The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 7 April, 2016 at 9.00am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – P Harrison**		J Ord	To Note	9.00
2.	**Declarations of Interest**		J Ord	To Note	9.00
3.	**Announcements**		J Ord	To Note	9.00
4.	**Minutes of the previous meeting**				
	4.1 Thursday 3 March 2016	Enclosure 1	J Ord	To Approve	9.00
	4.2 Action Sheet 3 March 2016	Enclosure 2	J Ord	To Action	9.00
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.10
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.20
7.	**Patient Safety and Quality**				
	7.1 Chief Nurse Report	Enclosure 4	D Wardell	To Note & Discuss	9.30
	7.2 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 5	A Becke	To Note & Discuss	9.40
	7.3 Charitable Funds Committee Exception Report	Enclosure 6	J Atkins	To Note	9.50
	7.4 Audit Committee Exception Report - Internal Audit Plan	Enclosure 7	R Miner	To Note	10.00
	7.5 Revalidation Report	Enclosure 8	T Beach/ P Stonelake	To Note	10.10
	7.6 Monitor Annual Declarations	Enclosure 9	G Palethorpe	To Note	10.20
	7.7 Corporate Risk Register/Assurance Framework	Enclosure 10	G Palethorpe	To Note	10.30
8.	**Finance and Performance**				
	8.1 Finance and Performance Committee Exception report	Enclosure 11	J Fellows	To Note & Discuss	10.40
	8.2 Integrated Dashboard Report	Enclosure 12	A Baines	To Note	10.50
	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 13	A Baines	To Note	11.00
9.	**Any other Business**				11.10

10.	**Date of Next Board of Directors Meeting** 9.30am 5 May 2016 Clinical Education Centre		J Ord		11.10
11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		11.10

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 3rd March, 2016 at 9:30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Paul Taylor, Director of Finance and Information
Julian Atkins, Non Executive Director
Paula Clark, Chief Executive
Paul Bytheway, Chief Operating Officer
Dawn Wardell, Chief Nurse
Doug Wulff, Non Executive Director
Paul Harrison, Medical Director
Ann Becke, Non Executive Director

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Glen Palethorpe, Director of Governance/Board Secretary
Anne Baines, Director of Strategy and Performance

16/023 Note of Apologies and Welcome

Apologies were received from Julie Bacon.

16/024 Declarations of Interest

There were no declarations of interest.

16/025 Announcements

The Board noted that Monitor the Trust regulator, had announced that the Trust is no longer in breach of its licence and the Chairman congratulated the teams for their hard work on behalf of the Board.

The Chairman congratulated the Chief Executive for being named as one of the top 50 NHS Chief Executives in the Health Service Journal.

The Board noted that there were a number of vacancies for elected Governors. The nominations open on the 17th March, 2016. Details are available on the Trust website.

16/026 Minutes of the previous Board meeting held on 4th February, 2016 (Enclosure 1)

The minutes of the last meeting were amended at page 3 item 16/019.1 Chief Nurse Report to read "The Chief Nurse confirmed that the Trust will be using a ready reckoner that utilises a red, amber, green system."

The minutes were also amended at the same sentence to read "The Medical Director offered his support to the approach in using additional support workers."

With these amendments the minutes of the previous meeting were agreed by the Board as a true and correct record of the meetings discussion and signed by the Chairman.

16/027 Action Sheet, 4th February, 2016 (Enclosure 2)

16/027.1 Chief Executive's Overview Report

Update on TTOs to the March Clinical Quality, Safety, Patient Experience Committee and April Board.

Update on TTOs to the March Clinical Quality, Safety, Patient Experience Committee and April Board.

16/027.2 Research and Development

The Research and Development Report will be presented to the June Board. The Director of Governance/Board Secretary confirmed that he had met with Dr Neilson to request that the report focuses more on strategy.

The Research and Development Report to be presented to the June Board. The report will focus primarily on strategic issues.

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.

16/028 Patient Story

Liz Abbiss, Head of Communications and Patient Experience, presented the patient story.

The patient had received regular care from the Trust over the past several years. The patient considered that the Trust was constantly improving and in particular had high regard for the staff, cleanliness, menu choice and food provision. The patient also praised the Respiratory Outreach Service provided at St James Medical Practice. The patient asked that his thanks were passed to the staff.

The Chairman commented that the story summarised the teamwork across the Hospital and epitomised the Trust's core values. The Chairman asked that the Board's thanks are passed to the staff on Ward C5.

The Chairman and Board noted the patient story.

16/029 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:** The Board noted the consistently good scores. Challenges continue with the A&E response rate and the Trust is awaiting the text messaging system.

- **2015 NHS Staff Survey Results:** The Workforce Committee will focus on the survey results. The Chief Executive stated that the Trust should be really pleased with the first cut results. Mr Fellows, Non Executive Director, asked how the results are communicated to staff. Liz Abbiss confirmed that the key highlights have already been communicated. The Medical Director commented that the results were a real achievement for the Trust. Mr Fellows agreed that they were excellent and that there is a direct correlation between staff engagement and patient care.

- **Monitor Enforcement Action:** The Monitor Governance Committee met on 29th February, 2016, and confirmed that the enforcement action would be removed without any conditions. The Trust is asked to work with Monitor to look at how the Trust achieved the performance so lessons can be used for the wider sector.

The Chairman and Board noted the report.

16/030 Patient Safety and Quality

16/030.1 Chief Nurse Report (Enclosure 4)

The Chief Nurse presented her report given as Enclosure 4.

The Chief Nurse presented on the key issues relating to infection control, including:

MRSA: No post 48 hr MRSA bacteraemia cases since 27th September, 2015.

C.Diff: 12 of the 34 apportioned cases were deemed avoidable/lapses in care. The CCG had commended the work of the Trust.

Norovirus: No cases to note.

The Chief Nurse presented on the key issues relating to safer staffing, including:

- Amber shifts (shortfall) had continued in a downward trend and was now at 20.

- Maternity saw a decrease in amber shifts for January. The Trust has gone out to advert for 5 new midwives as previously approved by the Board.

- One red (serious shortfall) shift in the month but no safety issues identified with this or any of the other shortfall shifts that affected quality of care. Patient safety continues to be the Trust's highest priority.

- 27 new graduate starters in February. 13 new starters are commencing in April and 23 applications had been received from other Universities around the Country for starting in April and October. The Chairman asked about the Return to Nursing campaign and whether the Trust had undertaken any specific targeting. The Chief Nurse confirmed that there are return to practice nurses in the April and October cohorts. The Chief Executive stated that the uptake had been low nationally. The Chief Nurse confirmed that the number of leavers had also reduced. The Trust is going out to recruit in the Philippines on 9th April, 2016. The Chairman commented that the lack of nurses is a national phenomenon and trusts must take their own actions to ensure the appropriate number of nurse staffing levels.

The Chairman and Board were pleased to note the encouraging report.

16/030.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5)

Mrs Becke, Non Executive Director, presented the Clinical Quality Safety Patient Experience Committee Exception Report, given as Enclosure 5. The Board noted the following key areas from the previous meeting:

- Assurances Received : There had been two mixed sex breaches in January, the Committee were assured over the actions being taken to deal with the breaches and the Trust was looking at the learning points. High Risk screening TIA indicators had dipped in November and December but were now back on track and the Trust was looking to ensure that data quality was correct in those areas. The Committee had received assurance via the Quality and Safety Group in respect of their agenda items including the outcome and learning from Quality Safety Reviews.

The Chairman and Board noted the report and the assurances received.

16/030.3 NHS Preparedness for a Major Incident (Enclosure 6)

The Chief Operating Officer, presented the NHS Preparedness for a Major Incident Report, given as Enclosure 6. The Board noted the following key areas:

A report had been previously presented to the Board in August. The paper gave an update on actions since that report. The Board noted that all actions were now complete. The Trust is expecting a new self assessment form in August and a further updated will be presented to the Board at that time.

The Board noted the funding request for decontamination suits for 8 per year over 3 years.

The Chairman and Board noted the report and approved the investment required for the decontamination suits. The Chief Operating Officer confirmed that he would ask Sharon Walford to present to the Board on Emergency Preparedness at a future general clinical presentation.

The Board noted the Trust's compliance with the recommendations and the contribution made by the Health Emergency Planning Team.

Sharon Walford to be invited to present on Emergency Preparedness at a future Board General Clinical Presentation.

16/030.4 Black Country Alliance Update Report (Enclosure 7)

The Black Country Alliance Programme Director presented his Update Report, given as Enclosure 7.

The Board noted the following key areas:

- Sub Specialty map for Urology
- Partnership work with Walsall
- Interventional Radiology
- Stroke Workshop
- Procurement Update

The BCA Board had agreed a small number of additional projects for next year and were expecting to agree the priorities of corporate services over the next 18 months.

The BCA Programme Director had attended the Dudley Health and Wellbeing Board the previous day. There had been some questions from the CCG representatives around the ambitions of the BCA and the role of Wolverhampton and also around public engagement. In the main the Health and Wellbeing Board were very supportive of the concept of the BCA.

The Medical Director had attended the BCA Stroke Workshop. The consensus view was that the BCA would have enough patients to meet the criteria to have 3 HASUs across the Alliance. Workstreams would be arranged to produce a detailed submission for commissioners.

The Director of Finance and Information confirmed that for 2016/17 there is £100k pressure for the BCA infrastructure and savings of that level had not yet been identified to meet the cost.

Mr Miner, Non Executive Director, asked if these were infrastructure costs associated with the BCA. The Director of Finance and Information confirmed that it was the cost of the team working across all 3 organisations. The Chairman commented that the Trust should look again at infrastructure costs to see if savings could be made.

The Chairman and Board noted the report, progress made, approaches taken and the commitment to continue.

16/030.5 Update on Quality Accounts Report (Enclosure 8)

The Chief Nurse presented the Update on Quality Accounts Report, given as Enclosure 8.

The Board noted the following key areas:

- Detailed 3rd quarter report to the Clinical Quality, Safety Patient Experience Committee.
- Pressure ulcers on track.
- Infection Control had been discussed under the Chief Nurse Report.
- Nutrition and Hydration meeting on target for Q3.
- Mortality exceeding the target.

The Board noted the good position for quarter 3 and partial assurance for Q4.

The Chief Nurse had attended the Dudley Overview and Scrutiny Committee to discuss the Quality Accounts. Members had been very engaged.

2016/17 priorities are now agreed. There had been no real changes to structure of the Quality Accounts report.

4 areas had been identified for external auditing, the Board noted that 18 weeks and the 4 hr ED waits target would be most appropriate to audit. The Chairman asked why those two specific areas had been chosen. The Chief Operating Officer confirmed that the 18 week target was a good choice but suggested that one of the other two should be chosen as they would be more beneficial than the A&E target. The Board agreed to the 18 week target and 62 day cancer waits target. The Medical Director agreed that this would be beneficial for the Trust.

Need agreement from Governors on internal target – put forward CDiff to CoG on 10th March.

The Chairman and Board noted the report and approved the 18 week and 62 day cancer wait audits and also noted that the targets would be presented to the Council of Governors on 10th March for their approval and endorsement.

16/030.6 Workforce and Staff Engagement Committee Report (Enclosure 9)

Mrs Becke, Committee Chair, presented the Workforce and Staff Engagement Committee Report, given as Enclosure 9.

The Board noted the following key areas:

- Update on Q3 staff Friends and Family test: There had been a small number of respondents. The number of staff who recommended the Trust as a place to receive care had increased from 84% to 93% and as a place to work from 66% to 83%.

- The Trust People Plan RAG report was received. The Committee had looked at the amber areas and had been assured that these would be delivered by the end of year.

- A long debate around appraisals was noted. The Trust is revising its policy and documentation and this will be presented back to the Committee. There was concern around not meeting KPIs. The Staff survey showed that staff felt appraisals were good.

Mr Fellows, Non Executive Director asked if there was any value in the Committee receiving a report by individual managers. The Committee Chair confirmed that this is being progressed and there will be objectives for each manager.

The Chief Nurse confirmed that the Committee had received an update on talent management and leadership and a good structured framework had been proposed.

The Chairman and Board noted the report and key areas.

16/030.7 Charitable Funds Committee Exception Report (Enclosure 10)

The Board noted that the report will be presented at the April Board meeting.

The Committee Chair confirmed that some areas were spending their proportion of funds available.

All remaining wards will be notified of their fund availability and proportion.

The Charitable Funds Committee Report to be presented at the April Board meeting.

16/031 Finance

16/031.1 Corporate Performance Report (Enclosure 11)

Mr Fellows, Committee Chair, presented the Corporate Performance Report, given as Enclosure 11.

The report provided a summary of the February Finance and Performance Committee meeting.

The Board noted the key highlights as follows:

- The Trust was on track to achieve the full year deficit of £3.1m which was significantly better than the predicted £3.7m.

- The Committee had requested Delegated Authority to approve the final 2016/17 budget.

- Performance against KPIs was noted to be strong particularly for the ED 4 hour wait target.

- The Committee noted the worsening position against the agency rules and price cap compliance and the actions being taken. The Trust will discuss IT procurement and nurse vacancies with Monitor.

- The Executive Team will provide and update on progress with the 2016/17 contract in the private Board.

The Director of Finance and Information gave a detailed update on the 2015/16 and 16/17 financial position. Mr Miner, Non Executive Director, asked about the Sustainability and Transformation Fund and whether the larger national deficit will have an impact. The Director of Finance and Information confirmed that the Trust's allocation may get adjusted.

The Chairman and Board noted the report and key areas and approved the delegated authority to the Finance and Performance Committee to approve the final 2016/17 budget.

16/031.2 Integrated Performance Report (Enclosure 12)

The Director of Strategy and Performance presented the Integrated Performance Report given as Enclosure 12.

The report covered the Trust's performance to January 2016, and included the following highlights:

- Overall performance continues to be good.

- Emergency access target: The Department had been under enormous pressure over the last two months and there had been an understandable deterioration of performance although the Trust should remain above target and amongst the top performers in the country for the year. January had seen the highest level of emergency activity ever experienced at the Trust and the highest number of ambulance transports. The Chief Operating Officer confirmed that this pressure had continued into the first two weeks of February. The Director of Strategy and Transformation confirmed that given the pressures experienced by the Trust, to continually remain at such a high level of performance was excellent. The Chief Operating Officer recognised the teamwork between Surgery and Medicine and confirmed that the new Director of Operations for Medicine had commenced that Monday.

- 62 Day Cancer Wait: It is envisaged that the Trust will have missed the target for January. There were weekly performance updates on the target with the division and it is hoped that the February position is improved although not to the required level. The Trust had identified key issues and were managing these with the divisions.

- Sustainability and Transformation Fund: The Board noted that accepting the fund confirmed its delivery of targets.

The Board noted that the trajectories agreed with the divisions were included in the report.

The Chairman and Board noted the report and key issues and ongoing work and asked for its thanks to be passed to the teams managing the front door.

16/031.3 Transformation and Cost Improvement Programme Summary Report (Enclosure 13)

The Director of Strategy and Performance presented the Transformation and Cost Improvement Programme Summary Report, given as Enclosure 13.

The Board noted the high level position as follows:

- CIP: Delivered its target of close to £16.7m.

- Key focus is currently on delivering the 2016/17 plan. The Trust had identified plans for all but £2m and was currently looking at the work of Carter to encourage ideas.

- Half of the schemes had been agreed through the Transformation Executive.

Mrs Becke and Mr Atkins, Non Executive Directors, congratulated the team on their achievements.

The Chairman and Board noted the report.

16/032 Any Other Business

Mrs Becke, Non Executive Director, congratulated the team who had instigated and were running the quality reviews. The Board heard that the change from previous review process was incredible excellent feedback had been received from staff and the Trust had seen some really positive behaviour changes.

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

16/033 Date of Next Meeting

The next Board meeting will be held on Thursday, 7th April, 2016, 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 4 February 2016

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
16/018	Chief Executive's Overview Report	Outcome of the review of TTOs to be referred to the Clinical, Quality, Safety and Patient Experience Committee.	PB	29/3/16	To April CQSPE
16/027.1	Chief Executive's Overview Report	Update on TTOs to the March Clinical Quality, Safety, Patient Experience Committee and April Board.	PB	7/4/16	In CQSPE Report to May Board
16/019.6	End of Life and Palliative Care Strategy Group Report	Further End of Life Care Update Report to be presented to the Board in April.	DWu	7/4/16	To May Board
16/030.7	Charitable Funds Committee Exception Report	The Charitable Funds Committee Exception Report to be presented at the April Board meeting.	JA	7/4/16	On Agenda
15/124.8	Research and Development	Chief Nurse to resolve the Research Nurse identification issue. Mr Miner and the Director of Governance/Board Secretary to meet to discuss R&D reporting format for Board and Audit Committee.	DWa RM/GP	2/6/16 2/6/16	
16/027.2	Research and Development	The Research and Development Report to be presented to the June Board. The report will focus primarily on strategic issues.	JN	2/6/16	
16/030.3	NHS Preparedness for a Major Incident	Sharon Walford to be invited to present on Emergency Preparedness at a future Board General Clinical Presentation.	PB	1/9/16	The date is as a result of the expectation that the standards will be available in July.

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 7th April 2016

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
- Freedom to Speak Up Guardian - approval

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

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive's Report – Public Board – April 2016

Patient Friends and Family Test:

Community FFT (February 2016)

Based on the latest published NHS figures (January 2016) the Trust met the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members. It is pleasing to note a continued increase in the number of patients responding.

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16
Community FFT percentage recommended	97%	98%	96%	96%	94%	93%	97%	95%	99%	97%	98%
Total number of responses	36	55	116	90	82	125	126	92	256	258	286
National average percentage recommended	96%	95%	95%	95%	96%	95%	95%	95%	95%	95%	*n/a**

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

Inpatient FFT (01.03.16 – 12.03.16 provisional)

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

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16 Provisional
Inpatient FFT percentage recommended	96%	97%	98%	97%	99%	97%	97%	97%	99%	98%	97%	96%
Inpatient response rate	16%	16%	14%	15%	20%	20%	13%	20%	17%	17%	17%	11%
National average percentage recommended	95%	96%	96%	96%	96%	96%	96%	96%	96%	96%	n/a*	

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

Key for inpatient RAG rating

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

A&E FFT (01.03.16 – 12.03.16 provisional)

The percentage of patients who would recommend the Trust's A&E to friends and family during the period 1st – 12th March shows an increase to 97% compared to 92% for February. The latest published NHS England figures (January 2016) show The Dudley Group scored 95% which is higher than the national average of 86%.

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16 Provisional
A&E FFT recommended percentage	90%	90%	92%	90%	95 %	90%	95%	91%	88%	95%	92%	97%
A&E response rate	8%	15%	12%	7%	6%	3%	8%	6%	6%	5%	8%	10%
National average percentage recommended	88%	88%	88%	88%	88 %	88%	87%	87%	87%	86%	n/a*	

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

Key for A&E RAG rating

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

The Dudley Group NHS
NHS Foundation Trust

Maternity FFT (01.03.16 – 12.03.16 provisional)

The Trust remains in the top 30% of trusts nationally for those who say they are extremely likely or likely to recommend our maternity services to friends and family with the exception of the postnatal ward service that have consistently maintained scores in the top 20% of trusts. Monthly scores for all services are equal to or better than the national average for the percentage of patients who would recommend the service to friends and family member with the exception of the post natal community service.

Maternity Area	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16 Provisional
Antenatal, percentage recommended	95%	96%	99%	93%	99%	97%	96%	98%	90%	98%	97%	93%
National average percentage recommended	95%	96%	96%	95%	95%	95%	96%	96%	95%	96%	n/a*	
Response rate	30%	39%	24%	37%	38%	36%	49%	26%	26%	23%	14%	7%
Birth, percentage recommended	100%	100%	100%	99%	99%	100%	99%	99%	100%	98%	99%	100%
National average percentage recommended	97%	97%	97%	97%	97%	97%	94%	96%	97%	97%	n/a*	
Response rate	26%	20%	14%	22%	25%	27%	30%	47%	18%	19%	27%	9%
Postnatal ward, percentage recommended	100%	100%	99%	99%	99%	100%	98%	98%	98%	98%	99%	100%
National average percentage recommended	94%	93%	93%	94%	94%	93%	95%	94%	94%	94%	n/a*	
Response rate	26%	20%	14%	21%	25%	28%	4%	47%	18%	19%	26%	9%
Postnatal community, percentage recommended	100%	100%	96%	94%	92%	100%	100%	100%	100%	91%	97%	100%
National average percentage recommended	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	n/a*	
Response rate	8%	10%	12%	8%	4%	6%	30%	2%	10%	5%	11%	3%

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

Key for maternity RAG rating

% of footfall (response rate)	*<15%*	*15%+*	
Antenatal	*100%*	*96-99*	*<95*
Birth	*100%*	*97-99*	*<96*
Postnatal ward	*98+%*	*93-97*	*<92*
Postnatal community	*100%*	*97-99*	*<96*

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

Outpatients FFT (February 2016)

The percentage of those who would recommend the service in February decreased to 84%, the Trust has not met the quality priority target of monthly scores that are equal to or better than the national average for the percentage of patients who would recommend the service to friends and family members.

FFT Outpatients Services	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16
Outpatients recommended percentage	84%	82%	82%	88%	90%	89%	88%	84%	88%	90%	84%
Number of respondents	49	93	82	66	67	742	721	403	553	530	365
National average percentage recommended	92%	92%	92%	92%	92%	92%	92%	92%	92%	93%	n/a*

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

The Dudley Group NHS
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Freedom to Speak Up Guardian:

The Department of Health responded to the Sir Robert Francis report on 'Freedom to speak up' and the investigation at Morecombe Bay University Hospitals NHS Foundation Trust in their report 'Learning not Blaming', published in July 2015. In this report, the Department accepted a number of recommendations including the one that there should be a "Freedom to Speak Up Guardian" in every NHS trust and NHS foundation trust, appointed by the Chief Executive, to act in a genuinely independent capacity to provide the leadership and support to create a culture where staff understand and feel confident in raising concerns, however insignificant they may appear, so that it becomes part of normal, everyday practice. As well as ensuring staff know how to and where to raise concerns, they should feel entirely confident that their concerns will be listened to and acted upon as necessary and, most significantly, that they will not experience any detriment for having raised their concerns. These new local roles are being supported through a network by the newly established office of the National Guardian.

The Freedom to Speak up guardian
The person will report directly to the Chief Executive providing a quarterly report on themes from concerns raised, how these have been navigated to the appropriate trust process, update on the outcome of previously raised concerns focusing on learning and changes made as a result of concerns raised. This report will then be presented to the Board.

The person will act as an advocate for the Trust's systems and processes for staff to raise concerns. The person will provide information to the Risk and Standards team on any areas of possible improvement for these systems based on feedback from those raising concerns.

The person will act as an advocate for learning, this will be achieved by working with the Risk and Standards team and the Divisions to ensure changes are made as a result of concerns raised.

The person will act as an advocate for those raising concerns, this will involve, alongside navigating the person to the right point in the Trust's processes, include the use of the Trust's whilstleblowing process where appropriate, ensuring that the person raising the concern is supported in raising their concern (this could involve liaising with HR to support the person whilst the concern is investigated for example).

The person will help with the development and delivery of Trust training on how to raise concerns, linking to their role as advocates for learning from issues raised and for ensuring the Trust retains an open culture.

The person will participate in regional / national networks for Speak up Guardians. As part of this the person will be expected to bring any learning from these networks to the attention of the Director of Governance and work with them on enhancing Trust's systems.

In summary the role is not about doing it all or being the way concerns are dealt with but more they act as an advocate and "friend" to those raising concerns to ensure our systems work and support the person raising the concern through the Trust's established processes.

The Trust's Freedom to Speak up Guardian
In recognition that the person needs to be accessible, working with the front line staff, independent of the Executive, have a supportive nature and link into the Trust's training and education processes we have approached Ms C Love Mecrow, Head of Non Medical Training from the nursing learning development team to take on this role for the Trust and I am delighted that she has accepted.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th April 2016 - PUBLIC

TITLE:	Chief Nurse Report		
AUTHOR:	Dawn Wardell – Chief Nurse Dr E Rees - Director of Infection Prevention and Control Derek Eaves - Quality Manager Nursing	**PRESENTER:**	Dawn Wardell Chief Nurse

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

SUMMARY OF KEY ISSUES:

Infection Control results for the month of March (as at 29/3/16)

- No post 48 hour MRSA bacteraemia cases since 27th September 2015
- No Norovirus
- As of this date the Trust is 14 cases over trajectory for this point in the year of total of 29 cases post 48 hour C. difficile on PHE Listing. The Trust is now 12 cases against the yearly trajectory of 29 cases of lapses in care.

Safer Staffing

- Amber shifts (shortfall) have shown an increase to 76, this is due to additional capacity open and fill rates from bank and agency.
- Maternity saw a rise in amber shifts in February to 13.
- One red (serious shortfall) shifts in month no safety issues identified or on any of the amber shifts that affected the quality of care.
- A benchmark review on fill rates provided by Unify has been carried out using local trusts, the trust is comparable.

Nursing Care Indicators

- There have been 8 escalations to level 3 now in place. Improvement seen in other areas.

IMPLICATIONS OF PAPER:

RISK	Yes		**Risk Description:** Failing to meet initial target for CDiff now amended to avoidable only
	Risk Register: Yes		**Risk Score:** 10
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Yes	**Details:** Safe and effective care
	Monitor	Yes	**Details:** MRSA and C. difficile targets
	Other	Yes	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD:

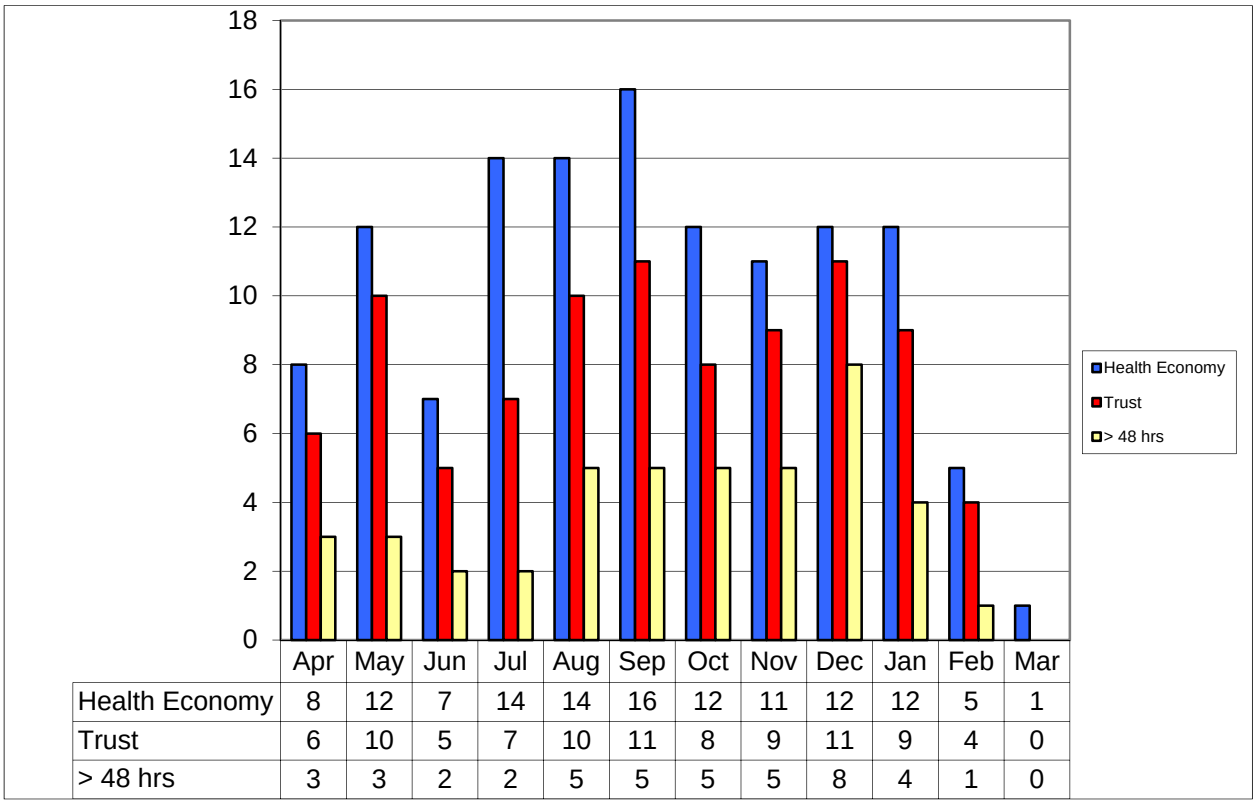
To receive the report and note the contents.

Chief Nurse Report

Infection Control

The target for 2015/16 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. At the time of writing (29.3.16) we have 0 post 48 hour case recorded in March 2016.

C. DIFFICILE CASES 2015/16



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	12	7	14	14	16	12	11	12	12	5	1
Trust	6	10	5	7	10	11	8	9	11	9	4	0
> 48 hrs	3	3	2	2	5	5	5	5	8	4	1	0

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], continues. Of the 43 post 48 hour cases identified since 1st April 2015, 40 cases have so far been reviewed by the apportionment panel, 36 of which have had apportionment agreed and 12 of these were deemed as avoidable. The main themes identified are: delay in sending sample, delay in isolation, poor documentation and incomplete stool charts.

There is a Trustwide C. difficile action plan in place to address issues identified by the RCA process as well as local plans for each individual case. Progress against the plan is recorded at the Infection Prevention Forum.

MRSA bacteraemia (Post 48 hrs) – There have been 0 post 48 hour MRSA bacteraemia cases since 27th September 2015.

Norovirus - no further cases.

Reference

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

Safer Staffing

Monthly Nurse/Midwife Staffing Position - February 2016

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. This document is currently undergoing a review.

Following the discussion at the Board at the end of 2015, this paper outlines the staffing situation on the general wards in relation to the agreed transitional 1:10 requirement, except when there is a high acuity/dependency of patients or when the actual staff on duty is two or more less than the planned staff. The ratios for specialist areas, such as critical care, paediatrics, maternity etc. which all have specific, more intensive requirements continue as before.

The accompanying chart (Appendix B) includes the monthly results of the NCIs for each area which provides a quality of care comparator. In addition the reports from April will also include the new monitoring system of an explicit, consistent RAG (Red, Amber and Green) rating system of the safety status on the ward, which the lead clinical nurses will undertake. This is being piloted at present.

This paper therefore endeavours to give the Board a view of the frequency when Registered Nurse to patient ratios do not meet the ratio on general wards of 1:10 on day shifts (there is no recommended ratio for night shifts, although the 1:12 ratio is used as a benchmark) and also the number of occurrences when registered staffing levels have fallen below the planned levels by two or more. It should be noted that these occurrences will not necessarily have a negative impact on patient care.

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

It can be seen from the accompanying chart the number of shifts identified as:

- Amber (shortfall of RN/RM 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 CSW staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available),
- Red (serious shortfall).

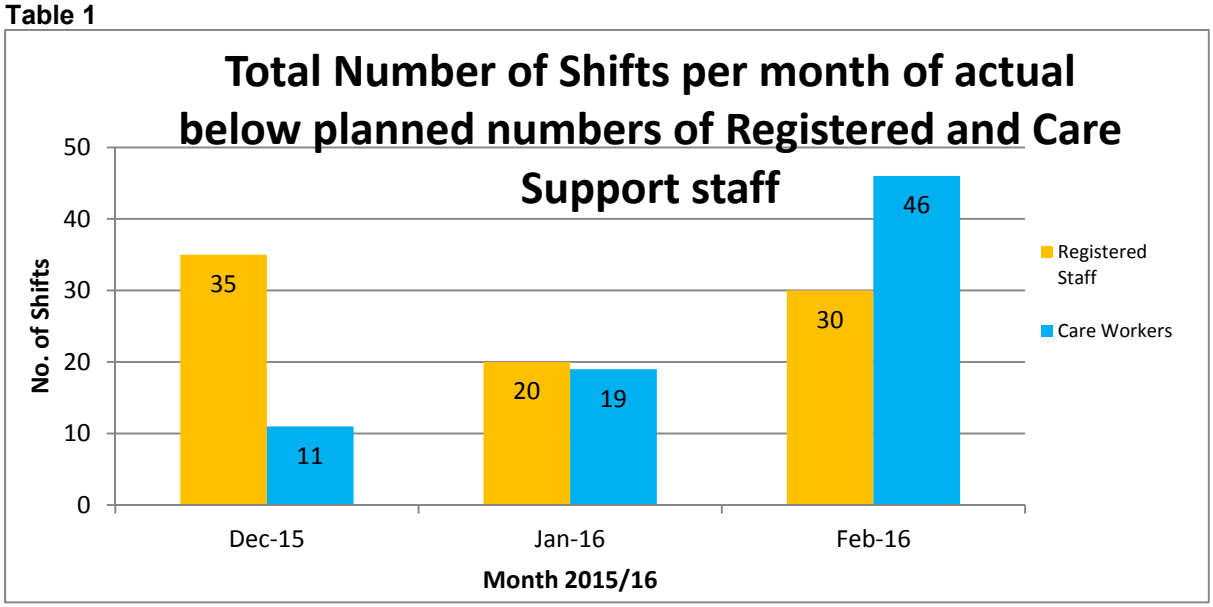
This total figure for this month has risen to 76 (39 and 46 in the two previous months) (see Table 1). When shortfalls have occurred, the reasons for the gaps and the actions being taken to address these in the future are outlined in Appendix A.

There is an overall upward trend due to the rise in CSW shortfall shifts. Other than two areas, the shortfalls are fairly evenly distributed across the wards. The maternity unit has vacancies, high volume cases and high workload. It accounts for just over a third (13) of the qualified and just under a half (22) of the unqualified shortfall shifts. There has been an increase in sickness this month and active recruitment initiatives are in progress and shortlisting has occurred for the care worker posts. Ward B4 is the second area for care

workers having just over a quarter (12) of those shortfall shifts with the bank not being able to supply staff when there are patients of higher dependency than normal. If the 1:8 ratio was still the benchmark for qualified nurses during the day, the majority of any further non-compliant shifts came mainly from three wards all of which had 1:9.6 ratios (five qualified nurses on a 48 bed ward). This month there has been one serious shortfall (red) shift. On the specific night shift, a station was closed on ward B1 which meant that there was one RN and two CSWs for the eleven patients and assistance was provided by the night co-ordinator, as required. Safety was maintained.

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

Table 1



Shift Fill Unify Data

This is collected by all hospitals and provided via UNIFY to the public website NHS Choices. Therefore it has been possible to do some local benchmarking to provide further assurance that the Trust is not an outlier with regard to fill rates.

	Qualified Days	Un Qual Days	Qualified Nights	Un Qual Nights
Trust Feb	93	95	96	99
Trust Jan	94	96	94	99
Trust A	89	114	88	132
Trust B	92	104	89	112
Trust C1	95	99	97	100
Trust C2	93	94	96	91
Trust D	96	95	96	101

What is interesting from the comparison is that it would seem that CSWs are being utilised to offset the Qualified Ratio/fill rate in a number of Trusts (A and B). This could however be a way of reporting differently as DGFT change the requirement if specials (1-1) are provided and so do not show as excess as it would seem occurs at Trust C and D also.

Nurse Care Indicators (NCI's)

The achievement of Green status has not yet been achieved for a number of areas despite improvements seen overall.

Rating	October 15 – Areas (Launch)	December 15 - Areas	January 16 - Areas	February 16 - Areas	March 16 - Areas
RED	15	4	3	7	6
AMBER	5	11	14	12	13
GREEN	4	9	9	8	8

The escalation procedure for those areas not yet in green remains in place and has been reviewed to ensure it maximises the time and support given to areas to achieve the requirements.

Escalations for March:

NCIs	
Level 1 Matron Level	8
Level 2 Head of Nursing Level	6
Level 3 Deputy Chief Nurse level	8

Nutrition Audit	
Level 1 Matron Level	9
Level 2 Head of Nursing Level	2

Dawn Wardell - Chief Nurse
29/03/16

Appendix A

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS FEBRUARY 2016

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	1 4	RN CSW	Vacancy x 5	On all five occasions the bank and agency were unable to fill. On all occasions assistance was provided by staff from wards A3 and C3. No safety issues were identified.
B1	1 1	RN CSW	Short Term Sickness x2	On the red night shift one station was closed and there were only 11 patients on the ward with one RN and two CSWs. Assistance was also available from the night co-ordinator. On the CSW shortfall shift the RN cover was 1:7 and so the ward was safe.
B2H	1	CSW	Vacancy/Sickness	The bank and agency were unable to fill. With the patients on the ward the nurse in charge assessed the ward as safe.
B2T	1	RN	Vacancy	The booked agency nurse did not arrive which meant a 1:12 ratio. The situation as escalated and no patient concerns were identified.
B3	4 2	RN CSW	Vacancy x 1 Staff sickness x 3	For the RN shifts: The bank and agency were unable to fill. No patient concerns were identified with assistance being provided by B2, B4 and C6 and a supernumerary nurse. For the CSW shifts: No patient concerns were identified with assistance provided by B2.
B4	1 12	RN CSW	Maternity Leave x 2 Increased dependency x 9 Vacancy x 1	For the RN shift: The lead nurse supported the ward. For the CSW shifts: The bank was unable to fill and in the majority of cases reorganisation of available staff enabled safe care to be given. On a number of occasions the lead nurse was also able to assist.
B6	1	RN	Vacancy	The bank and agency were unable to fill. Numbers of patients reduced so that there was a 1:12 ratio. Assistance was also provided by neighbouring ward.
C1	2	RN	Vacancy x2 Staff Sickness x 1	On one occasion the shift lead worked on a station. On both occasions safety was maintained with the patients who were on the ward at the time.
C3	2 1	RN CSW	Vacancy x 3	On all occasions the bank and agency were unable to fill. With the patient caseload on the ward that day safety was maintained.
C4	1	CSW	Vacancy and sickness	Although the bank initially covered the shifts, one bank staff cancelled and the other did not arrive. Safety was maintained although some skin bundles completion was delayed.
C7	1	CSW	Short Term Sickness	The bank was unable to fill. The remaining staff maintained safety.
C8	1	CSW	Short Term sickness	Staff were reorganised to maintain safety at all times.
CCU/PCCU	1	RN	Vacancy	The bank was unable to fill. Safety was maintained.
MHDU	3	RN	Sickness x3	Situation escalated, ITU unable to help. On one occasion two patients discharged to ward and agency nurse attended half way through the shift an on another a booked agency nurse did not attend. , Safety maintained in all three cases.
Maternity	13 22	RM CSW	Vacancy Maternity leave	Escalation policy enacted on all occasions. Bank unable to fill. On two occasions, midwives recalled from study days. On ten delayed inductions of labour. For CSW shifts: Bank unable to fill. Qualified staff undertook the roles. Active recruitment is occurring to these posts. No patient safety issues occurred.

APPENDIX B

Feb-16

SHIFT

WARD	NCI	STAFF	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16	
			D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	82	Reg																																
		Unreg															4/2														4/2		6/3	
WARD A2	89	Reg																																
		Unreg																																
WARD A3	95	Reg																																
		Unreg																																
WARD B1	88	Reg																																
		Unreg																																
WARD B2 HIP	99	Reg																																
		Unreg																							6/4									
WARD B2 TRAUMA	99	Reg																									3/2							
		Unreg																																
WARD B3	97	Reg																																
		Unreg																			5/2													
WARD B4	82	Reg									6/4																							
		Unreg	8/6	6/4	8/6		8/6								8/6		8/6		8/5		8/5				8/5									
WARD B5	77	Reg																																
		Unreg																																
WARD B6		Reg												2/1																				
		Unreg																																
WARD C1	85	Reg																	6/4															
		Unreg																																
WARD C2***	94	Reg																																
		Unreg																																
WARD C3	92	Reg																									7/5							
		Unreg																																
WARD C4	97	Reg																																
		Unreg														3/1																		
WARD C5	95	Reg																																
		Unreg																																
WARD C6	86	Reg																																
		Unreg																																
WARD C7	84	Reg																																
		Unreg																																5/3
WARD C8	65	Reg																																
		Unreg																								7/5								
CCU/PCCU	79	Reg																																
		Unreg																																
EAU	85	Reg																																
		Unreg																																
MHDU	100	Reg																			4/2													
		Unreg																																
CRITICAL CARE*	90	Reg																																
		Unreg																																
NEONATAL**	98	Reg																																
MATERNITY ****	91	Reg									18/14								18/16		18/16	18/16			18/14			17/14			18/17		18/15	
		Unreg	8/5				8/6		8/6		8/6	7/5					8/5				8/5		8/5		8/5						8/4		8/5	5/3

WARD	NCI	STAFF	17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
			D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	82	Reg																	3/1													
		Unreg													4/2																	
WARD A2	89	Reg																														
		Unreg																														
WARD A3	95	Reg																														
		Unreg																														
WARD B1	88	Reg										2/1																				
		Unreg					2/0																									
WARD B2 HIP	99	Reg																														
		Unreg																														
WARD B2 TRAUMA	99	Reg																														
		Unreg																														
WARD B3	97	Reg			6/4																		6/5		6/5		6/3					
		Unreg																			5/3											
WARD B4	82	Reg																														
		Unreg													7/5		7/5		6/4													
WARD B5	77	Reg																														
		Unreg																														
WARD B6		Reg																														
		Unreg																														
WARD C1	85	Reg																									6/4					
		Unreg																														
WARD C2***	94	Reg																														
		Unreg																														
WARD C3	92	Reg																					7/5									
		Unreg																			9/7											
WARD C4	97	Reg																														
		Unreg																														
WARD C5	95	Reg																														
		Unreg																														
WARD C6	86	Reg																														
		Unreg																														
WARD C7	84	Reg																														
		Unreg																														
WARD C8	65	Reg																														
		Unreg																														
CCU/PCCU	79	Reg					7/5																									
		Unreg																														
EAU	85	Reg																														
		Unreg																														
MHDU	100	Reg	4/3												4/3																	
		Unreg																														
CRITICAL CARE*	90	Reg																														
		Unreg																														
NEONATAL**	98	Reg																														
MATERNITY ****	91	Reg					18/14		17/15								18/15		18/14		18/16											
		Unreg		5/3			8/6		7/5		7/5		8/6		8/6		8/4		8/5		8/6						8/4					

Key Serious Shortfall | 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 staf

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

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

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

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 7 April 2016

TITLE:	**29th March 2016 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Ann Becke – Committee Chair for this meeting

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		**Y**

RECOMMENDATIONS FOR THE BOARD

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

To note that the NRL System flag was due to a data upload issue and not due to reduction in reporting incidents

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	29 March 2016	A Becke	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Operational Management assurance was provided on the performance in respect of key quality indicators including the strong performance in respect of preventing avoidable C-Diff cases, it should be noted that Public Health England record the total number of cases on their website regardless of avoidability;
- Following from the request for further assurance at the January meeting, Executive Management assurance was provided that the data reported in the months November and December supporting the High Risk TIA Screening indicator was correct showing there had been a dip in performance as reported;
- Executive Management assurance was provided in respect of the Trust's mortality case review process and that the Quality Priority would be achieved for 2015/16 (that being at least 85% of deaths are reviewed within 12 weeks);
- Executive Management assurance was provided over the SHMI data, linked to the case reviews the septicemia & sepsis audits arebeing undertaken in March 2016 and will be reported back to this Committee
- Secondary Malignancies is an area where a review of all cases within this condition group are being looked at and its outcome will be reported to the Quality and Safety Group;
- Executive Management assurance was provided in respect of incident reporting. There had been a data upload issue in respect of providing information to the National Reporting and Learning System which whilst corrected did trigger a data quality flag on the NRL System. Assurance was also provided that revised checking has taken place to ensure such errors if they occur will be dealt with more promptly allowing the revised data to be accepted for inclusion in published data;
- Operational Management assurance was provided in respect of the Quality and Safety Reviews, their delivery and the tracking of agreed corporate actions resulting from the reviews (this was an agreed item from the last report to this Committee);
- Executive Management assurance was received via the Quality and Safety Group in respect of their agenda items including the outcome and action training of learning from internal Quality Safety Reviews, the work of the Falls Group and that

the Sepsis CQUIN has been achieved for quarter 3.
Decisions Made / Items Approved
• Approval of 7 policies and 10 guidelines / procedures that had all been considered by Policy Group; • Approval to close 29 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced; and • Approval of the individual measures supporting the previously approved Quality Priorities.
Actions to come back to Committee (items the Committee is keeping an eye on)
• The decision made in respect of the Trust's delivery of the national Mortality Governance requirements; • The Sepsis audit and the Secondary Malignancies audit outcomes; • The Sign up to Safety Strategy; • Information on the Stroke performance; and • The outcome of the re-audit of the blood taking procedures within ED
Items referred to the Board for decision or action
To report to the Board the data upload issue in respect of submitting data to the National Reporting and Learning System and the assurance received that revised processes had been put in place within the new Datix system to prevent data upload issues in the future.

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 7 April 2016

TITLE	**Charitable Funds Committee Summary**		
AUTHOR	**Chris Walker** **Deputy Director of Finance**	**PRESENTER**	**Julian Atkins** **Non-Executive Director**

CORPORATE OBJECTIVE:

S01 – Deliver a great patient experience
S05 – Make the best use of what we have

SUMMARY OF KEY ISSUES:

Summary of key issues discussed and approved at the Charitable Funds Committee on 25th February 2016

RISKS	**Risk Register N**	**Risk Score**	
COMPLIANCE	**CQC**	**N**	
	NHSLA	**N**	
	Monitor	**N**	
	Other	**Y**	**To comply with the Charity Commission**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report.

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
Charitable Funds Committee	25th February 2016	Julian Atkins	yes	no
			Yes	

Declarations of Interest Made

None

Assurances Received

The Committee received an update on the financial position of the Dudley Group Charity as at 31st January 2016, which covered:

- Statement of Financial Activities
- Balance sheet
- Details of Fund activities
- Details of Fund balances in balance order
- Quarterly expenditure over 3 years
- Investment update
- Legacy update
- Funds where no expenditure had occurred in the current financial year

Total fund balances stood at £2.501m.
The total income received in the year to date was £334k compared to expenditure of £375k.
Investments totalled £1.161m.
Current assets totalled £1.351m.
General fund balances stood at £443k.

There are currently 26 funds out of a total of 90 that have not incurred any expenditure in the financial year to date. The Committee noted its legal responsibility to ensure donors wishes are adhered to. The Committee requested that the top 7 funds in value (of the 26 over and above £10k) submit a report to the next Committee detailing spending plans for the next 12 months. The remaining fund managers will also be contacted to remind them that funds should be used.

The Committee also received an update from the Charitable Fundraiser:

- The 'Just Giving' appeal and general community fundraising were performing higher than expected with the number of individual's involved increasing year on year.
- The 'Will Fortnight' generated £4,700 which was an increase on the previous year.
- The final amount raised by the charity football match and dinner and dance was £11,884.

- The 2015-16 fundraiser performance was £16,313 below plan at the end of January which was accepted by the Committee due to the extended period of illness of the Charitable Fundraiser for the first four months of the year.
- The Committee discussed the development of the Charity Hub and requested that it is revisited. Analysis of the proposed development costs are to be compared to the estimated increase in donations and discussed with the Chair of the Committee.

Decisions Made / Items Approved

The Committee received four bids for expenditure against the General Funds totalling £47,055. Three of the bids were approved with one bid rejected due to a specific fund being available to provide funding for the request. A bid for £28,400 for bed and chair alarms was approved however the Committee requested that the bidder attend the next meeting to present to the Committee how the alarms are used and what coverage of alarms there are across the Trust.

The Committee approved the 2016-17 Fundraiser's plan with a total contribution of £99,556.

Actions to come back to Committee

There were no actions to come back to the Committee.

Items referred to the Board for decision or action

There were no items to be referred to the Board

Enclosure 7

Committee / Group highlights report to Board / Committee

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Audit Committee	22/3/2016	Richard Miner	x	

Declarations of Interest Made

None

Assurances Received

- That the recovery in the number of R&D participants is still a priority.
- That the Internal Audit Progress Report confirms that the 2015/16 audit plan is on track albeit with an Amber/Red rating on disaster recovery. This and the IT Data Security review actions are being tracked and have been referred to the IT Steering Group. There is also follow up work on DNA letters as part of the Trust's Safeguarding Policy. Data Quality (as part of the Safer Staffing Reporting) which was given an Amber/Red rating, as previously reported, is being followed up.
- That the 2015/16 LCFS work plan has not highlighted any fraud issues that could impact the Annual Governance Statement.
- That the 2015/16 External Audit work (financial and quality) is progressing satisfactorily with no change to the audit risks previously identified.
- That the 2015/15 clinical audit programme is progressing within expected timescales.
- That the work of the Risk and Assurance Group supports the risk assessments made by the Executive Team.
- That the Caldicott and Information Governance Group continues to fulfil its role and keep the required areas under review, noting that there had been one Information Commissioners Office reportable IG incident, this related to some instances of access to records not being in accordance with Trust policy although this has not involved high risk data.
- The Director of Governance confirmation that the Annual Governance Statement will be completed in time for the Trust's Financial Statements and Annual Report ahead of the external audit.

Decisions Made / Items Approved

The Committee approved:

- The Internal Audit Plan for 2016/17 and the Internal Audit Strategy for 2016/17 to 2018/19. Emphasis continues to be placed on the "less comfortable" areas proposed by the executive team which the Audit Committee is happy to approve.
- The Local Counter Fraud Specialist workplan for 2016/17 and noted the revised future approach by NHS Protect.
- The 2016/17 forward clinical audit programme.
- The Policy Group Recommendations on 2 new policies (Confidentiality and Data Quality) and 4 revised policies which are that proper procedures are being followed in the implementation of new policies and guidelines.
- The Annual Governance Statement, as currently drafted, and that it provides a balanced view of the Trust's governance, risk management and control systems in place during the year.

Committee / Group highlights report to Board / Committee

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

- Follow up to the amber/red opinion on IT Data Security Review and Disaster Recovery by RSM as well as monitoring undertaken by the IT Steering Group. Follow up of Safeguarding Policy (DNA letters) and Data Quality (Safer Staffing).
- Conclusions to the NHS Protect response, a matter previously reported.
- Ongoing discussions with the external auditors regarding the final wording of the Trust's audit report following its removal from breach of licence.

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

- The proposed Internal Audit Annual Report for 2015/16 is expected to be at the second highest opinion: "An adequate and effective framework…….however our work has identified further enhancements…" These relate to IT issues (IT Data Security and IT Disaster Recovery).
- The proposed external audit report contains an "except for" modification reflecting the breach of licence during the year. This is an improvement from last year when the external auditors expressed an opinion that "we have been unable to satisfy ourselves that….".
- The Audit Committee's continued endorsement of the Risk Register and Assurance Register (together representing the Board Assurance Framework) and will be looking for the link with the reporting cycle for other committees.
- That the Audit Committee has no concerns over the levels of gifts, hospitality and sponsorship being received as recorded in the registers.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Internal Audit Strategy 2016-2017

Presented at the Audit Committee meeting of:

22 March 2016

RSM

CONTENTS

1 Introduction 2
2 Developing the internal audit strategy 3
3 Your internal audit service 6
4 Audit committee requirements 7
Appendix A: Internal audit plan 2016/17 8
Appendix B: Internal audit strategy 2016/17 – 2018/19 12
Appendix C: Internal audit charter 15
Appendix D: Our client care standards 19
For further information contact 20

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.

The Trust has recently improved its Assurance Framework to strengthen the reporting in regards to the level of assurances available for individual risks and ultimately the delivery of the Trust's strategic objectives. Our Internal Audit Plan and Strategy have been developed in conjunction with the Executive Team and Audit Committee with greater focus on the Assurance Dashboard and the levels of assurance required.

1.2 Vision

The Trust's vision is to be 'trusted to provide safe, caring and effective services because people matter.' The vision is supported by the Trust's values of 'Care, Respect and Responsibility'.

1.3 Objectives

The following of your strategic objectives are particularly relevant to the content of the coming year's internal audit plan:

- To deliver a great patient experience;
- To deliver safe and caring services;
- To drive service improvement, innovation and transformation;
- To be the place people choose to work;
- To make the best use of what we have; and
- To plan for a viable future.

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 evaluated your risk management processes and consider that we can place reliance on your risk registers / assurance framework to inform the internal audit strategy. We have used various sources of information (see Figure A below) and discussed priorities for internal audit coverage with the following:

- 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).**

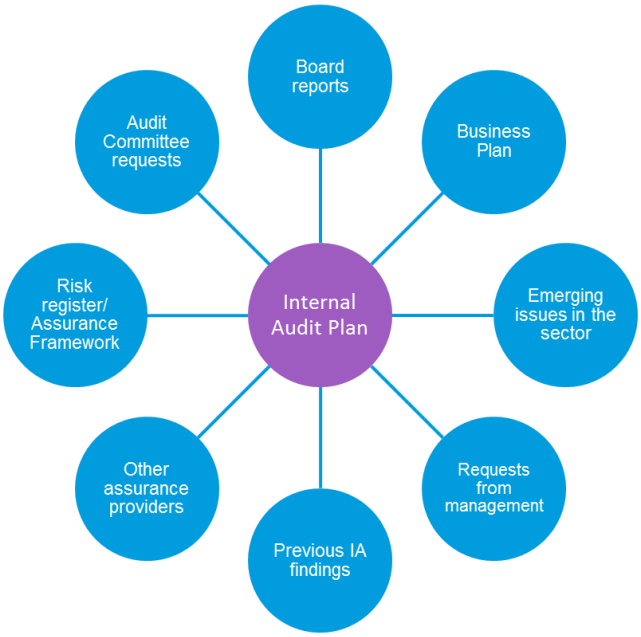


Figure A: Sources considered when developing the Internal Audit Strategy

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
Vacancy Management	The Trust has experienced a high level of staff (registered nurses and medics) leaving the Trust. Our review will therefore consider the issues around the retention of registered nurses and medics, and understand why they are leaving the Trust. We will include a review of exit interview information to understand if there are any consistent reasons, or trends, in why staff are choosing to leave. The review will also consider best practice identified elsewhere around the retention of staff.	N/A - Management Concern
IT Projects (new Electronic Patient Record system)	The Trust is in the process of developing the business case for the new electronic patient record system. Our allocation will be used to undertake gateway reviews throughout the decision making process.	SO3 Drive Service improvement, innovation & transformation
Safer Staffing Reporting	The review was deferred from 2015/16. The Trust is currently changing the process for the collation of staffing level numbers with data being collated electronically. Therefore our review will consider the accuracy and reliability of this process.	SO2 Safe and caring services
Pharmacy Department	The Trust has experienced a change in staff within the Pharmacy. This was identified as a potential area for a departmental review to be undertaken; however this will now be conducted internally within the Trust.	N/A - Management Concern

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.

The table above highlights where internal audit coverage may be of benefit but is not currently included in the strategy. In light of this we consider it prudent to inform you of other reviews that are taking place across the sector and tools that RSM can offer to aid in your assurance framework:

- Cyber Security;
- Contract Management;
- Temporary Staffing including rostering and application of agency cap;
- Unexpected deaths – incident management; and
- Vanguards and partnerships.

In addition, there is a range of health checks available including but not limited to the following areas:

- Board Assurance Framework preparedness;
- Contract Management;
- Environmental;
- Independent Board/Committee observations;
- Lean workshops; and
- Service Line Management.

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 providers, such as External Audit and Local Counter Fraud Specialists to ensure that duplication is minimised and a suitable breadth of assurance obtained.

3 YOUR INTERNAL AUDIT SERVICE

Your internal audit service is provided by RSM Risk Assurance Services LLP. The team will be led by Mike Gennard, supported by Alex Hire as your client manager and Mark Coton as assistant manager.

3.1 Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the International Standards for the Professional Practice of Internal Auditing and the International Professional Practices Framework (IPPF) as published by the Global Institute of Internal Auditors (IIA). Further details of our responsibilities are set out in our internal audit charter within Appendix C.

Under the standards, internal audit services are required to have an external quality assessment every five years. Our Risk Assurance 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 IPPF.

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”.

3.2 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 2016/17

Audit / Executive Lead	Scope for 2016/17	Days	Proposed Timing	Proposed Audit Committee
Risk Based Assurance				
Executive Team Resilience (Director of Governance/Chief Executive)	Following on from the Well-Led Board assessment in 2015/16, our review will consider the outcomes and actions from this including the development programme for the Executive Team.	10	November 2016	January 2017
Data Quality (Director of Finance)	The review will consider how the Trust is ensuring the data it reports is accurate and supported by appropriate documentation, particularly when reporting is external. We will review two key performance indicators included within the Trust's Performance Report; which will be agreed with management at the time of scoping the audit. Our review will benchmark the Trust against similar organisations in terms of reporting, presentation and measurability of data confidence levels.	20	June 2016	August 2016
Cost Improvement Programme – Monitoring (Director of Strategy and Performance)	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.	10	August 2016	November 2016
Safer Staffing Reporting (Chief Nurse)	This review was deferred from 2015/16. The Trust is currently changing the process for the collation of staffing level numbers with data being collated electronically. Our review will consider the accuracy and reliability of this process.	10	May/June 2016	August 2016

Audit / Executive Lead	Scope for 2016/17	Days	Proposed Timing	Proposed Audit Committee
IT Projects (new Electronic Patient Record system) (Director of Finance)	To provide advice and assurance as the Trust develops and delivers its IT Project.	7	As required	To the next appropriate Audit Committee
	The time allocation will be split into two gateway reviews with specialist support.	7	As required	To the next appropriate Audit Committee
Consultant Job Planning (Medical Director and Director of Strategy and Performance)	This is one of the Trust's Workforce CIP schemes. The review will focus on the process for managing consultant job planning including consideration of demand and capacity requirements within the Trust. Our work will be undertaken in conjunction with our LCFS colleagues.	12	September 2016	November 2016
Nurse Revalidation (Chief Nurse)	To provide assurance over the Trust's systems developed for nurse revalidation.	8	June/July 2016	November 2016
Emergency Planning / Major incident procedures (Chief Operating Officer)	We will consider the Trust's emergency planning arrangements in readiness for a major incident. We will benchmark the plans in place against other similar organisations for best practice.	15	July 2016	November 2016
Data Security (Director of Finance)	Following on from our work in 2015/16, the review will consider the application of data security controls across the Trust.	8	June 2016	August 2016
Strategic Development Planning (Director of Finance)	To review how strategic decisions, including business cases, are made and the audit trail/ evidence to demonstrate how the resulting decision was reached.	12	November 2016	January 2017

Audit / Executive Lead	Scope for 2016/17	Days	Proposed Timing	Proposed Audit Committee
Vacancy Management (Director of Finance)	To consider the issues around the retention of registered nurses and medics and understand why they are leaving the Trust. To include a review of exit interview information to understand if there are any consistent reasons, or trends, in why staff are choosing to leave. The review will also consider best practice identified elsewhere around the retention of staff.	15	April 2016	August 2016
Core Assurance				
Care Quality Commission (CQC) Readiness (Director of Governance)	To consider how the Trust Board assures itself of the on-going compliance against CQC standards. Our review will consider the embedding of the internal Quality and Safety reviews and the lessons learned approach.	12	December 2016	March 2017
Information Governance Toolkit Assessment (Director of Governance)	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 on to support the Trust's self-declaration. The review will be conducted in two phases.	8	December 2016 February 2017	March 2017 May 2017
Divisional Governance, Risk Management and Performance Management (Director of Governance and Director of Strategy and Performance)	An advisory review to support the Divisions in the embedding of the assurance mapping framework and ensuring that a robust governance structure is in place at a divisional level. This review will also consider the robustness of performance monitoring at a divisional level. This will take into consideration the new reporting tool being introduced at the Trust and provide benchmarking around the presentation, monitoring and reporting of performance information at a divisional level.	15	September 2016	November 2016

Key Financial Systems (Director of Finance):				
General Ledger Cash Receipting and Treasury Management Income and Debtors Payments to Staff Charitable Funds	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.	40	October/ November 2016	January 2017
Other Internal Audit Activity				
Contingency – Assurance Framework	To allow additional reviews to be undertaken in agreement with the Audit Committee or management based on the assurance gaps identified within the Assurance Framework.	5	As required	As required
Contingency	To allow additional reviews to be undertaken in agreement with the Audit Committee or management based on changes in risk profile or assurance needs as they arise during the year.	7	As required	As required
Follow up (Director of Finance)	To meet internal auditing standards and to provide assurance on action taken to address management actions previously agreed by management.	7 7	June 2016 November 2016	August 2016 January 2017
Management	This will include: • Annual planning; • Preparation for, and attendance at, Audit Committee; • Administration of our actions tracking database; • Regular liaison and progress updates; • Liaison with external audit and other assurance providers; and • Preparation of the annual opinion.	25	Ongoing	Ongoing

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APPENDIX B: INTERNAL AUDIT STRATEGY 2016/17 – 2018/19

Proposed Area for Coverage	Associated Risk Area and Links to Assurance Framework/Corporate Risk Register	2016/17	2017/18	2018/19
Risk Based Assurance				
Executive Team Resilience	The leadership, management and governance of the organisation fails to assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.	✓		
Data Quality	Failure to continue to deliver the key contractual /monitor delivery targets (18wks / ED / Cancer). (COR079)	✓	✓	✓
Cost Improvement Programme – Monitoring	Failure to deliver our CIP Programme. (COR080) Failure to maintain financial sustainability. (COR061)	✓	✓	✓
Safer Staffing Reporting	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing. (COR085)	✓		✓
Patient Experience	Poor service and standards that impact on the patient experience and lead to increases in complaints and claims.		✓	
Discharge Management	Failure to continue to deliver the key contractual / monitor delivery targets (18wks / ED / Cancer). (COR079)		✓	
IT Projects (new Electronic Patient Record system)	IT Strategy does not deliver. (COR089)	✓	✓	
Consultant Job Planning	Workforce reduction programme will adversely affect patient care and trust performance. (COR077)	✓		
Nurse Revalidation	Nurse / Midwifery revalidation fails. (COR081)	✓		
Emergency Planning / Major incident procedures	The Trust is required to have an up to date plan to manage major incidents and business continuity. (COR032)	✓		

Proposed Area for Coverage	Associated Risk Area and Links to Assurance Framework/Corporate Risk Register	2016/17	2017/18	2018/19
Safeguarding	Inadequate and ineffective systems in place to safeguard adults/children.		✓	
Lessons Learned – 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.			✓
Data Security	The Trust is required to have an up to date plan to manage major incidents and business continuity. (COR032)	✓		✓
Strategic Development Planning	Management concern.	✓		
Vacancy Management	Management concern.	✓		
Clinical Audit	Services do not meet national standards.		✓	
Cancelled Operations / Theatre Utilisation	Inadequate number of staff undertaking training in Theatre and Critical Care. (TAC 105)		✓	
Operational Budgetary Control	Failure to deliver our CIP Programme. (COR080) Failure to maintain financial sustainability. (COR061)			✓
Statutory and Mandatory Training	Management assurance required.		✓	
Core Assurance				
CQC	Failure to embed the improvements from our last CQC inspection. (COR084)	✓	✓	✓
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 and Governance	Review of the Trust's risk management processes and use of its assurance framework. The Trust does not continue to develop and embed a robust governance structure which is supported by effective processes.	✓	✓	✓

Proposed Area for Coverage	Associated Risk Area and Links to Assurance Framework/Corporate Risk Register	2016/17	2017/18	2018/19
Key Financial Systems:				
General Ledger and Financial Reporting	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.	✓	✓	✓
Creditor Payments			✓	✓
Cash Receipting and Treasury Management		✓		✓
Income and Debtors		✓	✓	
Payments to Staff		✓	✓	✓
IT Controls within the Financial Systems			✓	
Charitable Funds		✓		✓
Other Internal Audit Activity				
Contingency – Assurance Framework	To allow additional reviews to be undertaken in agreement with the Audit Committee or management based on the assurance gaps identified within the Assurance Framework.	✓	✓	✓
Contingency	To allow additional reviews to be undertaken in agreement with the Audit Committee or management based in changes in risk profile or assurance needs as they arise during the year.	✓	✓	✓
Follow up	To meet internal auditing standards, and to provide assurance on action taken to address management actions previously agreed by management.	✓	✓	✓
Management	This will include: • Annual planning; • Preparation for, and attendance at, Audit Committee; • Administration of our actions tracking database; • Regular liaison and progress updates; • Liaison with external audit and other assurance providers; and • Preparation of the annual opinion.	✓	✓	✓

APPENDIX C: INTERNAL AUDIT CHARTER

Need for the charter

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 International Standards for the Professional Practice of Internal Auditing; approval of the charter is the responsibility of the audit committee.

The internal audit service is provided by RSM Risk Assurance Services LLP ("RSM"). Your key internal audit contacts are as follows:

	Partner	Client Manager
Name	Mike Gennard	Alex Hire
Telephone	07778514762	07970641757
Email address	mike.gennard@rsmuk.com	alex.hire@rsmuk.com

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.

An overview of our client care standards are included at Appendix D of the internal audit strategy plan for 2016/17 – 2018/19.

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**

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.

Independence and ethics

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

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.

Conflicts of interest may arise where RSM provides services other than internal audit to The Dudley Group NHS Foundation Trust. 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 RSM expertise and will therefore raise awareness without compromising our independence.

Responsibilities

In providing your outsourced internal audit service, RSM has a responsibility to:

- Develop a flexible and risk based internal audit strategy with more detailed annual audit plans. 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 tasks requested by management and the Audit and Committee.
- Ensure the internal audit team consists of professional 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. Examples may include facilitation, process design and training.
- 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 together with corrective action recommended to management based on an acceptable and practicable timeframe.
- Undertake follow up reviews to ensure management has implemented agreed internal control improvements within specified and agreed timeframes.
- Provide a list of significant measurement goals and results to the Audit Committee to demonstrate the performance of the internal audit service.
- Liaise with the external auditor for the purpose of providing optimal audit coverage to the organisation.

Authority

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.

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 RSM unless specifically seconded to internal audit.

Key performance indicators (KPIs)

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 internal auditing 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.	

Reporting

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.

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

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

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 RSM Risk Assurance 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.

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 RSM. 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).

RSM has a Data Protection Policy in place that requires compliance by all of our employees. Non-compliance will be treated as gross misconduct.

Fraud

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.

Approval of the internal audit charter

By approving this document, the internal audit strategy, the Audit Committee is also approving the internal audit charter.

APPENDIX D: OUR 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 RSM 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 RSM to the agreed distribution list.
- Management responses to the draft report should be submitted to RSM.
- Within three days of receipt of client responses the final report will be issued by RSM to the assignment sponsor and any other agreed recipients of the report.

FOR FURTHER INFORMATION CONTACT

Mike Gennard (Head of Internal Audit)

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07778514762

Alex Hire (Client Manager)

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rsmuk.com

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th April 2016

TITLE:	**Medical Revalidation Update**		
AUTHOR:	**Teekai Beach Directorate Manager to the Medical Director**	**PRESENTER**	**Teekai Beach Directorate Manager to the Medical Director**

CORPORATE OBJECTIVE:
SO2: Safe and Caring Services
SO4: Be the place people choose to work

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 in Q2 and Q3 2015/2016 and highlights any issues. A more detailed quarterly report and annual report is made to the Workforce & Staff Engagement Committee.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director may result in a failure to properly discharge the duties of Responsible Officer for Medical Revalidation and the Trusts' function as a Designated Body.
	Risk Register: Y		**Risk Score: 8**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: SAFE; WELL LED**
	Monitor	**Y**	**Details:**
	Other	**Y**	**Details: GMC Good Medical Practice NHS Framework for Quality Assurance for Responsible Officers**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD:
The board is asked to note the contents of this report and approve commencement of the process to appoint a new Responsible Officer

The Dudley Group NHS
NHS Foundation Trust

March 2016

Revalidation Update

1. Summary

As of 31st December 2016 there were approximately 313 doctors with a prescribed connection to The Dudley Group NHS Foundation Trust.

This report updates the board following quarterly reports to The Workforce and Staff Engagement Committee for Quarters 2 and 3 of the year 2015/2016. The combined number of appraisals due for that period was 126, and a total of 98 held appraisal meetings within that period. 26 doctors had reasons for delay which were understood by the Responsible officer and reported to NHS England accordingly. 57 doctors had positive recommendations for revalidation and 8 were deferred, there were no doctors who were not recommended for revalidation.

The organisation has implemented the mandatory requirements of the Revalidation Framework for Quality Assurance Core Standards and reports areas for improvement in non-mandatory areas below. As part of the Framework annual Independent Verification Visit by NHS England Midlands & East was due to take place in February 2016, this was downgraded to a desktop exercise which the Trust participated in in February and a response from NHS England is awaited.

Finally the Board should note on-going plans to separate the role of Responsible Officer from that of the Medical Director

2. Background

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. A more detailed history and background to Revalidation has been outlined in previous papers to the board.

Revalidation arrangements have been in place in the Trust since the requirement to revalidate doctors every five years commenced in December 2012.

This report provides an update to the Board on Medical Revalidation further to the update presented November 2015. It meets the requirement for the Responsible Officer to provide a public update on medical revalidation & appraisal which will be provided in April and October each year going forward. Further assurance is provided to the board via the Workforce and Staff Engagement Committee which will receive quarterly reports as well as the Annual Report in May.

3. Governance

The Trust continues to be compliant with the Framework for Quality Assurance (FQA) presented in July 2014. Compliance is Monitored against the Core Standards set out in the FQA and are reported by exception as part of the development plan below.

The Trust is achieving the majority of the mandatory and good practice standards set by NHS England in April 2014. The table below shows progress against areas of concern as of October 2015. Actions and progress in each of these areas is monitored by the Workforce & Engagement Committee. Since the last board update an internal programme of training and development for medical appraisers and all doctors is in place including external training provided by the General Medical Council. Key areas for improvement are the implementation of learning and development programmes case investigators and case managers. However the Responsible Officer can now report that all internal case investigators are fully trained. All case managers have undertaken training with the National Clinical Assessment Service (NCAS).

	Core Standard	Progress March 2016
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.	
2.2.12	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.	
3.2.4	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)	
3.2.8	The responsible officer ensures that case investigators and case managers participate in peer networks to learn and share good practice.	

3a. Responsible Officer

The board should note developments with regards to standards 1.11 to 1.18 regarding the responsibility of the Trust to appoint a Responsible Officer.

The board will be aware that currently the Medical Director is also the Responsible Officer and that in 2013/2014 Medical Director's personal appraisal had highlighted as an action for his Personal Development Plan the development of a separate role of Responsible Officer. Given the expanding responsibilities of the Medical Director, and the potential conflict between that of the role of an executive director and statutory obligations of the Responsible Officer, The board accepted the proposal in June 2014 to ensure that the Deputy Medical Director was appropriately trained and resourced to assume the role. The Board should note that the Deputy Medical Director has completed the required training, his clinical commitments and operational responsibilities have been transferred.

The Deputy Medical Director will undertake a formal period of "shadowing" of the Medical Director in Q1 2016/2017 and a formal request to transfer the responsibility will be made in this financial year 2016/2017. It is recommended that the board review its compliance with Section 1 of the Core Standards following transfer of responsibility from the Medical Director to Deputy Medical Director.

1	The Designated Body and the Responsible Officer	Progress March 2016
1.1.1	The designated body has nominated or appointed a responsible officer in compliance with the Responsible Officer Regulations. The responsible officer is a licensed doctor who has been licensed continuously for the previous five years and continues to be licensed throughout the time they hold the role of responsible officer.	
1.1.2	The designated body has nominated or appointed an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection	
1.1.3	The responsible officer has sufficient time to carry out the role including the training, support and quality assurance requirements	
1.1.4	The designated body provides the responsible officer with sufficient funds, capacity and other resources to enable the responsible officer to carry out the responsibilities of the role.	
1.1.5	The responsible officer ensures an accurate record is maintained of all doctors with a prescribed connection to the designated body.	
1.1.6	The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer	
1.1.7	The responsible officer is actively involved in peer review and networking for the purposes of calibrating decision-making and organisational systems and processes	
1.1.8	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the *Responsible Officer Protocol*. Ideally at the beginning of the 3 month notice period.	
1.1.9	The responsible officer considers all relevant information from the doctor's full scope of work and through the complete revalidation cycle in making a recommendation about a doctor's fitness to practise.	

1.1.10	The responsible officer ensures that accurate records are kept of all relevant actions and decisions relating to the responsible officer role	
1.1.11	The responsible officer has mechanisms in place to assure the quality of the processes underpinning the Responsible Officer Regulations	
1.1.12	The responsible officer provides a report to the designated body's board (or an equivalent governance or executive group) and the higher level responsible officer, on compliance with the Responsible Officer Regulations and any other statutory requirements.	
1.1.13	The responsible officer provides the designated body's board (or an equivalent governance or executive group) with a development plan that addresses any identified weaknesses or gaps in compliance with the Responsible Officer regulations to agreed timelines.	
1.1.14	The responsible officer includes the report on compliance and resulting development plan in their own appraisal and revalidation portfolio.	
1.1.15	The responsible officer ensures that the designated body's medical revalidation policies and procedures comply with equality and diversity legislation.	
1.1.16	Where the responsible officer role is outsourced, the designated body must be satisfied that the service specification for the role (including responsible officer training, support and review) meets the required core standards.	
1.1.17	The responsible officer has completed a recognised training programme before making revalidation recommendations.	
1.1.18	The responsible officer attends three out of four regional networking events each year.	

Section 1: Core Standards, Framework for Quality Assurance for Revalidation

3b. Independent Verification Visit (Desktop Exercise)

The trust was notified in December 2015 that the Independent Verification Visit scheduled for 3rd February 2015 was postponed and replaced for this year by a desktop exercise. Feedback has not been received to date. It is understood that NHS Midlands & East have a large number of organisations to review including locum agencies and that the Trust is considered to be low risk and compliant with guidelines.

In 2014/2015 the Trust met its requirement to undertake independent verification of its systems for Revalidation and Appraisal by including the process on the internal audit plan. For this year 2015/2016 this has been removed audit plan as the review by NHS England will fulfil the requirement for annual independent verification.

4. Medical Appraisal Performance

A standardised quarterly return is provided to NHS England. For Quarters 2 and 3 these were returned on 11th November 2015 and 11th February 2016.

313 doctors had a prescribed connection to The Dudley Group NHS Foundation Trust as at 31st December 2016

- The majority of appraisals are completed by the due date (within 12 months of the previous appraisal (the reporting period)
- A smaller number of doctors complete appraisals with the GMC required period of 9-15 months and would be categorised for reporting purposes as "over due" (14 doctors in Quarters 2 and 3)
- Of the remaining 14 12 had special circumstances recorded as either leaving or have left the organisation, sickness absence, maternity leave, subject to investigation or new to UK practice. Only 2 doctors were escalated to the Responsible Officer for lack of engagement and both have now engaged with the appraisal process.

	Indicator	**Q1** (1 Apr to 30 Jun)	**Q2** (1 July to 30 Sep)	**Q3** (1 Oct to 31 Dec)
1	**Name of designated body** (or NHS England Area Team or Region)	The Dudley Group NHS Foundation Trust		
2	Number of doctors with whom the designated body has a **prescribed connection**	313		
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	41	74	52
3.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	30	62	36
3.2	Number of those within ♯3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	11	12	15
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	6	11	16
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**	5	1	1

4a. Appraisers

The trust has a total of 62 trained appraisers at present, which meets NHS England requirements of a minimum of 1:20 appraisers to doctors in each organisation.

Revalidation Lead and Associate Medical Director Dr Helga Becker has led a number of development session including training in Reflective Practice along with the GMC Regional Liaison Service. Regular drop in session are held by Dr Becker to provide support and advice to medical appraisers.

5 Revalidation Recommendations

The Trust has made timely recommendations for all doctors due within the last two reporting periods. The majority of deferrals were made due to insufficient information being contained within appraisal portfolios. Deferral is neutral and doctors are given between 4 to 12 months to meet the required standards.

Revalidation recommendations between	**Q2**	**Q3**	Total
Recommendations completed on time (within the GMC recommendation window)	33	24	57
Late recommendations (completed, but after the GMC recommendation window closed)	0	0	0
Missed recommendations (not completed)	0	0	0
Deferrals	2	6	8

6 Recommendations

The board is asked to note the contents of this report and to support plans to appoint the Deputy Medical Director as Responsible Officer in 2016/2017.

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7 April 2016

TITLE:	**Monitor Certification**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVE	**SO 6 – Plan for a viable future**		

SUMMARY

The Board is required to make a number of declarations to Monitor, in respect of its annual plan the following self certification is required.

Continuity of services condition 7 – availability of resources
Declaration of interim and / or planned term support requirements
Declaration of review of submitted data
Control total and sustainability & transformation fund allocation

Overall declaration that the submitted Annual Plan represents a true and fair view and the strategic commentaries are based on assumptions that the Board believe to be credible.

The attached document contains the detail of the declaration and the Trust's position against each of these.

IMPLICATIONS OF PAPER:

RISK	**Y**		**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		

RECOMMENDATION FOR THE BOARD

That the Board approves the self certification as attached.

The Dudley Group NHS
NHS Foundation Trust

Board Self Certification

1 Continuity of service condition 7 – Availability of Resources

The Board is required to make one of the following three declarations

1a After making enquires the Directors of the Licensee have reasonable expectations that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

1b After making enquires the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking account in particular (but without limitation) and distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3 below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested services

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

It is recommended that declaration 1a is made

2 Declaration of interim and/or planned term support requirements

The trust forecasts a requirement for Department of Health (DH) interim support or planned support for the year ending 31 March 2017

It is recommended that the declaration that DH support is NOT required is made

3 Statement of main factors taken into account in making the above declaration

There is nothing to add as statement 1a is made

4 Declaration of review of submitted data

The Board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template.

That a positive declaration is made. This is based on the internal check made within the Finance Team and senior review of the template submission and any indicated data quality flags. This process is applied to every monitor return.

5 Control Total and Sustainability & Transformation Fund Allocation

The Board has submitted a final operational plan for 2016/17 that meets or exceeds the required financial control total for 2016/17 and the Board agrees to the conditions associated with the Sustainability and Transformation Fund

This is agreed

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7 April 2016

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 a separate paper to the Board
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 approves the response attached for the submission by the 31 May 2016 (general conditions) and 30 June 2016 (corporate governance, ASHCs and governance and training of governors)

The Dudley Group NHS
NHS Foundation Trust

Board Certifications

The table below contains the detail of the declaration, its requirement, the Board's proposed response 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 previous 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**	These processes were referred to and their effectiveness was considered by the Accountable Officer when drafting the

Requirement		Board Response	Rationale
	staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		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. The Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair.
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; (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	**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 to the quality of the data supporting the Trust's performance reporting and decisions being taken. The Board has approved the Trust's long term strategy and annual plan. Key risks and associated assurance has been reported to the Audit

Requirement		Board Response	Rationale
	such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		Committee and Board during the year and the process has been subject to Internal Audit review which concluded positively over the Trust corporate risk and assurance processes.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the 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 Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission

Requirement		Board Response	Rationale
			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 Board appointments made in the year with the outcome of this reported to the Board's Remuneration and Nominations Committee as part of the relevant appointment process. An annual review of all Board Members continuation as fit and proper persons was also reported to the Board's Remuneration and Nominations Committee. 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

Requirement		Board Response	Rationale
			the Board is assured that the Trust retains 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 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board
on 7 April 2016

TITLE:	**Corporate Assurance and Risk Registers Summary report**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVES ALL			

Background

The Risk and Assurance Group met on the 8 March 2016 where it debated the assurances received and their potential impact on the risk ranking and agreed the Risk Register and Assurance Register was a correct reflection of the Trust's corporate risks for quarter 4. The output from this meeting was then presented to the Audit Committee on the 22 March who focused on the Assurances logged any gaps in assurance and their impact on the individual risk rating. To assist the Audit Committee the report included alongside the graphical presentation of the assurances the headline title of each assurance registered in the quarter from January 2016.

The Audit Committee confirmed that based on the information and explanations given at the Committee the Corporate Risk and Assurance Registers forming the Trust's Board Assurance Framework should be presented to the Board for their information.

Corporate Risk Assurance Register

The corporate assurance report shows the details of the assurances received to date, noting that this relates to assurances received in the first four or five months of the year. The assurance register also records the origin of the assurance, operational management through to an external source. As this assurance is collated across the year, Management and the Board will be able to see the relative strength of assurance against each risk underpinning each objective.

Assurance gaps

There have been no assurances logged against three risks. The first is COR090 relating to the separation of the RO and MD roles. As last month whilst work is ongoing in respect of a business case being considered by the Executives until this approved an enacted then actions and thus assurance of process improvement will not be available. The second relates to COR094 relating to the failure of all three analysers. As no further assurance has been provided the risk has been left at the same level as last quarter. The third relates to COR083 Failure to have a workforce / infrastructure that supports the delivery of 7 day working here positive assurance in the form of the outcome of the audit was logged last quarter which reduced this risk.

T*he Risk and Assurance Group and Audit Committee confirmed that whilst no*

assurance had been logged the risk score was appropriate for these three risks.

Negative Assurances

There are seven risks for which negative assurance has been received.

For five of these a degree of positive assurance has also been received. For three of these five risks the positive assurance has led to no increase in the residual risk. For the other two risks relating to safer staffing (COR085) and Patients' nutritional needs are not fully met during their hospital stay (COR086) the negative assurance has led to an increase in the residual risk.

The remaining two risks, where no positive assurance has been logged this quarter, one (COR084) relating to embedding CQC improvement has seen no increase in the residual risk but the other COR093 (regarding tier 4 beds being available) has seen the risk increase.

These were debated at the Risk and Assurance Group and the Audit Committee, both agreed the stated scores do reflect the current risk level to the Trust for the three with the increased score along with the three where no change has been made to the risk.

Reduced risks based on positive assurance

There have been three risks where positive assurance has been received that supports their reduced score. These relate to

COR082a Failure to achieve the target of no more than 29 C.Diff cases where a lapse in care is judged by the CCG to have occurred
This has reduced based on the assurance obtained and the strong current performance against the apportioned cases overall target of 29

COR077 Workforce reduction programme will adversely affect patient care and trust performance
This risk has been reduced to very unlikely and very low impact based on the reduced level of workforce reductions now needed (outside of those achieved via any agreed transformation programme)

COR088 Failure of Datix to support the business
The new system went live on 1st February, the reporting to the Divisions is being progressed once this has been embedded then this risk can be de-escalated

These were debated at the Risk and Assurance Group and Audit Committee both agreed the stated scores do reflect the current risk level to the Trust.

Corporate Risk Register

The Corporate Risk Register records the Trust's key risks linked to each of the Trust's

six objectives. The Register includes those key risks to the Trust's objectives as recorded with the Trust's annual plan (these are seen as the top down risks), it also includes those risks that have been escalated from the Trust's Divisions / Directorates (these are seen as bottom up risks).

As an appendix to the Corporate Risk Register there is a list of the key Division / Directorate risks which have not been escalated.

Increased risks
There are **three increased risks** since the last report based on negative assurance received

Reduced risks
There have been **three risks which have reduced** based on positive assurance received

De-escalated risks
There have been **no de-escalated** risks.

Archived risks
There has been **one archived risk.** This is COR095 as the waste pilot has been completed successfully.

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 but particularly well led**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF GROUP

Decision	Approval	Discussion	Other
			Y

ACTION FOR THE BOARD

To note the challenge and review undertaken by the Risk and Assurance Group and the Audit Committee.

To note the Trust's corporate risks as at March 2015

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK ASSURANCE SUMMARY – FEBRUARY 2016

Risk Dashboard – rolling risk score trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 05/06/15	Level 1	Level 2	Level 3	Risk 26/08/15	Level 1	Level 2	Level 3	Risk 21/12/15	Level 1	Level 2	Level 3	Risk 02/03/16	Level 1	Level 2	Level 3	
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer) *	20	20	G	A		15	G	A		15	G	G		15	A	A		8
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	25	16				16	G	G		16	G			16	G			8
	DG	COR084	Failure to embed the improvements from our last CQC inspection	12	8		G	R	12	R	R		12	R	G		12	R			6
	COO	COR092	Failure to deliver successful best practice cEPMA	25					15	new			De-esc								8
S02	MD	COR072	The Trust does not consistently send discharge information to the GP	20	20	R			8	G	G		4	G		G	4	G			4
	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	15				15	G	G	G	15		G		15	G	A		10
	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	20	G	G		20	G	G	R	15	A	G		20	A	G		15
	CN	COR081	Nurse / Midwifery revalidation fails	12	16	G	G		8	G	G		4	G	G		4		G		8
	CN	COR082	Failure to deliver the significantly reduced C.Diff target of just 29 cases within 2015/16	20	20	G	G		20	G	G		Revised risk see below								10
	CN	COR082a	Failure to achieve the target of no more than 29 C.Diff cases where a laspe in care is	10	Revised risk see above								10	G	G	G	8	G	G	G	5

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 05/06/15	Level 1	Level 2	Level 3	Risk 26/08/15	Level 1	Level 2	Level 3	Risk 21/12/15	Level 1	Level 2	Level 3	Risk 02/03/16	Level 1	Level 2	Level 3	
			judged by the CCG to have occured																		
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16	16	G			8	G	A		4		A		8	G	A		8
	CN	COR087	The number of grade 3 and 4 pressure ulcers potentially increase	12	12	G	G		12	G	G		8	G	G		8	G			12
	CN	COR093	Management of young people requiring care under the mental health act (tier 4 beds are not available)	20					12	new			8	R	A		12	R			8
	COO	COR094	The Biochemistry analyzers are prone to failure which has a detrimental impact across the Trust	20					16	new			8				8				10
	CN	COR095	Waste Management Pilot on b4/c3 fails	12									6	G			archived				6
	CN	COR096	Deterioration of patients leading to cardiac arrests	20									10	A	R		10	A			8
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20	20				20	G			15	G	G		15				15
	DIT	COR089	IT Strategy does not deliver	16	16				12		G		12		G		12		G		16
S04	CHR	COR077	Workforce reduction programme will adverselty affect patient care and trust performance	20	16		A		6				6		G	G	1		G		9
	MD	COR090	Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director	8	8				8				8				8				4
S05	DG	COR088	Failure of DATIX system to support the business	16	16				16	G			8	G			6	G			6

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 05/06/15	Level 1	Level 2	Level 3	Risk 26/08/15	Level 1	Level 2	Level 3	Risk 21/12/15	Level 1	Level 2	Level 3	Risk 02/03/16	Level 1	Level 2	Level 3	
	DIT	COR091	The IT DR arrangements are not effective	20	20				15		G		15	G			15			G	12
	DSP	COR080	Failure to deliver our CIP programme **	20	12				9	G	G		4	G	G		4	G	G		9
SO6	DF	COR061	Failure to maintian financial sustainability	20	16				16	G	G	G	12	G		G	12	G		G	5

* merged from three previous risks – prior period is highest risk score from each of the three indicators
** a similar risk was in the prior year (COR065) so this has been used for the past trend

Key for Risk Lead		Key for Strategic Objectives		Key for source of assurance	Key for assurance grading
CE	Chief Executive	**SO1:** Deliver a great patient experience		**Level 1 – assurance provided by Operational Management**	**G reen** **ALL** Positive assurance
MD	Medical Director	**SO2:** Safe and Caring Services		**Level 2 – assurance provided by Executive Manangement / Board Committee**	**A mber** **A MIX** of positive and negative assurance
CN	Chief Nurse	**SO3:** Drive service improvements, innovation and transformation		**Level 3 – assurance provided by an external source**	**R ed** **ALL** Negative assurance
DF	Director of Finance and Information	**SO4:** Be the place people choose to work			**A blank indicates no asurance was noted for that quarter**
COO	Chief Operating officer	**SO5:** Make the best use of what we have			
DSP	Director of Strategy and Performance	**SO6:** Plan for a viable future			
DG	Director of Governance				
CHR	Chief HR Advisor				
DIT	Director of IT				

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK REGISTER – MARCH 2016

Risk Dashboard – rolling risk score trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
					09/09/14	09/12/14	17/03/15	05/06/15	26/08/15	21/12/15	02/03/16			
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer) *	20	20	20	15	20	15	15	15		→	8
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	25	25	16	16	16	16	16	16		→	8
	DG	COR084	Failure to embed the improvements from our last CQC inspection	12			new	8	12	12	12		→	6
	COO	COR092	Failure to deliver successful best practice cEPMA	25				new	15	De-esc				8
S02	MD	COR072	The Trust does not consistently send discharge information to the GP	20	20	20	20	20	8	4	4		→	4
	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	8	15	15	15	15	15	15		→	10
	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	esc	20	20	20	20	15	20		↑	15
	CN	COR081	Nurse / Midwifery revalidation fails	12			new	16	8	4	4		→	8
	CN	COR082	Failure to deliver the significantly reduced C.Diff target of just 29 cases within 2015/16	20			new	20	20	Revised risk see below				10
	CN	COR082a	Failure to achieve the target of no more than 29 C.Diff cases where a laspe in care is judged by the CCG to have occured	10	Revised risk from above					10	8		↓	5
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16			new	16	8	4	8		↑	8
	CN	COR087	The number of grade 3 and 4 pressure ulcers potentially increase	12			esc	12	12	8	8		→	12
	CN	COR093	Management of young people requiring care under the mental health act (tier 4 beds are not available)	20				new	12	8	12		↑	8
	COO	COR094	The Biochemistry analyzers are prone to failure which has a detrimental impact across the Trust	20				new	16	8	8		→	10
	CN	COR095	Waste Management Pilot on b4/c3 fails	12					new	6	archived		New	6
	CN	COR096	Deterioration of patients leading to cardiac arrests	20					new	10	10		→	8

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
					09/09/14	09/12/14	17/03/15	05/06/15	26/08/15	21/12/15	02/03/16			
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20			new	20	20	15	15		→	15
	DIT	COR089	IT Strategy does not deliver	16			new	16	12	12	12		→	16
	MD	COR044	The need for a medical workforce plan that is fit for purpose	12	new	12	12	arc						4
S04	CHR	COR077	Workforce reduction programme will adverselty affect patient care and trust performance	20		esc	9	16	6	6	1		↓	9
	MD	COR090	Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director	8			new	8	8	8	8		→	4
S05	DG	COR088	Failure of DATIX system to support the business	16			esc	16	16	8	6		↓	6
	DIT	COR091	The IT DR arrangements are not effective	20			esc	20	15	15	15		→	12
	DSP	COR080	Failure to deliver our CIP programme **	20	20	20	20	12	9	4	4		→	9
SO6	DF	COR061	Failure to maintian financial sustainability	20	20	20	20	16	16	12	12		→	5

* merged from three previous risks – prior period is highest risk score from each of the three indicators
** a similar risk was in the prior year (COR065) so this has been used for the past trend

Key for Risk Lead	
CE	Chief Executive
MD	Medical Director
CN	Chief Nurse
DF	Director of Finance and Information
COO	Chief Operating officer
DSP	Director of Strategy and Performance
DG	Director of Governance
CHR	Chief HR Advisor
DIT	Director of IT

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

Key for risk	
New	New risk identifed
Esc	Risk esculated from lower division / directorate etc
De-esc	Risk de-esculated to the lower division / directorate to manage
Arc	Risk no longer valid

The Dudley Group NHS
NHS Foundation Trust

DIVISIONAL / DIRECTORATE KEY RISKS – MARCH 2016

Division	ID	Risk Description	Current Score						Trend	Target Risk Score
			30/04/15	31/05/15	26/08/15	21/12/16	02/03/16			
Medicine and Integrated Care	DMC007	There is a risk that the Trust may fail the Emergency Access standard which negatively affects the quality and safety of patient care	25	25	25	10	20		↑	10
	DMC009	Diagnostic capacity is insufficient to provide a safe, robust, fit for purpose service that meets the needs of the Trust	16	16	16	16	20		↑	
	DMC002	Failure to control Directorate overspend	20	20	20	16	16		→	4
	DMC006	Dudley Group NHS Foundation Trust is not meeting the needs of patients at the end of their life and is therefore providing a poor quality service (as shown with the failure of 6 out of 7 KPIs associated with The National Care of the Dying Audit for Hospitals)	16	16	16	16	16		→	4
	DMC005	Information generated from the DATIX System is inconsistent There is a possibility that incidents reported within the Medicine and Community Division may be missed and actions delayed.	8	8	16	16	16		→	4
	DMC013	Failure of the 3 Clinical Biochemistry main laboratory analysers, could lead to loss of service provision for an extended period leading to significant adverse impact on patient care.	new		20	15	15		→	10
	DMC014	There is a risk that the national Cancer Waiting Time Targets may not be achieved	new		25	15	15		→	10
Surgery	TAC015	Utlisation of the emergency obstetirc threate team	new		20	20	20		→	5
	OSS004	Inappropriate delay in patients having their follow up appointments (opthalmology)	esc		20	20	20		→	16
	NP035	Lack of paediatric medical workforce capacity to meet service demands, service standards and recommendations	16	16	16	16	16		→	9
	new	Inability to recruit and retain trained Operating Department Practitioners (ODPs) will result in theatres being unable to safely staff all current clinical activity.	new				16			12
	SUV005	Limited outpatient elective theatre in Urology.	15	15	15	15	15		→	9
	SUV006	The Trust is unable to guarantee the availaibity of BCG supplies for treatment of high risk non muscle invasive bladder cancer	15	15	15	15	15		→	15
Nursing	N030	Risk of staff and/or patients being injured during a period of restraint due to an act of physical aggression or challenging behaviour	new			12	12		→	12

Division	ID	Risk Description	Current Score						Trend	Target Risk Score
			30/04/15	31/05/15	26/08/15	21/12/16	02/03/16			
	N029	Paediatric Capacity	new			15	12		↓	12
	N032	Reduced ability to control temporary staffing resulting in Division financial overspend	new			12	16		↑	12
Corp Depts	M037	Lack of an effective a system in place to ensure that all junior doctors starting work in the Trust above FY have appropriate clinical skills.	new				20			10
	CE002	Insufficient resources in the Governance Team does not support the organisation	new	16	12	12	12		→	4
	ST001	Lack of progress on major service and cost improvement change leading to delays in qulality and efficency gains. Skill levels of Lean Practitioners not up to the level required to lead major change projects	16	16	16	12	4		↓	12
	PA009	Poor Clinic Utilisation and Management	new		15	15	12		↓	6
	PO12	An error could occur in prescribing, preparation or administration of an injectable medicine	new		15	10	6		↓	10
	P002	Incorrect prescribing of Oral Chemotherapy Drugs	15	15	15	15	10		↓	10
	CE003	NHS England may requires return of £2million Techfund if SAP not implemented.	new			16	16		→	12
	CE004	Loss of major DITS client in 16/17 will reduce revenue sufficiently to create a deficit with limited options to reduce costs without impacting the Trust	new			16	16		→	9
	CE005	Current IT project resources are not suffcinet to deliver current pipleing projects	new			16	16		→	9

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 7 April 2016

TITLE	Corporate Performance Report – February 2016 (Month 11)		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	Jonathan Fellows Non-Executive Director
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 31 March 2016.			

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:** Achievement of all Terms of Authorisation
	Other	**Y**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	31 March 2016	Jonathan Fellows	yes	no
			yes	

Declarations of Interest Made

None

Assurances Received

- The Forecast Out-turn position, based on 11 months financial performance, continues to be £3.1m deficit (in line with plans). This may be reduced at the year-end subject to agreement with Dudley CCG about the funding of an extension to the A&E department to improve urgent care facilities.
- The improved cash position for February 2016 and forecast for March 2016 was noted together with the reasons for additional cash received in March 2016 in particular
- The continued achievement of the A&E target in February 2016, together with the RTT and 6 week diagnostic target.
- Continued good performance on the number of C Diff and MRSA cases reported in month.
- Assurance not given on the 62 day Cancer or the VTE Assessment in February 2016 which both failed to meet their respective targets
- The CIP plan is forecasting £16.6m achievement compared to a plan of £16.7m
- Assurance not given on the Trust's ability to meet the agency cost cap of £5.7m in 2016-17 unless a significant plan is adopted to reduce the need to qualified nurse agency and medical staff in particular.

Decisions Made / Items Approved

- The 2016-17 budgets were agreed subject to a reduction of at least £982,000 of cost pressures and developments, delegated to the Chief Executive and Director of Finance to approve. Board of Directors delegated this responsibility to Finance and Performance Committee on 3rd March 2016.
- The contract structure for the 2016-17 Dudley CCG agreement was agreed, subject to the agreed financial parameters and value consistent with the approved budgets 2016-17
- That funding for the urgent care centre be accepted in 2015-16 on condition that the agreement is put in writing; the timing of the building work is constrained to less disruptive periods of the year; and that the Trust's contribution to the scheme financially is limited
- The corporate annual goals for 2016-17 were agreed and the Draft Operational Plan 2016-17 was agreed and should be recommended to the Board for approval at its meeting on 6th April 2016

Actions to come back to Committee

- The IT Full Business Case to be reviewed by F&P Committee after IT Steering Group to consider the financial aspects
- The reasons for the recent failure of the VTE Assessment target, together with a rectification plan
- Further report back on the outstanding Cost Improvement Schemes 2016-17

• A plan showing how agency costs could be reduced through the “spot purchase” of nursing home beds to be produced for the next F&P meeting
Items referred to the Board for decision or action
• The Annual Plan and Operational Plan 2016-17 to be recommended to Board for approval

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 07/04/2016

TITLE:	**Integrated Performance Report - February 2016**		
AUTHOR:	**Anne Baines Director of Strategy and Performance**	**PRESENTER:**	**Anne Baines Director of Strategy and Performance**

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

SUMMARY OF KEY ISSUES:

Attached is the Integrated Performance Report for the period to February 2016

Performance against the Emergency Access Target and Cancer Waits remained challenging in February 2016.

C. Diff is currently achieving target with 12 cases due to lapses in care against the target of 29, however there are 9 under review. There was a fall in overall cases in February down to 1 giving a year to date total of 43.

Performance continues to be good in regard to the national 18 week standard for Referral to Treatment Times.

The 6 week diagnostic performance was above target for January with a performance of 99.53%, however there are capacity challenges in Endoscopy and Imaging.

Stroke – Suspected High Risk TIA Scanned and Treated within 24hrs achieved the target

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: COR079**
	Risk Register Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:** *(Please select from the list on the reverse of sheet)*
	Monitor	**Y**	**Details:** Poor performance would result in the Trust being in breach of licence
	Other	**N**	**Details:**

ACTION REQUIRED FOR THE BOARD

Decision	Approval	Discussion	Other
x		x	

RECOMMENDATION FOR THE BOARD
Board of Director is asked to note the contents of the Integrated Performance Report for February 2016

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors 07/04/2016

Integrated Performance Report - February 2016

1 Introduction

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

2 Integrated Performance Report

2.1 Overall the Trust continues to perform well against some of the key indicators. Areas to highlight include

Achievement of all three Referral to Treatment (RTT) 18 week targets

Diagnostic waits met the target of 99% for the third consecutive month at 99.58% in February. The Division continue to implement action plans to maintain this position. Capacity issues in Endoscopy and imaging may result in a challenge putting a number of targets at risk. The Division are urgently reviewing the position and have been asked for rectification plans to ensure plans are in place to minimize the impact on the diagnostic targets and cancer targets. In addition they have been asked to develop a sustainable solution.

Clostridium Difficile (C. Diff)

The number of cases dropped in February to 1 from 4 in January, bringing the total reported year to date to 43. Those cases confirmed as lapses of care is 12 against the target of 29.

Performance has deteriorated in two key indicators – the emergency access target and cancer waiting times.

Emergency Access Target

The combined hospital and Urgent Care Centre performance (reported nationally) continued to deliver above target in February 2016 at **96.06%** combined. However, the Trust only (Type 1) performance was 92.74%.

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

	Attendances	Breaches	Performance
A&E Dept. Type 1	7710	560	**92.74%**
UCC Type 3	6491	0	**100.00%**

The Trust has continued to see a prolonged surge in activity with significant peaks in both Emergency Department attendances and ambulances, both above predictions for the vast majority of this month. Escalation to command and control procedures have been initiated whenever necessary. Since December 2015, we have seen a 10% increase in ambulances and a 5% increase in attendances. This is in addition to a significant increase in delayed transfers of care to over 100, a position not seen since September 2015. Analysis of the ambulance conveyancing increase has also begun, in addition to the development of additional weekly indicators. These will be used in a weekly Performance meeting now in place with the Divisions.

Cancer Waits

Due to the time required to validate individual pathways the cancer waiting times in this report for the last 2 months i.e. January and February are provisional only.

Cancer waits 62 Day from urgent GP referral to treatment performed below target for January at 81.3% and the provisional performance for February 81.7. Continual validation is underway. Weekly performance monitoring continues with the Director of Strategy and Performance and the Chief Operating Officer, with the Divisions providing forecasts based on planned activity and patients tracking lists analysis for the rest of the year. The performance by tumour site is shown at page 10**.**

Cancer 62 Day from referral to treatment following national screening has also dipped below the 90% target at 88.2% but this figure is provisional and relates to a single breach, the impact of a low numbers indicator. A rectification plan has been requested from the service. This will be escalated to the weekly meetings.

Cancer number of people who have breached beyond 104 days - in February 2016 was 8 for those untreated, with 1 of those note having a date for treatment.

3 Other areas requiring attention

* The Friends & Family measure of how many responses are collected (the footfall) remains below that required in some areas. The performance in ED remains well below the 15% target, but rose slightly to 7% in February. The introduction of a two way texting system to improve response rates continues.
* Outpatient activity –outpatient procedures continue to under-perform overall, and is significantly lower in February. Divisions will be asked to produce a rectification plan to address the activity in year.
* Community activity continues to be below target due to vacant community nursing posts & lower than expected referrals to some community teams, and has decreased still further in January. Recruitment into these posts continues although is not expected that this will recover the under-performance by the year end.
* The number of staff who had an appraisal within the required time frame has dipped slightly downwards to 79.2% in February. Discussions have been held with Divisions regarding the revision of performance monitoring to reflect the differences between the 12 month standard for all staff other than consultants, whose standard is for 15 months in line with medical validation.
* Stroke Reporting - Suspected High Risk TIA Scanned and Treated within 24 hours

  The 60% target was achieved in February at 75%. However, the figures for presenting High Risk TIAs are significantly lower than previously recorded. The Division is continuing to review the system and process, and long-term sickness/absence has affected the current process.
* The VTE Assessment Indicator has not met its 95% target for the first time in many months. The February 2016 performance of 94.35% has been attributed to staffing resources. The service has been asked for a rectification plan.

5 Sustainability and Transformation Fund trajectories 2016/17.

As part of the requirement for taking up the Sustainability and Transformation fund monies the Trust has been required to provide trajectories in a number of key areas for the second submission.

As required a further submission was made which revised the figures as follows:
a) emergency access target to reflect the Type 3 Urgent Care Centre activity
b) reflection of growth as used in contract activity
c) to confirm CCG agreement

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - February 2016

Quality & Risk			2015										2016			
Description		LYO	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD	YEF
Friends & Family – Community – Footfall				0%	0%	1%	1%	1%	1%	1%	1%	2%	2%	2%	1%	
Friends & Family – Community – Recommended %				97%	98%	96%	96%	94%	93%	97%	95%	99%	97%	98%	97%	
Friends & Family – ED – Footfall		20%	24%	8%	15%	12%	7%	6%	3%	7%	6%	6%	5%	7%	8%	
Friends & Family – ED – Recommended %		89%	92%	90%	90%	92%	90%	95%	91%	96%	93%	88%	96%	93%	92%	
Friends & Family – Maternity – Footfall		23%	26%	23%	22%	21%	20%	22%	23%	25%	32%	18%	17%	20%	22%	
Friends & Family – Maternity – Recommended %		99%	99%	99%	99%	99%	97%	99%	99%	98%	98%	97%	98%	98%	98%	
Friends & Family – Outpatients – Recommended %				84%	82%	82%	88%	90%	89%	88%	84%	88%	90%	84%	88%	
Friends & Family – Ward – Footfall		32%	50%	16%	16%	14%	15%	20%	20%	23%	23%	17%	17%	18%	17%	
Friends & Family – Ward – Recommended %		98%	98%	96%	97%	98%	97%	99%	97%	97%	97%	99%	96%	96%	97%	
HCAI – Post 48 hour Clostridium Difficile		38	5	3	3	2	2	5	5	5	5	8	4	1	43	
HCAI – Post 48 hour MRSA		0	0	0	0	0	0	0	2	0	0	0	0	0	2	
Incidents - Patient Falls, Injuries or Accidents			125	127	116	116	103	97	119	111	118	114	129			
Incidents - Pressure Ulcer		2,091	163	187	163	182	150	120	132	125	141	172	187	242	1,801	
Mixed Sex Sleeping Accommodation Breaches		0	0	0	0	0	0	0	0	0	2	0	2	0	4	
Never Events		1	0	0	0	0	0	0	1	0	0	0	0	0	1	
Serious Incidents – Not Pressure Ulcer		108	10	6	9	9	10	7	11	11	11	10	9	4	97	
Serious Incidents - Pressure Ulcer		197	26	21	20	21	17	17	10	18	17	30	26	12	209	
Stroke - Suspected TIA Scanned < 24hrs of Presentation		85.47%	81.25%	95%	100%	91.3%	88.89%	92.31%	85%	92.31%	50%	52.63%	85.71%	75%	85.88%	
Stroke Admissions : Swallowing Screen		78.46%	71.43%	81.25%	83.33%	72.09%	80%	74.07%	75%	78.38%	88.89%	87.88%	83.78%	84.85%	80.44%	

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - February 2016

Quality & Risk			2015										2016			
Description		LYO	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD	YEF
Stroke Admissions to Thrombolysis Time		80%	80%	69.23%	61.54%	42.86%	75%	61.54%	75%	37.5%	71.43%	33.33%	45.45%	37.5%	37.5%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		88.84%	82%	94.23%	92%	92.86%	94.34%	88.24%	92.68%	88.68%	88.68%	90.91%	92.68%	83.33%	90.8%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - February 2016

Finance			2015												
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD	YEF
Budgetary Performance		(£2,722)k	£276k	£535k	£113k	£148k	£934k	£448k	£54k	£504k	(£16)k	(£123)k	(£393)k	£2,480k	
Capital v Forecast		87.8%	100%	98.6%	99.7%	93.7%	74.5%	66.2%	96.6%	90.8%	82.1%	78.6%	70.3%	70.3%	
Cash v Forecast		109%	97.9%	104.9%	108.1%	87%	93.5%	94.8%	97.2%	89.2%	68.4%	88.4%	79.1%	79.1%	
CIP - Actual Performance			£1,773k	£1,218k	£1,298k	£1,516k	£1,743k	£1,002k	£1,370k	£1,452k	£1,329k	£1,289k			
Debt Service Cover		0.85	0.72	0.93	1.05	1.13	1.01	1.08	1.09	1.15	1.1	1.11	1.09	1.09	
EBITDA		£15,817k	£1,138k	£1,814k	£2,079k	£2,145k	£829k	£2,283k	£1,909k	£2,449k	£1,141k	£2,012k	£1,492k	£19,291k	
I&E (After Financing)		(£8,033)k	(£783)k	(£123)k	£183k	£201k	(£1,124)k	£346k	(£31)k	£518k	(£811)k	(£30)k	(£413)k	(£2,067)k	
Liquidity		7.22	6.1	5.76	5.41	6.28	5.16	6.03	5.78	6.27	5.25	5.45	5.16	5.16	
SLA Performance		£6,271k	£1,023k	£506k	£497k	(£723)k	(£401)k	(£429)k	(£146)k	(£29)k	£13k	£350k	£556k	£1,218k	
SLR Performance		(£8,032)k	(£782)k	(£123)k	£184k	£201k	(£1,124)k	£344k	(£31)k	£518k	(£810)k	(£30)k	(£413)k	(£2,067)k	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - February 2016

Performance			2015										2016			
Description		LYO	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD	YEF
A&E - A&E Attendances Seen Within 4 Hours (%)		94.7%	96.8%	98.6%	98.8%	99.1%	99.3%	98.5%	97.6%	98.9%	97.5%	97.1%	91.8%	92.7%	97.3%	
Activity - A&E Attendances		99,928	7,970	7,895	7,940	8,138	8,052	7,700	8,003	8,099	7,900	7,754	8,088	7,923	87,492	
Activity - Community Attendances		415,662	32,779	34,397	33,050	35,066	36,362	32,417	35,088	36,008	34,642	33,311	33,694	33,623	377,658	
Activity - Elective Day Case Spells		44,639	4,046	3,660	3,445	4,013	3,951	3,413	3,675	3,952	3,757	3,719	3,677	3,944	41,206	
Activity - Elective Inpatients Spells		6,953	564	482	525	580	580	508	537	572	580	481	500	515	5,860	
Activity - Emergency Inpatient Spells		50,876	4,314	4,426	4,282	4,183	4,205	4,077	4,105	4,296	4,265	4,553	4,573	4,423	47,388	
Activity - Outpatient First Attendances		125,382	12,196	10,391	10,059	11,359	11,488	9,298	10,758	10,712	11,159	10,599	11,304	12,290	119,417	
Activity - Outpatient Follow Up Attendances		320,876	27,791	26,142	24,480	28,055	27,442	23,254	26,290	25,988	27,030	25,648	26,438	27,421	288,188	
Activity - Outpatient Procedure Attendances		57,196	3,334	4,308	3,956	4,833	4,527	4,042	4,553	4,864	4,968	4,268	4,117	2,852	47,288	
RTT - Admitted Pathways within 18 weeks %		91.6%	94%	95.2%	95.3%	96.1%	95.6%	96.1%	94.3%	92.5%	93.3%	93.4%	94.4%	92.8%	94.4%	
RTT - Incomplete Waits within 18 weeks %		95.4%	95.3%	95%	95.2%	95.2%	95.6%	94.9%	95.1%	94.6%	94.4%	94.9%	95%	95.6%	95%	
RTT - Non-Admitted Pathways within 18 weeks %		98.7%	98.1%	97.7%	97%	98%	98.3%	98.1%	98.3%	97.5%	97.8%	97.8%	97.3%	97.4%	97.8%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		97.75%	98.11%	98.69%	99.27%	99.47%	99.34%	98.35%	98.41%	97.87%	98.85%	99.29%	99.52%	99.53%	98.97%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - February 2016

Staff/HR			2015										2016			
Description		LYO	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD	YEF
Appraisals		87.2%	87.2%	88%	80.6%	81.5%	80.8%	80.3%	80.1%	78.4%	75.6%	80.4%	80%	79.2%	79.2%	
Mandatory Training (Substantive)		80.68%	80.68%	81.53%	82.13%	82.8%	82.35%	83.51%	83.16%	84.11%	84.8%	85.16%	83.97%	83.31%	83.31%	
Sickness Rate (Performance Dashboard)		3.81%	3.80%	3.49%	3.70%	3.65%	3.51%	3.21%	3.28%	3.83%	3.80%	4.11%	4.62%	4.42%	3.79%	
Staff In Post (Contracted WTE)		4,181.19	4,181.19	4,090.77	4,073.22	4,045.78	4,019.79	4,018.55	4,039.04	4,075.01	4,069.24	4,064.03	4,087.57	4,125.26	4,125.26	
Vacancy Rate		9.42%	9.42%	8.42%	8.81%	9.51%	10.11%	10.33%	9.92%	9.93%	10.31%	10.59%	10.05%	9.24%	9.24%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - February 2016

Description	Target	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Paediatric	Skin	Upper GI	Urology	Total
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	93%	100%	98.2%	98.6%	91.5%	100%	100%	100%	100%	95.6%	93.5%	99.3%	**96.9%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	100%	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	97.1%	100%	100%	100%	100%	100%	-	100%	100%	100%	**99.2%**
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	98%	-	100%	100%	100%	-	-	-	-	-	-	100%	**100%**
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	94%	-	100%	100%	-	-	-	-	-	92.9%	-	100%	**95.5%**
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	96%	-	100%	100%	100%	-	-	-	-	92.9%	-	100%	**96.7%**
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	85%	-	-	100%	100%	100%	100%	100%	-	100%	100%	86.7%	**97.5%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	86.7%	100%	-	-	-	-	-	-	-	-	**88.2%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	100%	82.4%	66.7%	100%	33.3%	100%	-	100%	50%	61.1%	**82.6%**

Cancer – 62 Day – From Urgent GP Referral to Treatment performed below target for the second month with February at 82.6%. Continual validation is underway. Weekly performance monitoring continues with the Director of Strategy and Performance and the COO with the Divisions providing forecasts based on planned activity and PTL analysis for the rest of the year.

Cancer – 62 Day – From Referral to Treatment following national screening has also dipped below the 90% target at 88.2% but this figure is provisional and relates to a single breach, in a low numbers indicator. A report on this has been requested from the service.

Appendix 1: 62 DAY PTL 104 DAY Breaches

2015-16

	Month	Oct	Nov	Dec	Jan	Feb	Mar
Number of patients who are untreated	**Number of patients who have breached beyond 104 days**	8	15	19	15	8	
Number of patients who are untreated and either do not have a TCI date, or do not have a TCI date within target time.	**Number of patients who have breached beyond 104 days**	4	1	5	3	1	

Appendix 2: Sustainability and Transformation Fund Trajectories 2016/17

Diagnostics

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	5,627	5,676	5,725	5,774	5,824	5,873	5,922	5,971	6,020	6,069	6,118	6,168	6,217
Patients Waiting < 6 weeks	5,566	5,620	5,668	5,717	5,766	5,815	5,863	5,912	5,960	6,009	6,057	6,107	6,155
Patients Waiting > 6 weeks	61	56	57	57	58	58	59	59	60	60	61	61	62
Performance	98.92%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%

Assumptions

Baseline = average of April 15 to January 16 performance

Growth of 5.7% factored in (based on historic growth for modalities included within DM01)

Cancer

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	83.7	77.0	78.0	79.0	84.0	86.0	88.0	88.0	86.0	84.0	78.0	78.0	78.0
Treated within 62 days	71.2	65.5	66.5	67.5	72.0	74.0	76.0	76.0	74.0	72.0	66.5	66.5	66.5
Breaches	12.5	11.5	11.5	11.5	12.0	12.0	12.0	12.0	12.0	12.0	11.5	11.5	11.5
Performance	85.07%	85.06%	85.26%	85.44%	85.71%	86.05%	86.36%	86.36%	86.05%	85.71%	85.26%	85.26%	85.26%

Baseline = average of April 15 to January 16 performance

Growth/Phasing based on historic performance

Appendix 2 (contd.): Sustainability and Transformation Fund Trajectories 2016/17

A&E Type 1

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	7,968	8,144	8,144	8,404	8,286	7,945	8,269	8,351	8,148	8,014	8,364	7,649	8,287
Treated within 4 hours	7,783	8,027	8,044	8,331	8,230	7,759	8,111	8,259	7,917	7,790	7,696	7,471	8,095
Breaches	185	117	100	73	56	186	158	92	231	224	668	178	192
Performance	97.68%	98.56%	98.77%	99.13%	99.32%	97.66%	98.09%	98.90%	97.16%	97.20%	92.01%	97.67%	97.68%

A&E Type 3

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	6,242	6,156	6,361	6,156	6,361	6,361	6,156	6,361	6,156	6,361	6,361	5,749	6,361
Treated within 4 hours	6,242	6,156	6,361	6,156	6,361	6,361	6,156	6,361	6,156	6,361	6,361	5,749	6,361
Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Performance	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Combined

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	14,210	14,300	14,505	14,560	14,647	14,306	14,425	14,712	14,304	14,375	14,725	13,398	14,648
Treated within 4 hours	14,025	14,183	14,405	14,487	14,591	14,120	14,267	14,620	14,073	14,151	14,057	13,220	14,456
Breaches	185	117	100	73	56	186	158	92	231	224	668	178	192
Performance	98.70%	99.18%	99.31%	99.50%	99.62%	98.70%	98.90%	99.37%	98.39%	98.44%	95.46%	98.67%	98.69%

Baseline = average of April 15 to January 16 performance
Growth of 3% factored in
Includes both Type 1 and Type 3

RTT

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	13,776	14,149	14,118	14,106	14,142	14,190	14,165	13,977	13,883	14,137	14,210	14,168	14,027
Treated within 18 weeks	13,005	13,357	13,329	13,318	13,350	13,395	13,372	13,195	13,106	13,345	13,414	13,374	13,242
Breaches	771	792	789	788	792	795	793	782	777	792	796	794	785
Performance	94.40%	94.40%	94.41%	94.41%	94.40%	94.40%	94.40%	94.41%	94.40%	94.40%	94.40%	94.40%	94.40%

Baseline = average of October 15 to January 16 performance
Growth of 2.0% factored into figures in line with contract proposal

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 7th April 2016

TITLE:	**TITLE:** **Transformation and Cost Improvement Programme (CIP) Summary Report – March 2016**		
AUTHOR:	Alex Claybrook Interim Head of Service Improvement and Programme Management	**PRESENTER**	**Anne Baines** **Director of Strategy and Performance**

CORPORATE OBJECTIVE:

SO3: Drive service improvements, innovation and transformation
SO5: Make the best use of what we have
SO6: Plan for a viable future

SUMMARY OF KEY ISSUES:

The Trust has achieved £15.282m CIP against a year to date plan of £15.267m. The Trust is forecasting to achieve £16.620m against a full plan of £16.701m.

Transformation Executive Committee (TEC) met on 21st March 2016 to review the 2015/16 CIP status and CIP planning for 2016/17:

- The 2015/16 CIP plan consists of 30 projects of which all have been approved by TEC.
- The 2016/17 CIP plan consists of 40 projects. 29 projects have been approved by TEC to date and a further 11 PIDs are scheduled for TEC review.

The Trust has identified £9.763m against the 2016/17 target of £12.407m. As a result, there is currently a shortfall of £2.644m. TEC agreed that Finance, Operations and PMO will meet with each Directorate to assess their 2016/17 budget proposals and CIP plans to identify additional service and cost improvement opportunities by 14th April.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description:** ST001 – Capability to deliver the Programme of work ST002 – Delivery of the Programme negatively impacting on Quality of Care or Patient Experience Capacity to deliver Programme of work Change in Executive Lead
	Risk Register: **Y**	**Risk Score:** 12, 6, 12, 10 (respectively)

COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details:** Non delivery of CIP
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y	Y	

RECOMMENDATIONS FOR THE BOARD

Note progress during March, delivery of CIP to date and the current forecast outturn proposal.

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

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

CARE QUALITY COMMISSION CQC) : ***(Please select for inclusion on front sheet)***

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

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors

Service Transformation and PMO Update

7th April 2016

2015/16 Executive Summary

The Trust has an overall Cost Improvement Programme (CIP) target of £16,701k in 2015/16. To support this, the Trust has developed 30 projects to deliver savings in 2015/16. The Trust has identified provisional plans for 2016/17, made up of 39 projects to achieve its £12.4m CIP savings.

The projects have been split into four ambitious programmes to deliver the changes and benefits required. These programmes are:

- Value for Money
- Delivering Efficiency & Productivity
- Keeping People Closer to Home
- Workforce

A summary of CIP performance as at Month 11 is provided below (with supporting detail overleaf):

CIP Project Plans	Full Year Plan	YTD Plan	YTD Actual	YTD Variance	Y/E FOT	Y/E FOT Variance
TOTAL	£16,701k	£15,267k	£15,282k	£15k	£16,620k	-£81k

Of the 30 projects due to deliver savings in 2015/16, all 30 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC) and Quality Impact Assessment (QIA) panel.

Based on the Month 11 position, the Trust is **£15k** ahead of year to date plan and is forecasting to deliver **99.51%** of the full year plan. As a result, the Trust is forecasting to deliver a slight under-performance of **£81k** against the **£16,701k** CIP plan.

The Trust has identified 40 projects for delivery in 2016/17. Of which, 29 have been approved by TEC and 15 have been approved by a QIA panel. The remaining 14 TEC approved PIDs will be reviewed at future QIA panels which are being scheduled in April.

Executive Summary

Figures reported in £000's

	Planned	Actual	Forecast	Variance
FYE	£16,701	£15,282	£16,620	-£81
YTD	£15,267	£15,282	£15,282	£15

Exec Lead : Paul Taylor — Click for Details

Planned Recurrent	£3,357	Planned Non Recurrent	£645
Forecast Recurrent	£4,489	Forecast Non Recurrent	£645

Value for money Infrastructure

	Planned	Actual	Forecast	Variance against Plan
FYE	£4,002	£4,722	£5,134	£1,132
YTD	£3,668	£4,722	£4,722	£1,054

Exec Lead : Anne Baines — Click for Details

Planned Recurrent	£0	Planned Non Recurrent	£0
Forecast Recurrent	£0	Forecast Non Recurrent	£0

Keeping People Closer to Home

	Planned	Actual	Forecast	Variance against Plan
FYE	£0	£25	£28	£28
YTD	£0	£25	£25	£25

Exec Lead : Paul Bytheway — Click for Details

Planned Recurrent	£2,873	Planned Non Recurrent	£300
Forecast Recurrent	£3,580	Forecast Non Recurrent	£300

Delivering Efficiency and Productivity

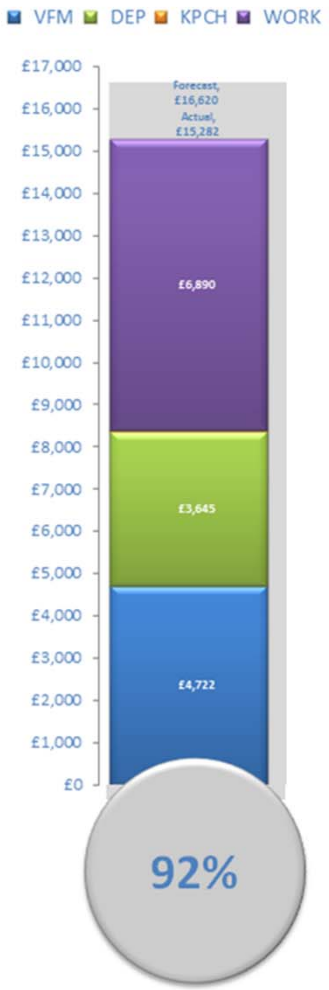
	Planned	Actual	Forecast	Variance against Plan
FYE	£3,173	£3,645	£3,939	£766
YTD	£2,895	£3,645	£3,645	£750

Exec Lead : Julie Bacon — Click for Details

Planned Recurrent	£9,331	Planned Non Recurrent	£125
Forecast Recurrent	£7,519	Forecast Non Recurrent	£0

Workforce

	Planned	Actual	Forecast	Variance against Plan
FYE	£9,526	£6,890	£7,519	-£2,008
YTD	£8,704	£6,890	£6,890	-£1,814



2015/16 Forecast Non Recurrent	£945k	% of Total CIP Forecast as Non Recurrent	5.68%