termination of the contract with Siemens.	12	August 2015	October 2015
Core assurance				
CQC (Director of Nursing)	To consider how the Trust Board assures itself of the on-going compliance against CQC.	10	July 2015	October 2015

Audit Area (Executive Lead)	Scope for 2015/16	Audit days	Proposed timing	Estimated Audit Committee date
Information Governance Toolkit Assessment (Director of Finance and Information)	The review will consider the following: • The Governance arrangements in place for the completion and sign off of the Information Governance Toolkit return; • The validity of the toolkit return based upon a review of a sample of toolkit requirements; and • The robustness of the IG Toolkit improvement plans, monitoring and reporting of these.	8	January 2016	May 2016
Board Assurance Framework (Associate Director of Governance)	Building on our understanding of the Trust's development, use and reporting of its Assurance Framework, a sample of assurances will be mapped back to source documentation. In addition, we consider any in year changes in regards to the reporting arrangements for the Board Assurance Framework.	10	January 2016	May 2016
Monitors Well Board (Associate Director of Governance)	This review will focus on the steps undertaken and governance processes introduced by the Board around Monitors Board Governance Framework, and the evidence in place to support the declaration that Monitor will require the Board to sign off. Our review will also consider and patient and public engagement.	10	December 2015	May 2016
Financial Systems (Director of Finance and Information)	We will undertake testing of the key financial controls relating to the following areas: • General Ledger • Creditor Payments • Payroll • Asset Management • IT Financial Controls Review Our work will be constructed to enable external audit to place reliance on our work to inform their risk assessment.	40	October / November 2015	January 2016
Other internal audit input				
Action tracking (Director of Finance and Information)	To meet internal auditing standards and to provide management with on-going assurance regarding implementation of recommendations.	14	Ongoing	Ongoing

Audit Area (Executive Lead)	Scope for 2015/16	Audit days	Proposed timing	Estimated Audit Committee date
Contingency (Director of Finance and Information)	To allow for additional audits to be undertaken at the request of the audit committee or management based on changes in assurance needs as they may arise during the year.	7	As required	As used
Audit management	This will include: • Planning • Ongoing liaison and progress reporting • Preparation for and attendance at Audit Committee; and • Development and publication of the annual internal audit opinion	25	Ongoing	As used
TOTAL		**260**		

Appendix B: Internal audit strategy

Proposed area for coverage	Scope and Associated risk Area	2015/16	2016/17	2017/18
Risk based assurance				
Data Quality	Data relating to Trust performance is inaccurate or is not available in a timely way which consequently results in inadequate information to support decision making.	✓	✓	✓
Delivery of the Business Plan	The Trust must ensure that it remains financial viable over a 5 year time period. At present, there is no indication that growth, exit or redesign of our major services lines over the next 5 years, will deliver the financial efficiencies required to mitigate the projected financial deficit over that time period. This means we are currently at risk of being put into 'special measures' by Monitor, and the administration of the Trust taken out of its hand. (BAF COR061)	✓	-	-
Cost Improvement Delivery	The current Trust plan of a £6.7m deficit is predicted on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to delivery this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years. (BAF COR065)	✓	✓	✓
Cost Improvement Programme – Quality Impact Assessment	Delivery of the turnaround plan negatively impacting upon the patient experience, quality of care and patient safety. (BAF ST002) Workforce Reduction Programme will adversely affect patient care and Trust performance by removing essential skills and reducing the capacity of the workforce. (BAF COR077)	✓	✓	✓
Safer Staffing Reporting	The Registered Nursing (RN) staffing levels do not meet Safe Staffing for Nursing in Adult Patient Wards in Acute Hospitals NICE/Guidance. (BAF COR076)	✓	-	✓
Patient Experience	Poor service and standards that impact on the patient experience and lead to increases in complaints and claims.	✓	✓	✓

Proposed area for coverage	Scope and Associated risk Area	2015/16	2016/17	2017/18
Doctor Revalidation	The Trust fails to follow the national guidance in place.	✓	-	-
Discharge Management	The Referral to Treatment (RTT) standard is at risk if the level of emergency attendance or admission activity rises or the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or, the theatre capacity and productivity is insufficient to meet demands, resulting in cancelled elective patients, breaches to the RTT standard and reduced income. (COR068)	✓	-	✓
Management Capacity	Management assurance required.	✓	-	-
Safeguarding	Inadequate and ineffective systems in place to safeguard adults/children.	✓	-	✓
IT Projects	To provide advice and assurance as the Trust's develops and delivers its IT project.	✓	✓	-
Whistleblowing	Failure to create an environment in which staff can safely and confidently raise concerns about patient care and safety.	✓	-	-
Data Security	Failure to maintain the security of data within the Trust.	✓	-	-
IT Disaster Recovery Plan	The Trust is required to have an up to date plan to manage major incidents and business continuity so that the Trust can deliver care to patients when a major incident is declared and continue to deliver patient care in the event of a serious outage or disruption to key services. (BAF COR032)	✓	-	-
Lessons Learnt – Complaints, Claims and Incidents	Failure to understand the implications of, and to act upon the issues arising from claims, complaints and incidents in order to prevent similar future occurrences.	-	✓	-
Performance Management	Management assurance required.	-	✓	-
Divisional Governance	Management assurance required.	-	✓	-

Proposed area for coverage	Scope and Associated risk Area	2015/16	2016/17	2017/18
Clinical Audit	Services do not meet national standards.	-	-	✓
Cancelled Operations/Theatre Utilisation	The Referral to Treatment (RTT) standard is at risk if the level of emergency attendance or admission activity rises or the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or, the theatre capacity and productivity is insufficient to meet demands, resulting in cancelled elective patients, breaches to the RTT standard and reduced income. (COR068)	-	✓	-
Operational Budgetary Control	The current Trust plan of a £6.7m deficit is predicted on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to delivery this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years. (BAF COR065)	-	✓	-
Consultant Job Planning	Failure to manage consultant job planning in line with agreed contracts may result in capacity issues and financial costs.	-	✓	-
Statutory and Mandatory Training	Management assurance required.	-	-	✓
Core assurance				
CQC	To consider how the Trust Board assures itself of the on-going compliance against CQC.	✓	✓	✓
Information Governance Toolkit Assessment	The Trust is required to be compliant with the requirements of the NHS Information Governance Toolkit. Our review will seek to provide independent assurance on the process being applied and sample test the evidence being relied up to support the Trust's self-declaration.	✓	✓	✓
Board Assurance Framework/Risk Management	Review of the Trust's risk management processes and use of its assurance framework.	✓	✓	✓

Proposed area for coverage	Scope and Associated risk Area	2015/16	2016/17	2017/18
Governance	The Trust does not continue to develop and embed a robust governance structure which is supported by effective processes.	✓	✓	✓
Financial Systems:	We will undertake testing of the key financial controls. Our work will be structured to also enable external audit to place their planned level of reliance on our work to inform their audit. This will include compliance testing of specific areas of the Standing Financial Instructions.			
General Ledger and Financial Reporting		✓	✓	✓
Creditor Payments		✓	-	✓
Cash Receipting and Treasury Management		-	✓	-
Income and Debtors		-	✓	✓
Payments to Staff		✓	✓	✓
Asset Management		✓	-	-
IT Controls within the Financial Systems		✓	-	✓
Charitable Funds		-	✓	-
Other Internal Audit input				
Action tracking	To meet internal auditing standards and to provide management with on-going assurance regarding implementation of recommendations.	✓	✓	✓
Contingency	To allow for additional audits to be undertaken at the request of the audit committee or management based on changes in assurance needs as they may arise during the year.	✓	✓	✓

Proposed area for coverage	Scope and Associated risk Area	2015/16	2016/17	2017/18
Audit management	This will include: • Planning • Ongoing liaison and progress reporting • Preparation for and attendance at Audit Committee; and • Development and publication of the annual internal audit opinion	✓	✓	✓

Appendix C: Internal audit charter

1.0 Need for the charter

1.1 This charter establishes the purpose, authority and responsibilities for the internal audit service for The Dudley Group NHS Foundation Trust. The establishment of a charter is a requirement of the Public Sector Internal Audit Standards (PSIAS) and approval of the charter is the responsibility of the audit committee.

1.2 The internal audit service is provided by Baker Tilly Risk Advisory Services LLP ("Baker Tilly"). Your key internal audit contacts are as follows:

	Partner	Client manager
Name	Mike Gennard	Alex Hire
Telephone	07778514762	07970641757
Email address	mike.gennard@bakertilly.co.uk	alex.hire@bakertilly.co.uk

1.3 We plan and perform our internal audit work with a view to reviewing and evaluating the risk management, control and governance arrangements that the organisation has in place, focusing in particular on how these arrangements help you to achieve its objectives.

1.4 An overview of the individual internal audit assignment approach and our client care standards are included at Appendix D and E of the audit plan issued for 2015/16.

2.0 Role and definition of internal auditing

"Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by introducing a systematic, disciplined approach in order to evaluate and improve the effectiveness of risk management, control, and governance processes".

Definition of Internal Auditing, Institute of Internal Auditors and the Public Sector Internal Audit Standards

2.1 Internal audit is a key part of the assurance cycle for your organisation and, if used appropriately, can assist in informing and updating the risk profile of the organisation.

3.0 Independence and ethics

3.1 To provide for the independence of Internal Audit, its personnel report directly to Mike Gennard (acting as your head of internal audit). The independence of Baker Tilly is assured by the internal audit service reporting to the Chief Executive, with further reporting lines to the Deputy Director of Finance – Financial Reporting.

3.2 The head of internal audit has unrestricted access to the Chair of Audit Committee to whom all significant concerns relating to the adequacy and effectiveness of risk management activities, internal control and governance are reported.

3.3 Conflicts of interest may arise where Baker Tilly provides services other than internal audit to [Client Name]. Steps will be taken to avoid or manage transparently and openly such conflicts of interest so that there is no real or perceived threat or impairment to independence in providing the internal audit service. If a potential conflict arises through the provision of other services, disclosure will be reported to the audit committee. The nature of the disclosure will depend upon the potential impairment and it is important that our role does not appear to be compromised in reporting the matter to the audit committee. Equally we do not want the organisation to be deprived of wider Baker Tilly expertise and will therefore raise awareness without compromising our independence.

4.0 Responsibilities

4.1 In providing your outsourced internal audit service, Baker Tilly has a responsibility to:

- Develop a flexible and risk based internal audit strategy with more detailed annual audit plans which align to the corporate objectives. The plan will be submitted to the audit committee for review and approval each year before work commences on delivery of that plan.
- Implement the audit plan as approved, including any additional reviews requested by management and the audit committee.
- Ensure the internal audit team consists of professional internal audit staff with sufficient knowledge, skills, and experience.
- Establish a quality assurance and improvement program to ensure the quality and effective operation of internal audit activities.

- Perform advisory activities where appropriate, beyond internal audit's assurance services, to assist management in meeting its objectives.
- Bring a systematic disciplined approach to evaluate and report on the effectiveness of risk management, internal control and governance processes.
- Highlight control weaknesses and required associated improvements and agree corrective action with management based on an acceptable and practicable timeframe.
- Undertake action tracking reviews to ensure management has implemented agreed internal control improvements within specified and agreed timeframes.
- Provide a list of significant performance indicators and results to the audit committee to demonstrate the performance of the internal audit service.
- Liaise with the external auditor and other relevant assurance providers for the purpose of providing optimal assurance to the organisation.

5.0 Authority

5.1 The internal audit team is authorised to:

- Have unrestricted access to all functions, records, property and personnel which it considers necessary to fulfil its function.
- Have full and free access to the audit committee.
- Allocate resources, set timeframes, define review areas, develop scopes of work and apply techniques to accomplish the overall internal audit objectives.
- Obtain the required assistance from personnel within the organisation where audits will be performed, including other specialised services from within or outside the organisation.

5.2 The head of internal audit and internal audit staff are not authorised to:

- Perform any operational duties associated with the organisation.
- Initiate or approve accounting transactions on behalf of the organisation.
- Direct the activities of any employee not employed by Baker Tilly unless specifically seconded to internal audit.

6.0 Key Performance Indicators (KPIs)

6.1 In delivering our services we require full cooperation from key stakeholders and relevant business areas to ensure a smooth delivery of the plan. We proposed the following KPIs for monitoring the delivery of the internal audit service:

Delivery	Quality
Audits commenced in line with original timescales agreed in the internal audit plan.	Conformance with the Public Sector Internal Audit Standards.
Draft reports issued within 10 working days of debrief meeting.	Liaison with external audit to allow, where appropriate and required, the external auditor to place reliance on the work of internal audit.
Management responses received from client management within 10 working days of draft report.	Response time for all general enquiries for assistance is completed within 2 working days.
Final report issued within 3 days from receipt of management responses.	Response to emergencies such as concerns of potential fraud with 1 working day.
Completion of internal audit plan by the end of the financial year.	

7.0 Reporting

7.1 An assignment report will be issued following each internal audit assignment. The report will be issued in draft for comment by management, and then issued as a final report to management, with the executive summary being provided to the audit committee. The final report will contain an action plan agreed with management to address any weaknesses identified by internal audit.

7.2 The Head of Internal Audit will issue progress reports to the Audit Committee and management summarising outcomes of audit activities, including follow up reviews.

7.3 As your internal audit provider, the assignment opinions that Baker Tilly provides the organisation during the year are part of the framework of assurances that assist the board in taking decisions and managing its risks.

7.4 As the provider of the internal audit service we are required to provide an annual opinion on the adequacy and effectiveness of the organisation's governance, risk management and control arrangements. In giving our opinion it should be noted that assurance can never be absolute. The most that the internal audit service can provide to the board is a reasonable assurance that there are no major weaknesses in risk management, governance and control processes. The annual opinion will be provided to the organisation by Baker Tilly Risk Advisory Services LLP at the financial year end. The results of internal audit reviews, and the annual opinion, should be used by management and the Board to inform the organisation's annual governance statement.

8.0 Data Protection

- Internal audit files need to include sufficient, reliable, relevant and useful evidence in order to support our findings and conclusions. Personal data is not shared with unauthorised persons unless there is a valid and lawful requirement to do so. We are authorised as providers of internal audit services to our clients (through the firm's Terms of Business and our engagement letter) to have access to all necessary documentation from our clients needed to carry out our duties.
- Personal data is not shared outside of Baker Tilly. The only exception would be where there is information on an internal audit file that external auditors have access to as part of their review of internal audit work or where the firm has a legal or ethical obligation to do so (such as providing information to support a fraud investigation based on internal audit findings).
- Baker Tilly has a Data Protection Policy in place that requires compliance by all of our employees. Non-compliance will be treated as gross misconduct.

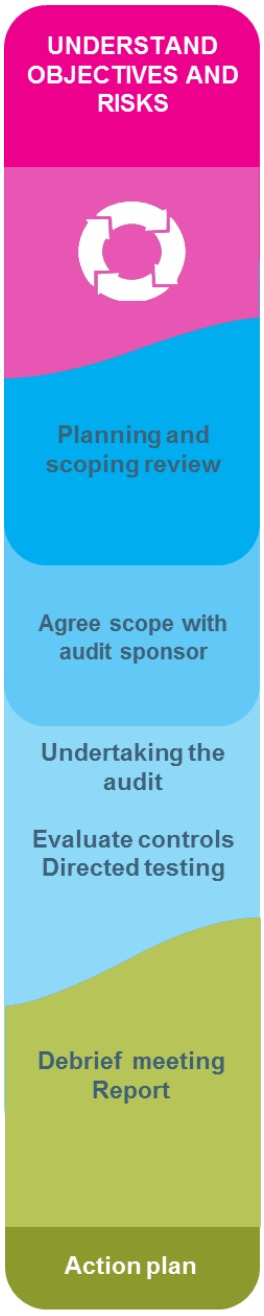
9.0 Fraud

9.1 The audit committee recognises that management is responsible for controls to reasonably prevent and detect fraud. Furthermore, the audit committee recognises that internal audit is not responsible for identifying fraud; however internal audit will assess the risk of fraud and be aware of the risk of fraud when planning and undertaking any internal audit work.

10.0 Approval of the internal audit charter

10.1 By approving this document, the annual plan, the audit committee is also approving the internal audit charter.

Appendix D: Our approach to an internal audit assignment



Each audit will be planned individually to ensure that the scope addresses the risks facing your organisation, and is therefore a useful source of assurance, providing assurance on the controls that you rely on to manage your risks and deliver your objectives.

We will meet with appropriate staff to understand the area under review and will then send you an Assignment Planning Sheet for your comment and sign off, so that we can discuss and agree the scope of each review; this provides the Audit Sponsor with an opportunity to comment on the scope of each audit. We will agree the audit date at the start of the year and you will receive a planning sheet at least four weeks before the audit commences.

Once the scope has been agreed, our audit fieldwork is carefully planned to ensure that we thoroughly test the right controls. Should we identify any major issues during the review, we will bring these to the attention of management straight away. We will keep you informed through the audit, and our team will be happy to answer any questions you may have. We will provide a list of information we will need when we issue the planning sheet so that you can prepare for the audit.

Before the internal audit team leaves site, we will hold a debrief meeting to discuss our findings with you and agree actions to address any control weaknesses.

Therefore, there will be no surprises when you receive the draft internal audit report, and you have an opportunity to comment on the report before it is issued for wider circulation.

Each formal assurance report will contain a clear opinion, so you know instantly if your risk management of this area is effective

Every internal audit report contains an action plan which is completed by management. Once the action plan is completed the report is issued as a final report. This provides the Audit Committee with a clear view of management's response to each finding, and also enables action tracking. As part of the annual plan we will undertake follow up work to provide the Audit Committee with an overview of progress in implementing actions that management have agreed.

CLIENT CARE STANDARDS

Discussions with senior staff at the client take place to confirm the scope six weeks before the agreed audit start date

Key information such as: the draft assignment planning sheet are issued by Baker Tilly to the key auditee four weeks before the agreed start date

The lead auditor to contact the client to confirm logistical arrangements two weeks before the agreed start date.

Fieldwork takes place on agreed dates with key issues flagged up immediately.

A debrief meeting will be held with audit sponsor at the end of fieldwork or within a reasonable time frame.

Two weeks after a debrief meeting a draft report will be issued by Baker Tilly to the agreed distribution list.

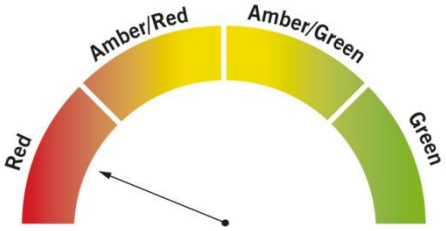
Management responses to the draft report should be submitted to Baker Tilly.

Within three days of receipt of client responses the final report will be issued by Baker Tilly to the assignment sponsor and any other agreed recipients of the report..

Appendix E: Overview of internal audit assignment opinions

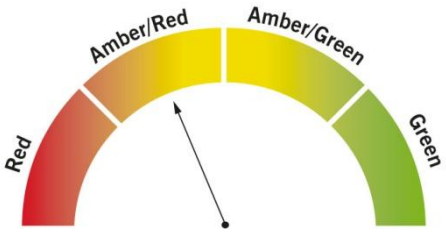
For internal audits classed as "risk based assurance" reviews (compared with advisory input), we use four opinion levels as shown below. Each assignment report will explain the scope of the review, and therefore the context and scope of the opinion.

Increasing level of assurance ↓



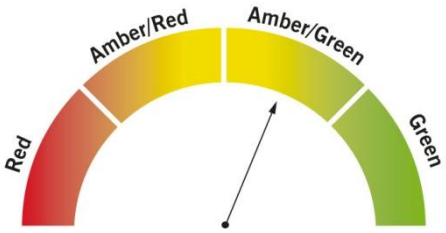
Taking account of the issues identified, the Board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective.

Urgent action is needed to strengthen the control framework to manage the identified risk(s).



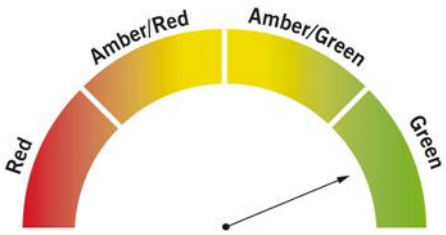
Taking account of the issues identified, the Board can take partial assurance that the controls to manage this risk are suitably designed and consistently applied.

Action is needed to strengthen the control framework to manage the identified risk(s).



Taking account of the issues identified, the Board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).



Taking account of the issues identified, the Board can take substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively.

For further information contact

Name: Mike Gennard

mike.gennnard@bakertilly.co.uk

Tel: 07778514762

Name: Alex Hire

alex.hire@bakertilly.co.uk

Tel: 07970641757

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 4 June 2015

TITLE:	Charitable Funds Committee 21 May 2015 Exception Report		
AUTHOR:	Mr D Bland Non-Executive Director	**PRESENTER**	Mr D Bland Non-Executive Director

CORPORATE OBJECTIVE: **S05; S06**

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 for this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details: Compliance with Monitor Licence**
	Other	**Y**	**Details: Auditors requirements**

ACTION REQUIRED OF BOARD OF DIRECTORS:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

Charitable Funds Committee highlights report to Board of Directors
On 4 June 2015

Meeting	Meeting Date	Chair	Quorate	
Charitable Funds	21st May 2015	David Bland	yes	no
			X	

Declarations of Interest Made

None

Assurances Received

Accounts are up to date

Annual report has been completed

Decisions Made / Items Approved

None - no fund raising activities are taking place at present due to long-term illness

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

Update on spending rate of charitable funds across the hospital

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

None

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 4 June 2015

TITLE:	**Monitor Certifications**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVES **SO 5 – Make the best of the resources we have**			

SUMMARY OF KEY ISSUES:

The Board is required to make a number of declarations to Monitor in respect of its License.

The Board is required to make a declaration of compliance (or not) in respect of the following 6 criteria

1 & 2	*Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
3	*Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
4	*Corporate Governance Statement - in accordance with the Risk Assessment Framework*
5	*Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
6	*Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act*

NOTE Declaration 3 is included in the APR 2015/16 Final Financial Template, which is required to be returned to Monitor per communications on final operational plan submissions.
NOTE Declaration 5 is not applicable

The attached document contains the detail of the declaration, its requirement, the Board's position (**all confirmed**) and for requirement 4, the supporting rationale which was required to be added,

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
	CQC	**Y**	**Details: well led**

COMPLIANCE and/or LEGAL REQUIREMENTS	**Monitor**	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

That the Board notes the submission made,

The Dudley Group NHS
NHS Foundation Trust

Board Certifications

The table below contains the detail of the declaration, its requirement, the Board's position for all those relevant (all confirmed) and for requirement 4 the supporting rationale which was required to be added,

Requirement		Board Response	Rationale
1&2	**General condition 6 - Systems for compliance with license conditions**		
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	**Confirmed**	
4	**Corporate Governance Statement**		
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed**	The Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Trust has also been rated as "good" by the CQC within the domain of well led within its most recent inspection.
2	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	**Confirmed**	The Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result.
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for	**Confirmed**	The Trust commissioned and external review of its Committee structures in 2013/14 with the recommendations

Requirement		Board Response	Rationale
	staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		implemented before the 1/4/14. The revised structure has operated for the whole year and through work of Internal Audit have been assured that it has operated effectively. The whole process was referred to and its effectiveness was considered by the Accountable Officer when drafting the Trust's Annual Governance Statement with the description of the effectiveness of the process described then considered by the Board as it endorsed the AGS.
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	**Confirmed**	The Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas. Assurance is routinely and regularly obtained as the quality of the data supporting the Trust's performance reporting and

Requirement		Board Response	Rationale
	(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		decisions being taken. The Board have approved the Trust's long term strategy and annual plan. As agreed with Monitor the Trust's plan is to be subject to an external review to confirm the assumptions being made that support the Boards view that the Trust is financially viable.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	There is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Quality Account and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set in consultation with the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and our Commissioners. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual

Requirement		Board Response	Rationale
			Governance Statement which in turn was subject to consideration by the Board prior to its submission to the Auditors and inclusion within the Annual Report.
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	The Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to recent Board appointments with the outcome of this reported to the Board's Remuneration and Nominations Committee as part of the relevant appointment process. The Board through its Workforce and Staff Engagement Committee has been assured over the sufficiency and quality of the Trust's staff. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains

Requirement		Board Response	Rationale
			an appropriately qualified workforce to deliver its services.
5	**Certification on AHSCs and governance**		
	For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC.	**Not applicable**	
6	**Training of Governors**		
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**	

ENCLOSURE 12A

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 4th June 2015

TITLE:	**CQC Inspection Report – Update and Closure Report**		
AUTHOR:	**Chief Executive - Paula Clark**	**PRESENTER**	**Chief Executive - Paula Clark**

CORPORATE OBJECTIVES:
SO1 – Deliver a great patient experience
SO2 – Safe and caring services
SO3 – Drive service improvement, innovation and improvement
SO4 – Be the place people chose to work
SO5 – Make the best use of what we have

SUMMARY OF KEY ISSUES:

The Trust was inspected by the Care Quality Commission in March 2014. Eight areas for improvement were highlighted and as part of the Trust's normal process action was taken in respect of each of the areas for improvement identified.

This paper takes the Board through each of the areas of concern raised by the CQC in March and provides information about the actions already taken. There are two areas which remains in progress, these are in respect of the Phlebotomy Service and the Trust's Ophthalmology provision where service redesign has meant that we are keeping the actions open to ensure these improvements achieve their intended outcomes.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Failure to embed the improvements from our last CQC Inspection
	Risk Register: Y		**Risk Score: 12**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: all domains (Safe, Responsive, Effective, caring and Well-led)**
	Monitor	**Y**	**Details: links to monitor's governance framework**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive the second update report on the actions taken and progress made since the CQC inspection in March 2014 and its subsequent report in January 2015.

To consider if further information is needed in respect of actions taken.

The Dudley Group NHS
NHS Foundation Trust

Care Quality Commission Inspection Report – Areas for Improvement Response

The Trust was inspected by the Care Quality Commission in March 2014. A number of areas for improvement were highlighted. This paper takes the Board through each of the areas of concern raised by the CQC in March and provides a position statement of the actions taken.

1. Do Not Attempt Resuscitation Policy: Adherence, Training and Audit:

Action identified by the CQC for the Trust to improve:

- DNACPR forms should be correctly completed and signed and reviewed at appropriate intervals

Progress against action:

Although the Inspectors found good adherence to the policy on the wards they had concerns with 2 out of 17 notes reviewed. The Trust enhanced its procedures to provide more assurance that compliance with the Trust policy would be adhered too. In summary these enhancements included

- DNAR is now on the new ward round checklist/bundle that has been developed with a Divisional Director. Ward clerks ensure there is a copy in each patient's notes.

- For patients with an active DNAR in place where there are concerns about capacity, each ward sends a list on a daily basis to the Mental Health team to check and challenge as appropriate.

- Training has been provided for medical staff by the Trust's legal advisors on 27th June 2015 and 13th November 2015 to ensure staff are up to date with the latest legal guidance and advice. Further sessions are diaries in so that such updates are provided.

- The Trust has developed an audit tool to be completed to monitor compliance to DNAR. This commences in June 2015.

Assurance:

- A new acute trust, Clinical Commissioning Group and Local Hospice policy for Do Not Attempt Resuscitation has been developed and ratified in October 2014. The policy works to the 2015 National Guidance on DNA CPR orders. The policy has been rolled out across the care community with the provision of on-going training and support.

- The trial for daily reviews of patients where there are concerns about capacity was proven to be a successful model to ensure on-going challenge and audit of compliance. This process has been taken over by the Resuscitation Officers and now includes in addition reviews following changes in circumstance for patients admitted and discharge with existing orders. This provides an on-going monitoring framework.

- Audit review of compliance will be reported to the Quality and Safety Group which feed the Clinical Quality Safety and Patient Experience Board Committee

Action closed

2. Emergency Department Flow:

Action identified by the CQC for the Trust to improve:

- Trust to review its flow of patients from A&E through the hospital

Progress against action:

At the time of the visit in March 2014 the Trust was failing the 4 hour ED target and had done so for two successive quarters. Concerns were raised by the Inspectors about the responsiveness of the service given the delays being experienced by patients.

The Trust also failed Q1in 2014/15, but management arrangements have since been changed and performance has improved to be one of the best in the region and nationally with the Trust achieving for each of the remaining quarters in 2014/15 the target. Focus on "pull" from the ED and improved processes on the wards has all contributed to this sustained improvement, despite the national pressure over the winter period. The Trust has also seen the successful introduction of the Urgent Care Centre on the Russells Hall site. A robust project plan was established supported by a "soft launch" in the month of March 2015 allowing operational issues to be resolved quickly prior to its full planned opening in April 2015.

Assurance:

The Trust has achieved the ED target for all quarters since July 2014 and has seen its national position for Q4 move from 107th of all DGHs to 7th. Q1 has continued this trend with an April achievement of 98.56% and a reduction in breaches from 712 in April 2014 to only 114 in April 2015, this has seen the Trust consolidate its position nationally in respect of the delivery of this target. The Trust's performance against all key targets including ED is challenged by the Finance and Performance Committee.

Action closed

3. Ophthalmology Clinic Provision:

Action identified by the CQC for the Trust to Improve:

- Trust to review its Ophthalmology provision (follow up of patients from the Ophthalmology clinic is not being undertaken for all patients following surgery). When this is done the patients can have a long wait to be seen.

Progress against action:
The pressure on the ophthalmology service is long standing. This has been for two reasons; firstly national shortage of consultants and secondly because of increasing demand as the population ages.

The Trust had a new glaucoma consultant start in March 2015 providing an extra 3 clinics per week for the management of this long-term condition. In addition a review of consultant job plans was completed for consultants who work sessions at Sandwell and West Birmingham which has initially repatriated three clinics back to Russells Hall Hospital.

The Trust is working with the Clinical Commissioning Group embedding a triage of referrals to ensure they are appropriate and are directed to the right clinician to reduce the consultant to consultant referrals and avoid wasted appointment slots. In addition work has been completed to ensure staff follow the Trust's own Access Policy to discharge patients who DNA (do not attend).

The service is monitored monthly and new ways of working continue to be explored. One of these is to look at increasing its nurse-led post op cataract clinics to include an extra evening clinic to provide additional capacity and patients an alternative time slot that may be more suitable around other commitments.

Assurance:

Performance of this service is monitored by Finance and Performance in terms of slot availability and by the Divisional Performance meetings held monthly. As these changes are recent it is too early to be assured that that the changes made are sufficient to address the waiting times so this action is being classified as open.

Action Open

4. Phlebotomy Capacity:

Action identified by the CQC for the Trust to Improve:

- The Trust must review its capacity in phlebotomy clinics at both Russells Hall and Corbett Hospital (in both areas patients are standing and waiting for long periods)

Progress against action:
The Inspectors witnessed crowded clinics with patients waiting long periods and in some cases having to stand. This was unusual as at the time of the inspection most patients were being seen quickly, many within a few minutes. However demand on the service continues to increase and with the launch of the Urgent Care Centre the Trust has made changes in the service provision which during the early month of these changes increased the wait for some sessions.

The phlebotomy service has increased the total number of 'bleeding stations' within the three Trust sites, relocating the service at RHH to accommodate the Urgent Care Centre, additional new location at Dudley Guest in March 2015 and at Corbett with more 'bleeding stations' (from May 2015) and additional waiting area to accommodate approx. 25-28 seats. All sites have an electronic system to record time of arrival and time individuals were called through to the phlebotomist. This allows the monitoring of maximum and average wait time and patient numbers which is supporting the Service in their on-going development of the workforce plans to better align to patient flow and demands.

In addition, the establishment has been increased but not all not all posts have been recruited to as yet and the service is scoping the introduction of planned bookable appointments for some types of referral. This will work in parallel to the current walk-in service and support of Outpatient clinics

Assurance:

The Trust received an increase in patient complaints in relation to the service at Russells Hall Hospital due to combination of the reduced service from Russells Hall and patients not wanting to initially travel further and from an issue that the General Practitioner letters sent to patients did not reflect the new time slots and their location so patients had wasted journeys.

More recent information is that these issued have worked through the system and the more service delivery is bedding down. However we are keeping this action as open as it remains early to assess the impact of the service changes. Further assurance will also become available from the planned Patient Safety Leadership Walk-rounds which will visit this area later this year and its outcome is reported to the Patient Experience Group which feed the Clinical Quality Safety and Patient Experience Board Committee

Action Open

5. Documentation for the Use of Compression Stockings:

Action identified by the CQC for the Trust to Improve:

- The Trust must review its documentation on the use of compression stockings on the critical care unit.

Progress against action:
During the inspection it came to light that the forms used for VTE assessment could be confusing for staff who were not familiar with them. The Inspectors were concerned that this could lead to patients who may need compression stockings not being given them potentially putting them at risk.

After the inspection all critical care patients were checked and they had all received either compression stockings or the appropriate VTE prevention treatment.

As a result of the CQC visit the Trust changed the VTE assessment form to make this much clearer and to avoid any confusion during the summer of 2014.

In addition all wards and departments receive a daily email alert if no VTE assessment has been entered on the electronic system, staff follow this up with medics to ensure its completion. The alert notifications are monitored by the anticoagulation team who escalate none compliance.

Assurance:

The changes to the form and the practice/procedure to be followed have been fed back to the staff on Critical Care at 'Huddle Board' meetings, staff meetings and by the Link Nurse.

Compliance with VTE assessments is monitored monthly via the Safety Thermometer audit and reported to the Quality and Safety Group (a reporting group of the Clinical Quality Safety and Patient Experience Board Committee).

Action closed

6. Incident Recording and Reporting:

Action identified by the CQC for the Trust to Improve:

- The Trust must review its incident recording and reporting, as it is not consistent across the organisation.
- Learning from incidents was not consistently shared across the organisation

Progress against action:
The inspection found that in many areas this was good but there was some inconsistency. Although the Trust is a medium reporting trust nationally it is recognised we can do better. Therefore the governance team at both a Corporate level and at a Divisional level have been working to share learning and improve communication in respect to incidents, complaints and claims.

The Trust has made improvements in respect of its governance communication flows across the organisation. This has been achieved by the initiation of monthly meeting for Divisional Governance Leads to meet with the Corporate Governance team to share knowledge of incidents and issues, discuss new initiates regarding "learning events" and ensure a coordinated and agreed way forward to embed good governance frameworks and learning across the organisation.

Additional training has been provided to support incident reporting and investigation within the Trust with further joint training with the CCG being provided on Root Cause Analysis. The Trust is actively working with its IT Department to re-launch our upgraded and remapped DATIX incident and complaints management database, which is to be supported by a programme of training for staff focusing as much on the process of incident management as it will on the reporting and learning from past events.

Assurance:

The Trust participated in a CQUIN scheme with on "learning" and has revised its reporting to draw out lessons / trends / themes and then track the learning from this reporting. The CCG have commented very positively on this change to our reporting and the Trust received the full CQUIN value associated with this scheme. The Clinical Quality, Safety and Patient Experience Committee of the Board supported by a Complaints Review group have scrutinised the revised reporting and the levels of incidents and any reported trends across the year, this regular reporting is embedded into the Committee's cycle of business.

Action closed

7. Staffing Level Reporting and Recording in Maternity:

Action identified by the CQC for the Trust to Improve:

- The Trust must review its method of agreeing staffing levels in maternity so that only one figure is understood by the whole trust.

Progress against action:
This was an issue of reporting midwife to birth ratios rather than direct concerns about staffing levels. The Inspection team wanted to ensure clarity with the Trust reporting one measure in the unit so that there was a better understanding of staffing levels on a daily basis.

The Trust agreed staffing levels is monitored using the same tool across both nursing and midwifery. This involves ward staffing levels being monitored daily using the Safer Staffing Tool and biannual reviews using the Safer Nursing Care Tool. This measures compliance of an agreed staffing level for each area and allows the Trust to be sure that one understood measure of staffing is reporting across the Trust.

Assurance:
The results of the Nurse / Midwife Staffing position is reported monthly to the Board of Directors and is published on the Public website. This measure is also discussed at the Matron's meetings. Further assurance over the data quality of the measured data is being provided by Internal Audit in 2015/16 as part of their cyclical review of data quality across the Trust.

Action closed

8. Staffing Levels and Cover for Vacant Shifts:

Action identified by the CQC for the Trust to Improve:

- The Trust must ensure that staffing levels and cover for vacant shifts is satisfactory and does not place overreliance of staff who have already worked full shifts to cover these

Progress against action:
The Inspection team were content that the Trust had the appropriate staffing levels in place but concerns were raised about the reliance on bank staff, many of whom were Trust staff, to fill vacant shifts.

In a difficult recruitment climate for qualified nurses, the Trust has continued to recruit and had undertaken another successful round of recruitment in Portugal. The latest round of recruitment has brought the Trust close to full establishment for qualified nurses. We are still actively recruiting to ensure that we are we are able to meet new vacancies as they arise through natural turnover.

The Trust plays a leading role in the Black Country Education and Training Council and the Chief Executive has a seat on the West Midlands Health Education Board. Therefore the Trust is in a good position to influence training and education and has been successful in getting increased training numbers and courses for sonographers and ODPs in addition to more nurse training places. Although this strategy will take three years to come to fruition with the new graduates, the Trust will continue its policy of recruiting abroad and in trying to make Dudley Group the best place to work to attract local candidates in a difficult market.

Ward staffing levels are monitored daily and reported to the Board on a monthly basis under the Safer Staffing initiative. The reliance on bank and agency staff use has reduced over 2014/15 and is evident in the reporting to the Finance and Performance Committee.

Assurance:

The results of the Nurse / Midwife Staffing position is reported monthly to the Board of Directors and is published on the Public website. This measure is also discussed at the Matron's meetings.

The Finance and Performance Committee regularly scrutinise the use of bank and agency staff and have assured the Board on the "grip" being applied by the Division in this area.

Further assurance over the data quality of the measured data is being provided by Internal Audit in 2015/16 as part of their cyclical review of data quality across the Trust.

Action closed