The Dudley Group NHS
NHS Foundation Trust

Annual Report and Accounts 2011/12

Incorporating Quality Report

CARE

RESPECT

RESPONSIBILITY

WHERE PEOPLE MATTER

The Dudley Group NHS Foundation Trust

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Incorporating Quality Report

Presented to Parliament pursuant to Schedule 7,
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Content

All information contained in this report was correct at the time of publication.

We would appreciate any feedback you would like to give us on both the format and content of this report. You can do this by emailing communications@dgh.nhs.uk or phoning 01384 244404 and speaking to a member of the communications team.

Chairman's welcome

Welcome to this year's Annual Report. The past 12 months have been every bit as challenging as we predicted with the changing landscape of the NHS that affects not only our Trust but the wider health economy.

The Board of Directors has focused, relentlessly, on delivering the business plan for 2011/12. We have kept our patients and their safety at the heart of everything we do, as evidenced by the Quality Accounts, whilst making those tough but necessary cost and efficiency savings.

I have been on a number of patient safety walkrounds at Russells Hall Hospital to learn first hand the challenges we face and how we deal with them. I have also followed Matron's presentation to the Board by spending time with them to learn more about the work they and their teams do. I have also spent time in Theatre with Amtul Carmichael and Musthaq Ahmed and their teams and in the Emergency Department with Raj Paw and Jo Taylor. I come away from any visit I make hugely impressed by the commitment and enthusiasm of our staff and how their efforts contribute to the quality of care we give to our patients, and to the overall success of the Trust.

We were joined at the start of the year by colleagues from Community Services. They have made a smooth transition to working within the Trust and we have already seen benefits emerge as we ensure that the quality of care we provide to our patients is seamless, appropriate and in the right setting.

All of this work is reflected in our good performance against national key priorities, exceeding our targets in many areas including the amount of time patients with cancer wait to be treated from the time they are diagnosed.

One of the vital links between the hospitals, community services and the people who use our services are our Council of Governors.

During the year we had our most successful Governor elections to date. We received an unprecedented 42 applications for the 15 Governor vacancies. This very much highlights the passion people in our local communities feel about their hospital and being involved in their healthcare.

As part of the Trust Constitution review, working closely with Governors we reviewed our Constitution including the number of Governors who serve on the Council. The outcome of the review was a Constitution which is fit for purpose in the second decade of the 21st Century, including a more focused Council with a reduced number of Governors, from 39 to 25.

Governors provide invaluable feedback from many of our 16,000 Members and work closely with the Board of Directors contributing to vigorous discussion and debate as they challenge us to deliver the very best service to our patients, carers and their families.

I would like to thank our Governors who have left the Council for their contribution to the effectiveness of our Council. They saw us through the early and sometimes challenging years as we got to grips with being a Foundation Trust.

Kathryn Williets stepped down at the end of April 2012, as a Non Executive Director, to pursue her academic studies. Kathryn served eight years with the Trust and is known for her empathy with patient care, particularly that of the elderly. She will be missed by the Board of Directors for her contribution to the Trust and for her sense of humour and wisdom. I will miss Kathryn as her helpful advice and guidance helped me to step up to being Chairman of The Dudley Group.

We ended the year in a financially stable position and this is all credit to our dedicated staff who have risen to the challenges by delivering excellent care while becoming more efficient at what we do. However the challenge continues for as far into the future as we can see.

We now have the Health and Social Care Bill 2011 Act with all the changes this will mean for the whole health economy. I want to reassure our staff, patients their families and carers that the changes within the bill are central to the Board's work as we commit to be the best possible healthcare organisation.

Chairman

John Edwards CBE

Chief Executive's overview

As we look back over 2011/12, we can reflect on some of our achievements which place our patients, their carers and families where they should be – at the very heart of top quality healthcare in Dudley.

The Trust's commitment to being the very best place to work and to receive healthcare is borne out by the launch of our new vision and values.

Our new vision, 'Where People Matter', was the idea of a member of staff who took part in a competition to come up with the ideal words that summed up what it means to work at The Dudley Group and how it feels to receive healthcare at our three hospitals or in the community.

We had more than 800 suggestions and, after much discussion and debate, chose 'Where People Matter' because we feel it gives us a real sense of where we are going and what we want to achieve as a healthcare organisation.

This vision is underpinned by our new values: Care, Respect and Responsibility which demonstrate one of our most important aims: to provide the best possible patient experience. To do that we want to create an environment that encourages our staff to get things right for every patient, every time.

Helping us to achieve this are our new Patient and Customer Care Ambassadors, handpicked for their exemplary behaviour towards patients, their families, visitors and colleagues. We expect the ambassador programme to continue in popularity over the coming months and years as more and more staff put themselves forward to be a part of it.

One of the ways we measure how well we are doing to improve patient experience is the introduction of real-time surveys. Patients are able to tell us about their experiences and the quality of our services via our portable electronic survey tablets.

They can also feed back their comments at newly introduced Patient Panels which take place at regular intervals in our Clinical Education Centre at Russells Hall Hospital. Patients are invited to talk on a variety of topics including access to our services and the quality and range of food we provide for inpatients. Their valuable feedback is used to improve the services we offer.

The safety of our patients is paramount and we have pledged to continue putting patient safety at the centre of our services by signing up to the national campaign, Patient Safety First in 2009.

We also continue regular Leadership Walkrounds where senior management visit wards and departments to talk with staff about any concerns they have regarding patient safety in their areas.

Last year began with a schedule of at least three visits a month and included for the first time community departments, such as Audiology, Occupational Therapy and

Physiotherapy at Brierley Hill Health and Social Care Centre. As well as ensuring that directors get to know what front line staff are saying about patient safety, each visit results in an action plan.

We also use a systematic approach to service transformation, research and innovation to make improvements that benefit all our patients and ensure we meet our key priorities and targets.

To highlight some of our achievements:

- Rapid access cancer referrals: we are seeing 97.2 per cent of rapid access cancer referrals within two weeks (national target 93 per cent) and 99 per cent of breast symptom referrals within two weeks (national target 93 per cent).

- We admitted, transferred or discharged 97.27 per cent of patients within four hours of arrival against a national threshold of 95 per cent.

- We admitted 95.7 per cent of patients within 18 weeks of referral and 99.2 per cent of non-admitted patients were seen within the target. This achievement put us in the top ten of acute trusts for quarter two.

Integral to providing high quality care is a passionate workforce. We are committed to improving morale because our staff make the biggest difference and, as part of our strategy to improve how patients experience the care they receive, they continue to be placed at the centre of change with our engagement project, Listening into Action (LiA).

Already almost 2,000 staff have taken part in LiA and are using this tried and tested method to make improvements and service changes that benefit both staff and patients. LiA enables us to take a fresh look at how we deliver our services in these tough financial times and build on our excellent reputation.

During 2011/12 we have:
Delivered 5276 babies
Treated 37,777 day cases
Saw 516,876 outpatients
Treated 98,452 patients in the Emergency Department

Our PFI partners have:
Packed and laundered around 3.1 million pieces of linen
Supplied 1800 new pillows
Cleaned and delivered 156,000 uniforms
Cleaned more than 5,000 miles of corridor

Chief Executive

Paula Clark

Our new vision and values

The Dudley Group NHS Foundation Trust has launched a new set of vision and values to help give us a real sense of where we are going as a healthcare organisation.

Our new vision is **'Where People Matter'**. It was the idea of a member of staff who took part in a competition to come up with the ideal words that summed up what it means to work at The Dudley Group and how it feels to receive healthcare at our three hospitals or in the community.

We had more than more than 800 suggestions and chose 'Where People Matter' because we feel it is memorable and meaningful to everyone including our staff, our patients and their families and carers.

This vision is supported by our three new values:

- **Care**
- **Respect**
- **Responsibility**

At the heart of everything we do are our patients – and one of our most important aims is to provide the best possible patient experience. To do that we want to create an environment that encourages our passionate workforce to get things right for every patient, every time.

We believe our new vision and our values perfectly sum up the journey we are on to achieve our goal of being the best place to receive healthcare, and the best place to work.

Report from the Board of Directors

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.

Currently we serve a population of around 400,000 people from three hospital sites at Russells Hall, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge, providing the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands regions. We also provide specialist adult community based care in patients' homes and in over 40 centres in the Dudley MBC community.

The Trust was authorised by Monitor, the independent regulator of NHS foundation trusts, to commence operation as an NHS Foundation Trust from 1st October 2008 and on 1st April 2011, acquired the Adult Services arm of Dudley Primary Care Trust, transferring over 400 WTE staff to the new Trust and increasing turnover by c£20m per annum. In response to this important change the Trust sought from Monitor, and was granted, approval to change its name to The Dudley Group NHS Foundation Trust.

The Trust's hospitals form part of a Private Finance Initiative (PFI) with Summit Healthcare and its appointed service providers: Interserve Facilities Management and Siemens Healthcare. The Trust is run by a Board of Directors, which is accountable for its performance against its terms of authorisation, to a Council of Governors. Details of those who served as Directors of the Trust and as Governors are set out from page 32 of this Report.

2011/12 has been the most challenging year in recent memory for the NHS in England, as the Coalition Government has responded to deteriorating national economic conditions by reducing public expenditure in real terms. In the NHS this approach has been underpinned by a programme of demand management and quality lead cost reduction (the QIPP initiative) and cash funding marginally lower than inflation for the year. This trend has once again coincided with local Primary Care Trusts seeking to reduce levels of spending on commissioned patient care, especially in the acute sector. This despite growing demand for our services in Dudley and growing customer expectations. The Dudley Group has delivered cost savings from improved efficiencies of £12.7m during the year, mainly through reduced spending on agency staff.

Against this challenging background our overall business achievements in 2011/12 have been commendable and can be summarised as:

- Financial surplus of £627,000
- Monitor financial rating of 3 (out of 5 maximum)
- Achievement of the 18-week's national maximum waiting targets for both admitted and non-admitted patients

- Achievement of the four hour waiting target in A&E
- Successful integration of adult community services
- Significant further investment in additional substantive clinical staff and buildings and specialist equipment

Page 60 of this Annual Report details our contractual arrangements with local Primary Care Trusts (PCTs) for the provision of services for 2011/12 and details of our performance against key national priorities and performance targets can be found within the Quality Report appendix on page 44.

Whilst performance during 2011/12 across the range of targets and standards has once again been excellent, the Trust did experience problems in the area of infection control (*Clostridium difficile* (C. diff) incidents) in the first half of the year. As a result the Trust exceeded its annual target number of C. diff cases of 77 by 45 cases. This resulted in Monitor rating the Trust as 'Amber/Red' for Governance during the year. It is important to note that the Trust consulted national infection control experts at the earliest opportunity and has been operating well within monthly trajectory levels in the latter months of the financial year. The Regulator has not found the Trust to be in breach of its terms of authorisation during the year.

Once again, during 2011/12 the Trust took the decision to invest heavily in front line clinical services to continually improve the quality of care to patients.

From April 2010, the Department of Health has introduced a system of legal registration of service providers in England and requires a clear demonstration and evidence of the achievement of standards of healthcare. In support of our application for registration from that date, the Trust made declarations to the Care Quality Commission (CQC) and shared its development plans in a number of clinical areas including the ongoing training of clinical staff (and the appropriate recording of this) and the improvement of the quality and availability of clinical notes. The Trust has operated within its CQC licence throughout the year.

In view of the impact of the UK recession on the local economy, the Trust has adopted a policy of settling the invoices of local suppliers promptly. In 2011/12 the Trust settled 99 per cent of trade invoices within 30 days.

As an NHS Foundation Trust we have made no political or charitable donations during 2011/12.

To promote improved patient safety, the Trust has continued its programme of Directors' patient safety walkabouts and has worked closely with patient groups and Members and Governors of the Foundation Trust to develop a more responsive service to patients.

In addition, the Trust has invested heavily in medical equipment during the year and during 2011/12 commissioned a new MRI Scanner and state of the art decontamination units at Russells Hall and Corbett hospitals. A major programme of developing an

electronic patient record was commenced with the successful roll out of electronic technology in the Emergency Department concluded in the autumn.

During the year the Board of Directors has placed increased emphasis upon the importance of good communications with staff. Regular team briefings and a lively intranet facility has kept staff informed about changing clinical and business related issues. A full programme of 'Listening into Action' events have been facilitated on a wide range of issues during the year. This process has complemented the continued roll out of a lean transformation programme across the Trust.

In summary, 2011/12 has been a challenging year for the Trust in both a clinical and business sense but has also been a year of significant and sustained achievement.

Our Services as of 1st April 2012

Russells Hall Hospital	Corbett Hospital Outpatient Centre	Guest Hospital Outpatient Centre	Community Services
Anaesthetics	Anaesthetics provide some services at Corbett	Outpatient clinics including: • Dermatology • Gastroenterology • Neurology • Pain Management • Renal • Respiratory	Audiology
Anticoagulation	Day Case Surgery Unit		Blood Borne Virus
Audiology	Dietetic clinic		Chronic Obstructive Pulmonary Disease (COPD) Respiratory Nurse Service
Cancer services	Multi-professional rehab		
Cardiology	Orthotics		Continence Service
Clinical Haematology	Outpatient clinics including: • Cardiology • Dermatology • Gastroenterology • Obstetrics and Gynaecology • Older Persons and Stroke • Trauma and Orthopaedics • Urology	Pain management programme	Contraception and Sexual Health
Critical Care Unit		Pharmacy	Dermatology
Day Case Surgery Unit		Physiotherapy and Occupational Therapy	Diabetes Specialist Team (Primary Care)
Dermatology		Radiology (X-ray)	Dietetics
Diabetes and Endocrinology		Respiratory Assessment	District Nursing
Dietetics		Speech and Language Therapy	ENT – Ear, Nose and Throat
Early Pregnancy Assessment Clinic			
Emergency Assessment Unit			Heart Failure
Emergency Department (Accident and Emergency)	Pharmacy		Macmillan Community Palliative Care Team
Fracture clinics	Phlebotomy (blood tests)		Neurology Primary Care Service (including MS, Parkinson's Nurse specialists and Integrated Living Team
Gastroenterology	Physiotherapy		
Genito-urinary medicine	Podiatry		Occupational Therapy
Head and Neck surgery including Ear, Nose and Throat (ENT) and Maxillofacial	Radiology (X-ray, DEXA bone scanning)		Palliative Care Support Team (Joint Agency)
	Speech and Language Therapy		Physiotherapy
Inpatient wards	Wheelchair service		Physiotherapy – Orthopaedic Assessment
Maternity			Podiatric Surgery
Maxillo Facial Prosthetics			Podiatry – community and biomechanical
Medical and clinical inpatient services			Respiratory Assessment
Medical High Dependency Unit			Speech and Language Therapy
Neurology			Stroke Rehabilitation

Obstetrics and Gynaecology			Thunderburds – rapid response team to help prevent hospital admissions
Older Persons and Stroke			
Oncology			Tissue Viability (including leg ulcer)
Ophthalmology			
Orthodontics			Virtual Ward
Orthoptics			
Orthotics			
Outpatients			
Paediatrics and Neonatology			
Pain Management			
Pathology			
Pharmacy			
Phlebotomy (blood tests)			
Plastic Surgery			
Podiatry			
Pre-operative assessment			
Psychology			
Radiology (X-ray, MRI and CT scanning)			
Renal			
Respiratory Assessment			
Respiratory Medicine			
Rheumatology			
Skin Lesion clinic – Care Plus (Private patient clinic)			
Speech and Language Therapy			
Surgery including breast, colorectal, upper and lower GI and vascular			
Surgical Assessment Unit (for GPs)			
Surgical pre-operative assessment			
Surgical High Dependency Unit			
Theatres			
Therapy Services including Physiotherapy and Occupational Therapy			
Trauma and Orthopaedic including fracture neck of femur unit			
Urology			
Women and Children's Outpatient Department			

Patient safety
We give priority to the delivery of high quality care to all patients by ensuring that patient safety is at the heart of everything we do.

While it is important for us to meet national targets and to remain in financial balance, this must not be achieved at the expense of the safety of our patients. As part of this we ask all staff to complete incident forms if things do go wrong so that we can investigate the circumstances, learn lessons and change practice, when relevant.
We provide safe, high quality care to many thousands of people every year but sometimes, despite our best efforts, things can and do go wrong. If a patient is harmed as a result of a mistake or error in their care, we believe that they, their family or those who care for them, should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response. This is something that we call being open.

Being open, learning from our mistakes and changing practice contributes to the high quality of care we aspire to.

Eliminating mixed sex accommodation
The Dudley Group NHS Foundation Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is not in the patient's overall best interest, or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in the critical care unit), or when patients actively choose to share (for instance in the renal dialysis unit).
If our care should fall short of the required standard, we will report it. We will also set up an audit mechanism to make sure that we do not misclassify any of our reports. We will publish the results of that audit on the Trust's website and we have the existing compliance for 2010 and for 2011 on the website at:
http://www.dgoh.nhs.uk/your-stay-in-hospital/single-sex-accommodation

Service changes and improvements 2011/12

Care Plus at The Dudley Group
The Trust has launched 'Care Plus at The Dudley Group' to offer patients private specialist-delivered care at affordable prices.

Our plan for private work is to offer outpatient appointments and day case procedures in the evenings and on Saturday mornings at Russells Hall Hospital.
The new private patient service began with a skin lesion clinic to offer people who are seeking private care the option of choosing The Dudley Group.

The clinics are run out-of-hours by our plastic surgeons and offer efficient, safe, consultant-delivered treatment for many procedures, including those no longer available on the NHS.

Conditions we will treat include: moles, seborrhoeic warts, tattoos, torn earlobes and botox injections for excessive sweating.

Private patients have the reassurance of a team of NHS consultants and state of the art facilities with access to a range of diagnostics.

The service will not impact on NHS patients' waiting lists and any income generated from private work will be reinvested into the NHS to develop our services for the benefit of all patients.

Temporarily restriction to maternity bookings
Our maternity unit remains to be a popular choice for mums-to-be and we are continuing to see an increased number of women choosing to have their babies at Russells Hall Hospital.

To continue providing safe, effective care for women and their babies accepted for delivery at Russells Hall Hospital, we have reluctantly taken the decision to temporarily limit future bookings to the maternity unit for a period of 12 months from April 2012 while we look into the feasibility of increasing capacity to meet demand.

Working with our commissioners, the maternity unit at City Hospital and our Overview and Scrutiny Committee a decision was taken to restrict referrals for low risk women whose GP surgery was located within a 16 minute travel time from City Hospital where the maternity unit has capacity to take additional births.

Second Magnetic Resonance Imaging (MRI) scanner
Our aim to offer patients faster quality imaging and more accurate diagnosis, along with shorter waiting times, took a step forward with the delivery of a second MRI scanner at Russells Hall Hospital in May 2011. The installation of the Siemens Magnetom Verio 3T offers superior speed and resolution with improved image quality and increases the number of patients we can see. The scanner is also wider, offering 33 per cent more space to help reduce the claustrophobic feeling some patients feel.

State of the art Endovascular Aneurysm Repair (EVAR) Suite
Our state-of-the-art endovascular (EVAR) suite was officially unveiled at Russells Hall Hospital by Stourbridge MP Margot James on Friday 9th March 2012.

The £1.5m combined angiography and operating theatre suite features a Siemens Artis Zee ceiling mounted system that offers vascular surgeons high speed, high resolution 3D images of blood vessels and gives patients lower doses of radiation.

The suite is also fully integrated with the hospital's radiology display system which allows doctors to import cross sectional images into the intervention suite while they are operating on patients. The new technology is also much safer for patients: doctors can diagnose bleeds that can occur from a wide range of causes such as ulcers, tumours

and fibroids. It can also detect small leaks during and after endovascular aneurysm repair which helps reduce complications.

Virtual Ward
Virtual Ward was fully established and further embedded during 2011. Virtual Ward is a means of providing case management to people in the community who are most vulnerable to repeated unplanned hospital admissions. The aim is to coordinate and optimise the social, medical and psychological health of its patients in the community. Patients admitted to a Virtual Ward remain in their own homes, but receive intensive case management from members of the multidisciplinary team. They are particularly focused on the management of long-term medical conditions. Further options are being explored to underpin the multidisciplinary management of the patients admitted to the virtual ward.

Emergency Department Electronic Patient Record (EPR)
During 2011 our Emergency Department (ED) became the only ED in the country to go live with a fully functioning Electronic Patient Record with e-prescribing, electronic ordering, electronic referrals to inpatient specialties and full patient tracking.

We moved to an EPR and away from paper referrals and orders to improve patient safety, process efficiency and quality of care for emergency patients. Electronic processes were put into place to aid assessments, including triage assessments, child safeguarding, medical clerking and patient transfer. This major change to working methods launched in November 2011 with minimum ED process redesign and while maintaining performance against the quality indicators. Benefits have been realised in terms of patient safety and quality of care as well as patient tracking, improved documentation, document retrieval and saving staff time.

More information about service enhancements and innovations during 2011/12 can be found in the Quality Report section.

Listening and learning

The Trust values and welcomes all feedback to help us ensure we meet the needs and expectations of our patients, their families, our staff and our stakeholders; as a Foundation Trust we are also legally obliged to take consideration of our Members' views as expressed through our Council of Governors.

The Trust has a number of systems in place for obtaining patient feedback:

- Lead nurse walkrounds allow time for face to face patient feedback
- Our Governors provide feedback from our members and wider communities
- Patient Panels on specific topics
- NHS Choices and Patient Opinion online feedback
- Patient Advice and Liaison Service (PALS)
- Complaints data
- Surveys

- Liaison with our Local Involvement Network (LINk), Health Select Committee and MPs
- Holding and attending community events

Patient feedback is a regular agenda item at the Board of Directors enabling both Executive and Non-Executive Directors to consider patient views alongside other performance information.

See pages 8 to 11 of our Quality Report (appended to this Annual Report) for more information about our priorities for patient experience.

No formal consultations have taken place during the year; however we maintain close contact with our Local Involvement Network (LINk), patient groups and the Health and Adult Social Care (HASC) Select Committee. During the year we have attended the HASC Committee to report on applying geographic restrictions to our Maternity service, Outpatient rescheduling, Contraception and Sexual Health services integration and to present a draft report on our Quality Report for 2011/12.

Patient Advice and Liaison Service (PALS) – welcoming concerns, comments and compliments

At The Dudley Group we try to make sure that our service is the best it can be but sometimes, despite our efforts, things can go wrong. The Patient Advice and Liaison Service, or 'PALS', is here to help when patients or relatives have concerns and, whenever possible, will try to help put things right. PALS does this not only by working to help individuals but also aiming to improve services by contributing to the quarterly Patient Experience Report with data presented both to the Board and to our Council of Governors.

The PALS team acts as the first point of contact for patients who need help with a concern and will provide advice, support and information. During 2011/12 our PALS team helped 1,110 people with a wide variety of concerns and queries. Our PALS team can be contacted on 0800 073 0510.

Below are some examples of changes to be made and changes made as a result of PALS concerns during 2011/12:

- Office Manager alerted to problems with call handling system. Meeting was arranged within a week to address issues with service provider
- Matron and Lead Nurse contacted and discussions took place with consultant about ensuring patients are aware who to contact with problems after leaving department – procedures altered to make sure patients have advice on ringing the ward in case of concern
- Matron contacted following problem due to lack of communication to ensure patients have timely follow-up appointment – procedures were reviewed so appointment now made for patient to be seen by consultant and all relevant paperwork completed before patient leaves
- Patient was concerned that his appointment was not within the time span he was told – PALS contacted Ward Sister who investigated and there had been error on computer system. A new form was introduced to avoid this happening again

- Individual staff counselled by managers regarding issues, including practice and attitude
- Arranged numerous meetings for patients and relatives to meet with respective clinicians and managers or nursing staff to resolve concerns

How many people have PALS helped in 2011/2012?

Quarter	Concerns	Queries	Compliments
Q1	212	35	79
Q2	255	30	134
Q3	204	54	190
Q4	266	54	141 + numerous gifts/chocs etc.
TOTAL	937	173	544

Complaints

As you can see from the table above, in the 2011/12 year we received 544 formal thank you cards and letters; this does not include the many verbal thanks we receive. However, we do recognise that occasionally things go wrong and we believe we should do everything we can to put things right if this happens and learn from any mistakes we may have made.

The main purpose of a complaint is to remedy situations as quickly as possible and to provide an explanation to complainants. We try to ensure each patient is satisfied with the response they receive. It is important that individuals feel their complaint has been fairly listened to, treated with respect and any issues resolved.

Complaints are an important source of information about how patients view our services, and we are committed to learning from the complaints raised and making changes to the benefit of all patients.

If local resolution fails, there is a one stage review by the Parliamentary and Health Service Ombudsman.

The number of complaints against patient activity during 2011/12 was 0.05 per cent (0.05 per cent in 2010/11). During the year we received 375 complaints, an increase of 13 per cent on the previous year in terms of numbers of complaints, but the inclusion of community complaints (from 1 April 2011) accounted for 40 per cent of the increase.

The Trust has acknowledged all complaints within three working days of receipt and all complaints are assessed and, according to the complexity of the complaint, a timescale agreed. Complainants dissatisfied with their response from the Trust can request the Health Service Ombudsman to accept it for further review. During the year one complaint was investigated by the Health Service Ombudsman and the outcome was that it was not upheld.

For more information about complaints for 2011/12 please see our Quality Report page 33.

Patient information
The Trust has more than 600 leaflets on various conditions and treatments, as well as aftercare advice. Information is produced in plain English and made available in large print, audio, Braille and alternative languages on request.

The Trust has a clear policy which details the process for developing, producing, ratifying and archiving all the Trust patient information ensuring information is kept up-to-date.

Hospital Volunteer service
More than 400 volunteers from the local community give their time on a regular basis to make a real difference to patients, visitors and staff at the Trust. The Hospital Volunteer Service is part of our PALS service and is managed by the volunteer co-ordinator. Individuals volunteer for a variety of reasons including: the satisfaction of knowing that they are doing something for others, the chance to make new friends, to gain experience of a busy hospital environment, to gain confidence and strengthen interpersonal skills. Volunteers are asked to pledge a minimum of 100 hours.

Some of the tasks volunteers have undertaken include:

- Mealtime assistance
- Changing patients' drinking water
- Undertaking patient surveys
- Clerical support
- Patient friends
- General ward volunteers
- Outpatient hosts
- Emergency Department hosts
- X-ray Department support
- Main reception way-finding
- Enquiry desk
- Chaplaincy

The dedicated work of all our volunteers is highly valued by the Trust, and it is pleasing to realise that volunteers also get satisfaction from their role.

About our Staff

The Trust is the second largest employer in the Dudley borough with 3910 full time equivalent (FTE) staff, an increase of 465 from 2011 primarily due to the transfer of Dudley Adult Community services on 1st April 2011. The table below gives a breakdown of staff numbers by professional group.

Staff Group	As at 31st March 2012 Full time equivalent
Add Prof Scientific and Technical	154.97
Additional Clinical Services	743.27
Administrative and Clerical	751.99
Allied Health Professionals	272.25
Estates and Ancillary	0.34
Healthcare Scientists	106.15
Medical and Dental	458.62
Nursing and Midwifery Registered	1414.00
Students	8.99
Grand Total	3910.57*

*see note on page 24

In a 24/7 operation it is always a challenge to ensure that everyone is communicated with. We have developed a number of ways of doing this which include the ever popular Trust intranet 'The Hub' where staff can access information on Trust issues, policies, news and views from colleagues. It is also used as a forum to gather views from staff before decisions are made, such as in setting our new vision 'Where people matter' during this financial year, with a competition to come up with a strapline that summed up the quality service that we strive to deliver.

Our popular staff and Members magazine 'Your Trust' continues to be published quarterly and is available on both our intranet and website as well as in printed copy. Our Chief Executive also maintains a monthly CE Update staff briefing to keep staff up-to-date on the Trust's strategic direction, new policies and other timely staff news. This is a great way of getting information out to everyone including those who do not have regular access to the Hub.

The Trust has continued with its Listening into Action and Transformation programmes this year which have enabled staff to get involved in changes that affect the areas where they work. More information on these programmes can be found on pages 25 to 29. Staff can also get involved via the Patient Safety Walkrounds; an ongoing rota of visits to clinical areas by where a Non Executive and Executive Director, accompanied by a member of the Governance team, talk to staff about current issues, then develop an action plan which is followed up at the next walk round. More on the Patient Safety Walkrounds can be found in our Quality Report on page 35.

Work has also continued with our Clinical Directors to ensure that each month they are provided with a statement of their directorates' financial and governance position. This enables them to make proactive decisions at their management meetings and review

performance set against objectives for their teams. Messages about the Trust's performance are also communicated via the Hub and CE team briefing.

Sickness absence continues to fall with the Trust finishing at 3.65 per cent against the Trust target of 3.85 per cent.

Q1 actual	3.53%
Q2 actual	3.74%
Q3 actual	3.73%
Q4 actual	3.61%
Full year actual	3.65%

The Trust turnover rate has also reduced this year to approximately 7.93 per cent. Please note that this figure does not include the transfer of community staff on 1st April 2011, nor community staff turnover. This is due to the TCS transfer process (terminating an assignment and then creating a new assignment), artificially inflating the overall total percentage and not giving a true reflection of turnover of staff.

We are continuing with a programme for line managers on how to handle employment related topics.

We take the health and safety of our staff very seriously and are pleased that once again in 2011 the Trust was awarded a RoSPA Occupational Health & Safety Award. The award recognises organisations that have demonstrated the best health and safety management performance within specific industry sectors.

The Health and Safety team are particularly proud of the benefits achieved with the continuing reduction in reported accidents within the organisation, due to employee involvement. As well as heightening staff awareness by motivating them to take avoiding action when recognising a workplace hazard or the dangers of poor working practices. The Trust's Health and Safety Department is committed to raising Occupational Health and Safety awareness amongst all of its employees and that of its partners. The Trust remains convinced that it can continue to lead rather than follow other organisations in the application of best practice in maintaining its Occupational Health and Safety awareness programme in raising the standards of Health and Safety management and to recognise the efforts of all who have contributed to its success.

Occupational Health continues to be a fully integrated part of HR and have been part of the team that has enabled employees to return to work fully fit sooner thereby lowering the absence percentage. We continue to provide a Physiotherapist and Counsellor Service

Equality and diversity

Equality and diversity impact assessments process is now embedded in the Trust's ways of working to ensure that we are offering the best possible service to a complete cross section of the community. All our policies are equality and diversity impact assessed before being approved. We are passionate about ensuring both our employment statistics from NHS Jobs and our training activity is available to everyone.

Again this year we have been awarded the two tick's disability symbol – a national standard which recognises that we are positive about employing disabled people.

The Equalities Act 2010 requires the Trust to publish a Single Equality Scheme, an Equality Assurance Statement and a minimum of two equality objectives. These obligations have all been met and are available to view on the equality page of the Trust website.

We have also set up a Diversity Management Group with representatives from a cross section of staff in the Trust who will oversee the progress of the equality objectives together with the principles of the single equality scheme. The group will meet at least four times per year and have a Terms of Reference that reports to the Risk and Assurance committee.

Disability employment statistics

		% of all applications received	% of applicants shortlisted	% of applicants appointed
Disabled Person	**Yes**	3.10%	4.33%	3.13%
	No	96.20%	94.83%	95.49%
	Undisclosed	0.70%	0.84%	1.39%

Note regarding whole time equivalent HR and finance difference in number

HR (p22) reporting obtains the FTE in post for a specific date where as Finance (p61) reporting obtains the contracted FTE worked over a period of time. This means that if there are a number of employees who have left during a month, it is possible that the HR report will not pick this FTE up. It also means that if there are a number of leavers on a specific date the Finance report may not include this FTE. Therefore, an individual leaving mid way through March, Finance would show 0.5 FTE, whereas HR would show zero because there would be no one in post at 31/3. For an individual starting mid way through March, Finance would show 0.5 WTE, whereas HR would show 1.00 FTE because there is 1 person in post at 31/3. This is the reason for the slight difference in FTE being reported.

NHS workforce statistics

An analysis of our workforce statistics indicates they are comparable with both the local Dudley population and other NHS Acute Trusts. Historically the Trust has seen a higher proportion of female workers than males, and this is typically reflected across other NHS Acute Trusts.

Age	Workforce	
	1st April 2011 to 31st March 2012	1st April 2010 to 31st March 2011
18-19	0.18%	0.1%
20-24	5.46%	5.8%
25-29	12.63%	13.1%
30-34	12.36%	12.5%
35-39	12.27%	12.3%
40-44	15.06%	15.0%
45-49	15.55%	15.1%
50-54	12.63%	12.2%
55-59	8.78%	8.2%
60-64	4.20%	4.8%
65+	0.88%	0.9%
Gender		
Male	16.01%	17.0%
Female	83.99%	83.0%
Ethnicity		
White	73.88%	73.0%
Mixed	0.86%	1.0%
Asian or Asian British	8.87%	9.6%
Black or Black British	2.32%	2.6%
Other	1.48%	1.6%
Not stated	12.58%	12.2%

Listening into Action

Listening into Action (LiA) is an engaging way for our staff to make improvements to the services we provide patients as well as changes to their own working environment.

Through feedback events called LiA conversations, LiA gives staff at every level across the hospitals and in the community the confidence to come together and pool their ideas to make service improvements.

Chief Executive Paula Clark launched LiA in 2010 with a series five big conversations and introduced a number of initiatives after hearing what staff said was important to them.

These have included showing staff appreciation with the reintroduction of Long Service Awards for staff who have reached milestone years' service with the Trust. We have also created a Roll of Honour which highlights the many compliments and letters received by PALS and by individual wards and departments. These compliments are published daily on our staff intranet.

Since the launch of LiA, almost 32 teams from different wards and departments have held an LiA conversation and almost 2000 staff have taken part. In February 2012, we held an LiA on the Quality Report to provide an overview Provide an overview of the Trust's quality priorities (2011/12) and how they had progressed so far and to look at the quality priorities for 2012/13. See page 7 of the Quality Report for more information.

Below are some of the first ten teams to adopt LiA, their missions (objectives for the changes they wanted to see) as well as a few of the main changes they made as a result of listening to staff involved.

- **Pharmacy:**
    - **Mission**: to improve communication within the department.

    - **Outcomes**: they have introduced a bi-monthly departmental Pharmacy Information Leaflet (The PIL), all visitors now wear name badges and new staff photos are displayed on their notice board. They are using a tracker system to help them prioritise and manage workloads and the technicians' rota is being used as a messaging system to let everyone know where colleagues are.

- **Maternity Outpatient Department:**
    - **Mission**: to reduce waiting times in the antenatal clinic.

    - **Outcomes:** the team has changed the way it runs clinics so women do not all arrive in the department at the same time and they have introduced a stamp on appointment cards advising women of their standard appointment slots. Women are now being asked to speak to the midwife if they think they will need longer. Big efforts are also being made to ensure clinics start on time.

Stroke Care:

- **Mission:** to transfer 100 per cent of stroke (and Transient Ischemic Attack (TIA)) patients from the Emergency Department (ED) to ward A4 (stroke ward) within four hours of arrival at ED.

- **Outcomes**: to date 48 per cent of patients are getting to A4 within four hours of arrival at ED compared with approximately two per cent prior to LiA. They are improving access to imaging 24/7 – nurses can assess a patient and ring and request a scan to help them achieve target to CT scan 50 per cent of stroke patients within one hour. They are also improving stroke education for all staff for signs and symptoms.

Customer Care LiA:

- **Mission**: for all staff at all times to personally commit to strong customer care values to ensure that everyone we come into contact with – including patients, visitors, colleagues and partners, are treated with care and respect.

- **Outcomes**: as a result of staff feedback, the Trust has created 30 Patient and Customer Care Ambassadors. They have been handpicked from among staff working across different wards and departments to be role models to their colleagues, and to inspire all staff to adopt exemplary behaviours towards each other and to patients. Using the views of the staff on the programme, and feedback at the LiA, they have developed a draft set of basic standards, including treating patients and visitors warmly and politely; to resolve problems and answer queries when asked; to never raise voices or show loss of temper and to anticipate the needs of people and act accordingly.

In the last few months, a number of new teams have held LiA conversations as a way of improving their services. They are analysing the feedback from those who attended and drawing up action plans. Some of these include:

Team	**Mission**
Clinical Audit	To raise the profile of clinical audit across the organisation, working with staff to review standards and capture changes in practice giving improved patient care.
Community Podiatry	To reduce waiting times, for non-high risk patients in community podiatry services.
Dietetics	To improve the quality of referrals to the department and reduce inappropriate referrals.
Finance	To improve the way we communicate the financial position of the Trust to budget holders and increase cost awareness.
GI	To ensure all patients with suspected GI bleed receive immediate assessment and monitoring, and endoscope with 25 hours.
Health Records	To improve the availability of patients' case notes.
Health & well being	To improve staff health and well-being by reducing work related stress levels, improving the working environment and changing the culture to offer staff more support.
Medical secretaries	To create a concrete, standardised and timely turnaround for patient letters.
Outpatient Department	To improve team working, collaboration and communication between outpatient specialty teams to improve the patient experience.
Urology	To establish a dedicated urology unit with a Multi-Disciplinary Team (MDT) approach and skilled workforce that delivers high quality care and a positive patient experience to achieve reduced lengths of stay, drive down unnecessary re-admissions and explore service developments.
Volunteers	How to best utilise volunteers for the benefit of patients, staff and the volunteers themselves.

LiA puts staff who know the most at the centre of change and it is becoming the accepted and popular way for staff to make improvements in their areas for the benefit of patients and staff alike.

Transformation
Our Transformation Team has continued to run a series of projects derived from Lean Action Weeks and Lean Action Days. The various teams have delivered significant improvements to both efficiency and effectiveness with enhancements to patient experience.

Across all directorates, including corporate functions, members of staff from different areas have come together for more than 24 projects to focus on improving the way we deliver care in, for example, all Wards, Community Nursing, General Surgery, Acute Medical Unit, Rheumatology, Oncology, Elderly Care and Outpatients.

The Productive Ward Project – Releasing Time to Care is part of a national project to help ward teams decide how best to run their wards so they can reduce wasted time and interruptions to spend more time directly caring for patients. In the past year, it has been extended into the Community Nursing operations.

As part of the Productive Wards project, the Mandated Meals module supported the Trust's Nutritional Lead in implementing quality measures around meal times and individual Patient Information Boards for improving and standardising the conveyance of care focused information.

As part of the Enhanced Recovery Programme (ERP) the Joint Hip and Knee School, run by Trauma and Orthopaedics on a Wednesday and Friday afternoon at The Guest, provides a dedicated pre-operative assessment clinic for patients. This has provided massive benefits for patient experience through the delivery of a professional education and psychological conditioning session, which helps to prepare patients for their elective surgery. This is followed by a highly efficient clinical assessment session where monitoring and patient assessment questionnaires are filled in, using a well practised flow, ensuring that patients move from one part of the assessment process to the other with no, or at very worst, minimal waiting. This has provided tangible benefits for the patient experience, whilst helping the Trust to increase the number of patients brought in on the day of surgery and reduced the length of stay.

Currently we have a project focused exclusively on the improvement of Patient Experience throughout the Trust.

Transformation is about finding more efficient ways of working while increasing the quality of care our patients receive. We will launch at least another 25 projects in 2012/13.

'Grow Your Own' novice programme
A bespoke novice training programme has been developed to give people who have no previous caring experience the chance to learn the basics of nursing care and apply for a permanent position as a Healthcare Support Worker. The Healthcare Support

Training Programme was launched to address the problem of recruiting skilled clinical support workers into the Trust.

The novice programme aims to 'grow our own' and was designed by Maggie Lewis, Professional Development Lead for Clinical Support Staff, and her team, who run the programme.

Training is offered on either a three month full-time or six month part-time contract and begins with an induction week where novices learn the fundamental clinical skills including bed bathing and turning patients; how to prevent pressure sores; nutrition and feeding; communication skills; patients' rights; dignity in death and nursing patients who experience pain. Entrants are supervised by a registered nurse and are assigned a band three support worker as a "buddy". They are also monitored by an assessor while they achieve the required set of clinical skills.

The novice programme is proving so popular that more than 70 people, ranging from shop assistants to forensic scientists, have gone through the programme to secure permanent contracts on wards throughout Russells Hall Hospital. It has also been very well accepted by staff in the clinical areas and is a successful way of recruiting quality support workers who have the potential to progress and, ultimately, be sponsored for nurse registration.

One of the first eight novices has completed her healthcare support worker training and is now on a Learning, Education and Progression (LEaP) course preparing for her nursing degree.

2012/13 will see a new intake of novices, and so far 306 people have applied for 15 coveted places.

The programme has now been adopted as part of the Workforce Plan for the Trust.

National Staff Survey 2011

The 2011 National Survey was completed between October and December 2011 with a sample of 850 randomly selected individuals invited to participate. The results are used by the CQC to benchmark against other Trusts to represent the organisation when measured against other acute trusts.

There has been a 10 per cent increase in the response rate moving the Trust to a response rate of 42.7 per cent. Whilst this is an improvement it is below the national average.

The findings for the survey have been analysed at three levels:

- Compared to national average results for 2011
- Compared to last year Trust results
- Compared to other local Trust results

The Trust has developed an individual directorate analytical tool to help understanding and engagement of teams.

Overall Engagement

Overall staff engagement (the higher the score the better)	**Score out of a total of 5**	Ranking
Trust score 2011	3.65	Above (better than) average
Trust score 2010	3.50	
National 2011 average for acute Trusts	3.62	

The Department of Health published results are as follows:

Top 4 key findings (KF) overall (those that compare most favourably with other acute trusts in England)	2011	Comparison to 2010	Ranking compared with all acute trusts
KF26. % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	9%	No change	Lowest (best) 20%
KF24. % of staff experiencing physical violence from staff in the last 12 months	0%	No change	Lowest (best) 20%
KF38. % of staff experiencing discrimination at work in the last 12 months	10%	No change	Lowest (best) 20%
KF29. % of staff feeling pressure in the last 3 months to attend work when feeling unwell	23%	No change	Lowest (best) 20%

Bottom 4 key findings (KF) overall (those that compare least favourably with other acute trusts in England)	2011	Comparison to 2010	Ranking compared with all acute trusts
KF28. Impact of health and well-being on ability to perform work or daily activities	1.61*	No change	Highest (worst) 20%
KF23. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	9%	No change	Above (worse than) average
KF12. Percentage of staff appraised in last 12 months	76%	No change	Below (worse than) average
KF21. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	No change	Below (worse than) average

*total of the key finding converted to a score out of 5

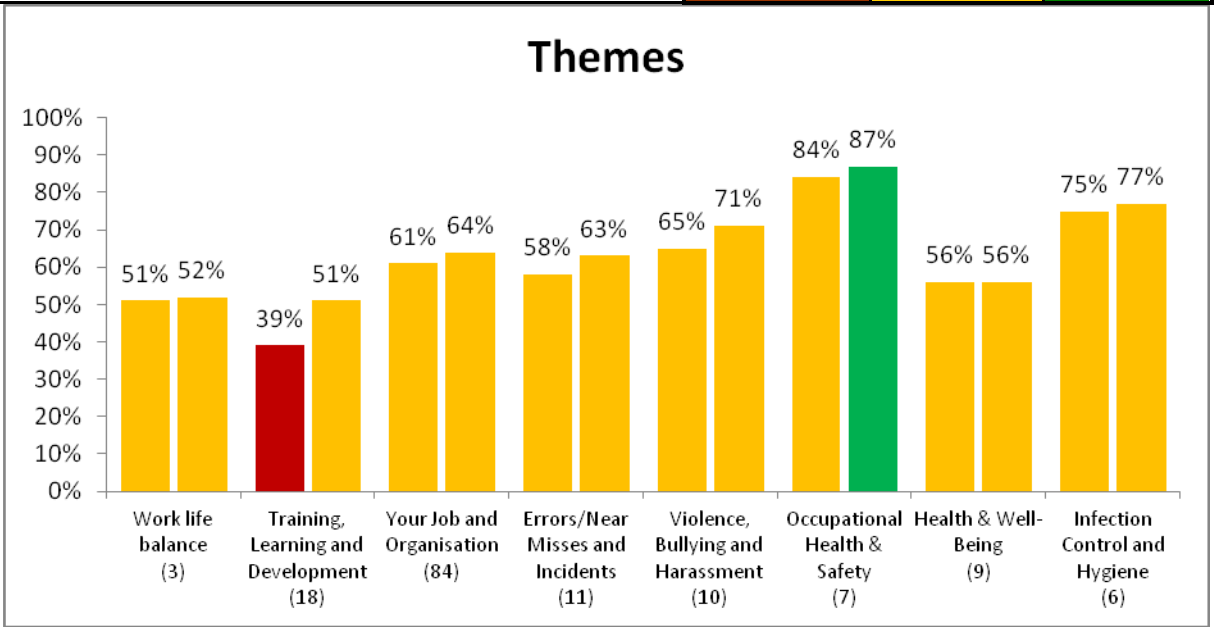
Although the tables indicate no change since last year, this masks some of the activity as there has been a significant increase in response rates and all of the themes have improved with the exception of one area which has stayed the same. There are no red rated themes this year. The staff engagement figure has also improved which has moved the Trust into the next level of responses.

In addition to the above findings there are two key questions that relate to how staff feel about promoting the Trust as a place to work and receive treatment.

Net Promoter Questions	2011	2010	Change
If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust	67%	56%	11%
I would recommend my Trust as a place to work	56%	49%	7%

The overall results are compiled into eight 'themes'. For seven themes there has been an improvement on last year, and for Health and Wellbeing the response has remained the same.

Themes key			
All questions included in the survey are themed into sub-categories. The graph below illustrates the average score for questions in each sub-category. Data for the last two years is shown.			
Key	**0%-49%**	**50%-84%**	**85%+**



Individual Directorates will develop their own action plans to address issues within their team. Corporately the Trust will be focusing on staff motivation to work at the Trust through a programme of staff recognition schemes and staff engagement. We will also be holding a series of focus groups to further understand how people feel about working in the Trust and this will add to the overall information gathered and be addressed through the action plan. As part of the Listening into Action programme we are planning to send out our Mood Meter Survey again this year which will enable the Trust to evaluate the action taken and the progress made in the period of time before the next national survey.

Council of Governors and Members

Our Council of Governors was formed with effect from the 1st October 2008 and was subject to a comprehensive review in 2011.

The Council of Governors is responsible for holding the Trust Board of Directors to account for its stewardship of the organisation; the majority of our Governors are elected through our Membership. The Council consists of 25 Governors in total:

Public elected – 13 Governors
Staff elected – 8 Governors
Appointed from our key stakeholders – 4 Governors

Tables summarising the Council of Governors and the constituencies they represent can be found on pages 37 and 38.

The Trust Board works closely with our Council of Governors with regular Director and Non Executive Director attendance at both full Council meetings and the Committees of the Council. In preparing Trust strategy, the Board has regard to the views of the Council.

The Board is accountable to the Council of Governors ensuring it meets its terms of authorisation. General meetings of the Council of Governors are held in public. During the year 2011/12, the Council of Governors has met formally on six occasions.

A register of interests is maintained by the Trust and is available on request from the Foundation Trust office by calling (01384) 321124 or emailing foundationmembers@dgh.nhs.uk

The Council of Governors operates through the following committees:

- Membership Engagement Committee
- Strategy Committee
- Governance Committee
- Remuneration Committee
- Appointments Committee

The Council of Governors has the following key roles:

- Appointment of the chair, including appraisal and performance management
- Appointment of the Non Executive Directors
- Appointment of external auditors
- Advising the Trust Board on the views of Members and the wider community
- Ensuring the Board of Directors complies with its terms of authorisation and operates within that licence
- Recruitment and engagement of Members
- Advising on strategic direction

Governor attendance at Full Council meetings 2011/12		**Attendance at Council of Governors meetings out of six**
Mr Darren Adams	Public: Stourbridge	5
Mr Nazir Ahmed	Public: Central Dudley	2
Mrs Kacey Akpoteni	Public: Rest of the West Midlands	5
Mr John Balmforth	Public: Halesowen	4
Mrs Jane Beard (end of term 30/9/11)	Public: Halesowen	2 (out of 4)
Mrs Rosemary Bennett (end of term 30/9/11)	Public: North Dudley	1 (out of 4)
Ms Pamela Boucher (end of term 30/9/11)	Appointed: DGH volunteers	4 (out of 4)
Mr Richard Brookes (end of term 30/9/11)	Public: Brierley Hill	2 (out of 4)
Mr Brian Chappell (elected Dec 11)	Public: North Dudley	2 (out of 2)
Mrs Gill Cooper	Appointed: NHS Dudley	4
Mr Ian Dukes	Staff: Medical and Dental	2
Ms Catherine Earle (end of term 30/9/11)	Public: Stourbridge	2 (out of 4)
Mr Robert Edwards (elected Dec 11)	Public: Brierley Hill	2 (out of 2)
Mr Bill Etheridge	Public: North Dudley	3
Cllr Lesley Faulkner	Appointed: Governor: Dudley MBC	2
Dr Parshotam Gupta (end of term 30/9/11)	Public: Central Dudley	0 (out of 4)
Mr Simon Hairsnape (end of term of office 31/10/11)	Appointed: Worcestershire Primary Care Trust	1 (out of 4)
Mrs Joanne Hamilton (elected Dec 11)	Staff: Nursing and Midwifery	2 (out of 2)
Mr Bill Hazelton (elected Dec 11)	Public: Central Dudley	2 (out of 2)
Mr David Heath (elected Dec 11)	Staff: Allied Health Professionals and Healthcare Scientists	2 (out of 2)
Mr Phil Higgins (end of term 31/10/11))	Appointed: West Midlands Ambulance Service	3 (out of 4)
Cllr Anne Hingley (end of term 31/10/11)	Appointed: Wyre Forest District Council	2 (out of 4)
Mr Atif Janjua (end of term of office 30/9/11)	Public: Central Dudley	0
Mrs Karen Jaunzems (elected Dec 11)	Staff: Non Clinical	2 (out of 2)
Mr Rob Johnson	Public: Halesowen	5
Mrs Diane Jones	Public: South Staffordshire	5
Professor Martin Kendall	Appointed: University of Birmingham Medical School	5

Governor attendance at Full Council meetings 2011/12		Attendance at Council of Governors meetings out of six
Professor Linda Lang (end of term 31/10/11)	Appointed: Wolverhampton University School of Health and Wellbeing	2 (out of 4)
Mrs Alison Macefield (elected Dec 11)	Staff: Nursing and Midwifery	2 (out of 2)
Mr David Ore (end of term of office 30/9/11)	Staff: Non Clinical Staff	3 (out of 4)
Ms Stephanie Pritchard (elected Dec 11)	Public: Tipton and Rowley Regis	2 (out of 2)
Mr Major Robins (elected Dec 11)	Public: Stourbridge	2 (out of 2)
Mrs Janet Robinson (end of term of office 30/9/11)	Public: Rowley Regis	1 (out of 4)
Mr Graham Russell (end of term of office 30/9/11)	Staff: Nursing and Midwifery	2 (out of 4)
Mr Roy Savin (end of term of office 30/9/11)	Public: Stourbridge	3 (out of 4)
Mrs Pat Siviter (end of term of office 30/9/11)	Public: Wyre Forest	2 (out of 4)
Mrs Jackie Smith (elected April 11)	Staff: Allied Health Professionals and Healthcare Scientists	4
Ms Jane Southall (end of term of office 30/9/11)	Staff: Nursing & Midwifery	3 (out of 4)
Mr David Stenson (elected Dec 11)	Public: Brierley Hill	2 (out of 2)
Mr Peter Totney (resigned 30/9/11)	Public: Brierley Hill	3 (out of 4)
Mrs Mary Turner (end of term 31/10/11)	Appointed: Dudley Council for Voluntary Service	4 (out of 4)
Mr Terry Venables (elected April 11)	Staff: Partner Organisations' Staff	3
Mrs Julie Walklate (elected Dec 11)	Staff: Nursing and Midwifery	1 (out of 2)
Cllr Steve Waltho (end of term of office 30/9/11)	Public: Brierley Hill	2 (out of 4)
Mr Harvey Woolf (end of term of office 30/9/11)	Public: North Dudley	3 (out of 4)
Board of Directors attendance at full Council of Governor meetings		
Mr Paul Assinder	Director of Finance and Information	5
Mr David Badger	Non Executive Director	6
Mrs Ann Becke	Non Executive Director	1
Mr Richard Beeken	Director of Operations and Transformation	2
Mr David Bland	Non Executive Director	2
Ms Paula Clark	Chief Executive	6
Mr John Edwards	Chairman	6
Mr Jonathan Fellows	Non Executive Director	2
Mr Paul Harrison	Medical Director	2
Mrs Denise McMahon	Nursing Director	4
Mr Richard Miner	Non Executive Director	3
Ms Tessa Norris	Director Community Services & Integrated Care	6
Ms Annette Reeves	Head of Human Resources	5
Mrs Kathryn Williets	Non Executive Director	2

Council of Governors Review 2011/12

Each year the Council review their effectiveness and during 2011/12 the Council chose to work closely with the Trust Board and Deloitte to complete this task. This included a review of the composition of the governing body and proposals to merge some of our constituencies. In October 2011 Monitor, independent regulator of foundation trusts, approved the following changes.

Constituency/Class	No. of Governors
Public	
Brierley Hill Ward	2 *(formerly 3)*
Central Dudley Ward	2 *(formerly 3)*
North Dudley Ward	2 *(formerly 3)*
Stourbridge Ward	2 *(formerly 3)*
Halesowen Ward	2 *(formerly 3)*
Tipton and Rowley Regis *(formerly two separate constituencies)*	1
South Staffordshire and Wyre Forest *(formerly two separate constituencies)*	1
Rest of West Midlands	1
Total Public	**13** *(formerly 20)*
Staff	
Medical and Dental	1
Nursing and Midwifery	3 *(formerly 2)*
Allied Health Professionals and Healthcare Scientists	2 *(formerly 1)*
Non clinical	1
Partner organisations	1
Total Staff	**8** *(formerly 6)*
Appointed (by a statutory or partnership organisation)	
NHS Dudley	1
Dudley Metropolitan Borough Council	1
University of Birmingham Medical School	1
Governor appointed by Dudley Council for Voluntary Service, who may be a Dudley Group NHS Foundation Trust Hospital Volunteer.	1
Total Appointed	**4** *(formerly 13)*
Grand Total	**25** *(formerly 39)*

Membership of Council Committees 2011/12
Governor lead responsibilities:

- **Mr Darren Adams**
  Lead Governor
  Chair, Membership Engagement Committee
  Chair, Remuneration Committee

- **Mr Rob Johnson**
  Chair, Governance Committee

- **Mr John Balmforth**
  Chair, Strategy Committee

- **Professor Martin Kendall**
  Chair, Appointments Committee

Governor resignations, elections and re-appointments
The Trust received one resignation during the year:

Governor	Constituency
Mr Peter Totney	Public: Brierley Hill

At the end of September 2011 some of our Governors who had been with us since achieving foundation trust status in October 2008, reached the end of their first three year term of office and elections were held to elect Governors to the vacant posts once the changes to the Trust Constitution had been approved by Monitor. The Trust saw an unprecedented number of candidates come forward; a total of 42 candidates for 15 vacancies.

In accordance with our Constitution, the Trust uses the method of single transferable voting for all elections. This system allows voters to rank candidates in order of preference and, after candidates have either, been elected or eliminated, unused votes are transferred according to the voters next stated preference.

Electoral Reform Service (ERS), which is an external agent, was appointed by the Trust to oversee the election process.

The election process concluded in December 2011 and returned the following Governors for a three year term:

Public Elected Governors	Constituency
Mr David Stenson	Public: Brierley Hill
Mr Robert Edwards	Public: Brierley Hill
Mr Bill Hazelton	Public: Central Dudley
Mr Brian Chappell	Public: North Dudley
Mr Rob Johnson	Public: Halesowen
Mr John Balmforth	Public: Halesowen
Mr Darren Adams	Public: Stourbridge
Mr Major Robins	Public: Stourbridge
Mrs Diane Jones	Public: South Staffordshire and Wyre Forest
Ms Stephanie Pritchard	Public: Tipton and Rowley Regis
Staff Elected Governors	**Staff Group**
Mr David Heath	Staff: Allied Health Professionals and Health Care Scientists
Mrs Karen Jaunzems	Staff: Non Clinical Staff
Mrs Joanne Hamilton	Staff: Nursing and Midwifery
Mrs Julie Walklate	Staff: Nursing and Midwifery
Mrs Alison Macefield	Staff: Nursing and Midwifery

The following organisation re-appointed a Governor for a further three year term to serve on the Council of Governors:

Appointed Governor	Appointing organisation
Professor Martin Kendall	University of Birmingham Medical School

Governors who are 'mid term' are listed along with their end of term of office scheduled at the end of the month noted as per list below:

Public Elected Governors	**Constituency**	**End of term of office**
Mr Nazir Ahmed	Public: Central Dudley	June 2013
Mr Bill Etheridge	Public: North Dudley	June 2013
Mrs Kacey Akpoteni	Public: Rest of the West Midlands	March 2013
Staff Elected Governors	**Staff Group**	
Mrs Jackie Smith	Staff: Allied Health Professionals and Health Care Scientists	March 2014
Mr Ian Dukes	Staff: Medical and Dental	February 2013
Mr Terry Venables	Staff: Partner Organisations' Staff	March 2014
Appointed Governors (Nominated)		
Mrs Gill Cooper	NHS Dudley	June 2013
Awaiting appointment	Dudley Council for Voluntary Service	------
Councillor Lesley Faulkner	Dudley Metropolitan Borough Council	March 2012

For a full list of current Governors, visit the Trust website at www.dudleygroup.nhs.uk

Engagement with Governors and Members
The Trust encourages and supports Governors in raising public awareness of the work of the Trust and their role within their constituencies. The 'out there' initiative continues to support Governors to undertake their important role in finding out what people think about the Trust and bringing that feedback to the Trust Board of Directors.

Throughout the year Governors have been busy out and about in their communities and have attended a number of community and support groups, including Lung Rehabilitation Support Group, Pilkington, Sedgley Townswomen Guild, Gornal and Sedgley Cancer Support Group, Stourbridge Rotary, West Midlands Pensioners Convention and Dudley Stroke Association. Governors have also participated in various other community events including Dudley College Freshers Fayre, Halesowen College Health and Environment Day, Older Peoples Forum, and BME engagement events.

Council of Governors meetings are held quarterly and Trust Members and the wider public are welcome to attend and observe. They are regularly attended by Executive and Non Executive Directors and often include presentations and question and answer sessions with key clinicians and staff from across the Trust to help Governors understand how the organisation works. Approved minutes from the full Council of Governor meetings can be found on the Trust website at www.dudleygroup.nhs.uk

Following receipt of an External Review of Governor Effectiveness report in the summer of 2011 and Governor elections in the autumn of 2011 the committee structure supporting the effective working of the Council of Governors was reviewed and redesigned. Three committees have now been established with Governor members and with Executive and Non Executive Directors nominated to attend. Terms of reference have been developed and ratified by the full Council of Governors. These committees focus on:

- Strategy
- Governance and Assurance
- Membership Engagement

Training is provided allowing experts from within and outside the Trust to work with Governors to identify key aspects of their role including how they influence strategy within the Trust, how they undertake their secondary governance duties and how they will engage with members and the wider community so that their views and opinions can be heard.

During the first quarter of 2012/13 work plans will be developed so that the impact of the work undertaken by Governors can be monitored to show the added value their role brings to the Trust's wider patient and public engagement strategies.

Contact procedures for people to talk to their Governors and/or Directors of the Trust Board

There are several ways our Trust Members or members of the public can contact either their Governor or a member of the Trust Board of Directors:

- At our public Council of Governors meetings
- At our Annual Members' Meeting

For dates and times for these and other Members events, please contact the Foundation Trust office:

- Telephone: (01384) 321124
- Email: foundationmembers@dgh.nhs.uk or governors@dgh.nhs.uk
- Write to: Freepost RSEH-CUZB-SJEG, 2nd Floor C Block, Russells Hall Hospital, Pensnett Road, Dudley, DY1 2HQ

Several of our Governors are also happy to be contacted directly and their details can be found on the Members section of our website or via telephone (01384) 321124.

Membership recruitment and engagement

Our Members are local people and staff from all walks of life and to be eligible for membership must be over 14 years of age – there is no upper age limit. Full details of who is eligible to register as a Member of the Trust is contained within our Trust Constitution which is available at www.dudleygroup.nhs.uk. Any public Members wishing to come forward as Governor when vacancies arise or vote in Governor Elections must reside in one of our constituencies. Trust staff are automatically included as a Member within the staff groups as set out on page 42 unless they choose to opt out.

This year we have continued to promote Trust Membership to our local communities and the importance of having a voice by encouraging them to share with us their experiences. All of our events this year have been successful in terms of promoting the Trust and have also been successful in increasing Membership as a whole, including our underrepresented groups. The table below shows the top five most successful recruitment activities.

Top five most successful recruitment activities during 2011/12

Date		Members recruited
23/11/11	Health and Environment Fair – Halesowen College	379
15/09/11	Dudley College Freshers Fayre	200
2011/12	Volunteers/via post/through Governors	216
2011/12	From appointment letters	51
21/09/11	Peters Hill Primary School open evening	35

At the end of March 2012 we had a total of 12,505 public members (including those outside of the West Midlands).

Membership growth and Target for 2012/13

Membership sector	31/03/2011 actual	31/03/2012 actual	2012/2013 projected
Public (including outside of the West Midlands)	11,692	12,505	13,000
Staff	4,391	5,165	5,175
Total	16,083	17,670	18,175

Our recruitment strategy for 2012/13 is to focus on developing opportunities to reach our target of 13,000 public Members by the end of March 2013, refine recruitment activity to target areas of shortfall and continue to strive to ensure our Membership is reflective of the communities we serve. Our strategy also includes developing more opportunities for engaging with our Members to gain feedback that the Trust can use to improve the patient experience.

Our 'Meet your Experts' health fair events and behind-the-scenes tours continue to prove a real success with both our Trust Members and members of the wider community. Many have provided valuable feedback and learned more about our services, including some of our younger Members who show a keen interest in the work of our hospitals as a potential career choice. We have hosted seven Member events, ranging from health fairs to behind-the-scenes tours and seminars, with 346 Members and their guests attending.

We also aim to recruit Members who wish to be actively involved with the Trust. There are two levels of Membership: passive and active. We are pleased that we have increased our total 'active' Membership to 3,600 (excluding those living outside of the West Midlands).

All Members will continue to receive information about the Trust via our quarterly magazine 'Your Trust' and also:

- Be involved in shaping the future of healthcare in Dudley by sharing their views*
- Be able to vote in Governor elections*
- Be able to stand for election to represent their constituency*
- Be invited to attend our health fairs and Member tours

* excluding those living outside of the West Midlands

Membership report as at 31st March 2012

Public constituencies	Number of members
Brierley Hill	1,588
Central Dudley	2,128
Halesowen	1,086
North Dudley	1,294
Rest of West Midlands	1,240
South Staffordshire and Wyre Forest	1,235

Stourbridge	1,590
Tipton and Rowley Regis	2,116
Total Public Members *(excluding outside of the West Midlands)*	**12,277**
Staff constituencies	**Number of members**
Medical and Dental	486
Nursing and Midwifery	2,518
Allied Health Professionals and Health Care Scientists	626
Non Clinical	883
Partner Organisations	652
Total Staff Members	**5,165**

Membership breakdown by age, gender and ethnicity

	Membership	
	31st March 2011	**31st March 2012**
0-16	191	168
17-21	1,749	2,176
22+	9,380	9,552
Not stated	372	609
Male	4,405	4,755
Female	7,287	7,750
White	10,232	10,582
Mixed	220	295
Asian or Asian British	761	844
Black or Black British	242	285
Other	61	68
Not stated	176	431

Board of Directors

The Board of Directors was established and constituted to meet legal minimum requirements as stated in the Health and Social Care (Community Health and Standards) Act 2003, and the requirements of the NHS Foundation Trust Code of Corporate Governance published by Monitor.

A Board evaluation process is in place to enable it to undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors, in line with the Combined Code.

The Board of Directors Nominations Committee works closely with the Council of Governors' Appointments Committee to review the balance and appropriateness of Board members skills and competencies. Board effectiveness is assessed annually and the process is monitored by the Appointments Committee. The Board is satisfied that the balance experience and skill set of Board members remains fit for purpose.

Non Executive Directors can only be removed by a 75 per cent vote of the Council of Governors following a formal investigatory process, and the taking of independent legal advice, in accordance with guidance issued by Monitor.

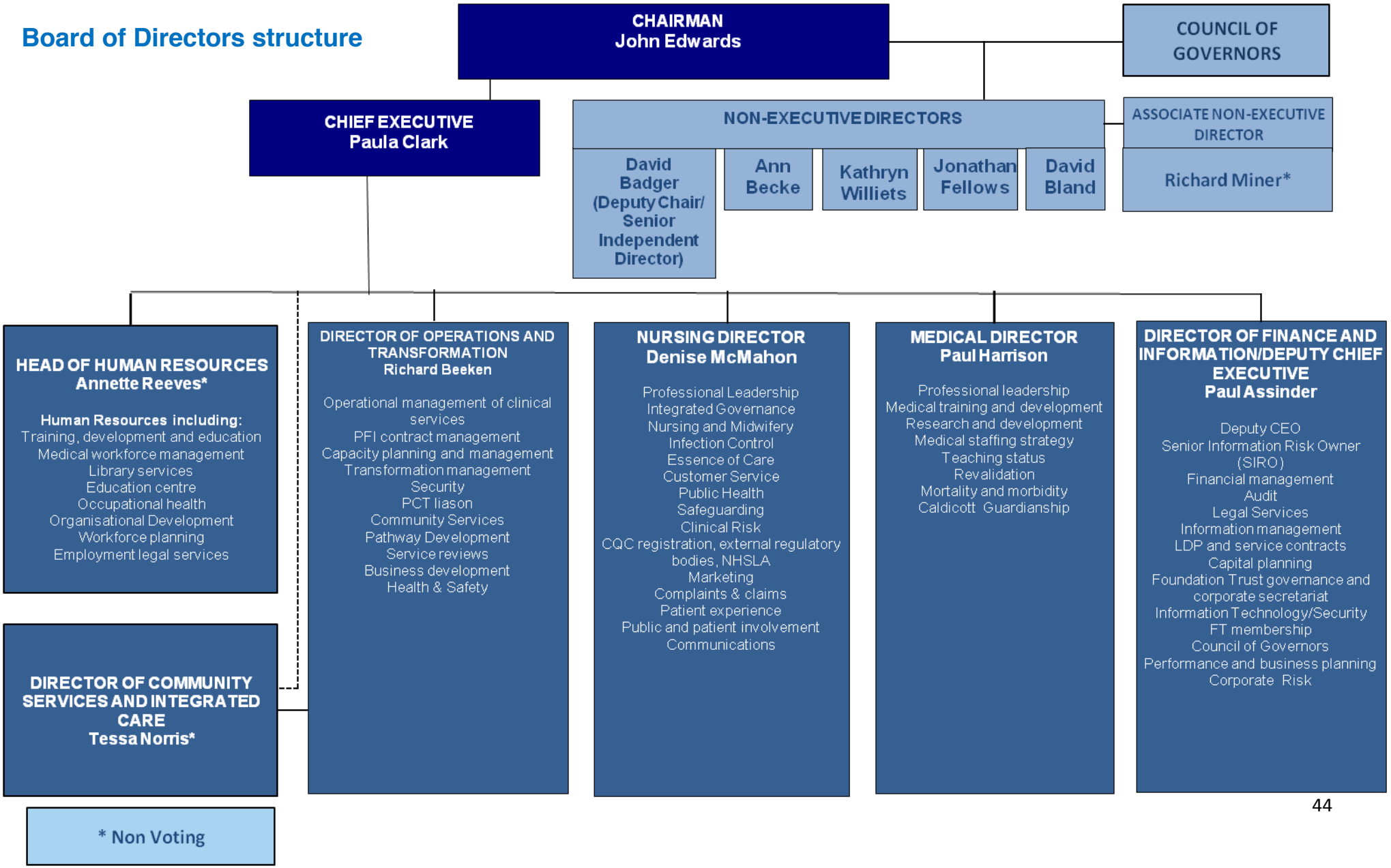
A Register of Directors' Interests is held by the Board Secretary and is available for inspection on request.

Directors in post during the financial year

Position	Name	Commencing	End
Chairman	John Edwards	01.11.10	31.10.13
Chief Executive	Paula Clark	01.10.09	
Director of Finance and Information	Paul Assinder	22.08.05	
Director of Operations and Transformation	Richard Beeken	15.06.10	
Medical Director	Paul Harrison	01.06.06	
Nursing Director	Denise McMahon	12.05.08	
Non Executive Director/Deputy Chairman and Senior Independent Director	David Badger	01.12.02	31.12.12
Non Executive Director	Ann Becke	01.11.05	30.10.12
Non Executive Director	Jonathan Fellows	25.10.07	30.09.14
Non Executive Director	Kathryn Williets	01.05.04	30.04.12
Non Executive Director	David Bland	01.08.10	31.07.13
Association Non Executive Director	Richard Miner	01.10.10	30.09.13

More detailed information about each Director can be found on pages 45 onwards.

Board of Directors structure



John Edwards CBE – Chairman
John joined the Trust on 1st November 2010. He is the former Chief Executive Officer of Advantage West Midlands (AWM), the regional development agency. In 2008, John was awarded a CBE for services to the regional economy.

John is a Quantity Surveyor and Project Director by profession and spent his early career in the private sector. He joined the Rural Development Commission, where he worked in a number of operational roles and finally as Chief Executive. Continuing his interest in economic development and regeneration, John joined Business in the Community in 1998 as Managing Director of Regeneration.

John joined AWM in 2000 where he oversaw an investment budget of £350m. AWM was independently evaluated, by the National Audit Office, as an excellent organisation achieving the maximum 4 star rating and by PWC as the most effective of the Regional Development Agencies with every £ invested delivering over £8 of benefit for the West Midlands.

Since 2008 he has continued to advise both government bodies and private companies on strategic economic regeneration policies and their impacts. John is a Consultant to Squires, Sanders & Dempsey (UK) LLP an international law practice. He is also a Principal Fellow at the University of Warwick's Warwick Manufacturing Group (WMG) where he is overseeing the development of the International Institute for Product and Services Innovation (IIPSI), John chairs the IIPSI Board.

John is committed to help lead The Dudley Group to become an even better performing organisation committed to providing the best quality care to all our patients.

Non Executive Directors

David Badger – Non Executive Director, Deputy Chairman and Senior Independent Director
David was appointed as a Non Executive Director in 2002 following many years' experience of public service in local authority and community regeneration settings. David led many education, training and health initiatives which involved local communities through the development of stakeholder groups as well as community participation in strategic planning.

Management roles included direct responsibility for major capital and revenue budgets, Private Finance Initiatives for schools, school governance and financing and human resources.

Appointed as Deputy Chairman and Senior Independent Director of the Trust in 2008, David is committed to the continuing development of the Trust and the relationship with the local community. To this end he is particularly keen to promote and support relationships between the Trust Board, Governors and our Members.

Ann Becke – Non Executive Director
Ann brings to the Trust 26 years experience in global sales and marketing as Head of Professional Services for BT. Her career has been mainly in consultative sales and sales management where she provided strategic direction and leadership.

A graduate in World Class Service Management from Leeds University, she is a trained coach and mentor and was instrumental in setting up a global BT external client 'women in business' network to promote talent in the boardroom. Recognised as a member of the BT talent pool she was also a role model for the delivery of inspirational leadership, customer satisfaction and diversity. She was also a member of the PPI (Patient and Public Involvement forum) gaining valuable insight into the NHS.

In her role as a Non Executive Director, Ann is Chair of the Risk and Assurance Committee, a member of the art and environment group and is the lead for Safeguarding, both within the Trust and the wider health economy. She is also a Trustee of Dudley Clinical Education Centre's Charity and represents the Trust on the Dudley Children's Partnership Board.

Ann has been Chair and Vice-Chair of the Chernobyl Children's Lifeline (Wolverhampton/Kinver Link) charity for the past 18 years and is actively involved in both the local and business community raising awareness and significant funding to support the aims of the charity. In 2009 Ann received an award for outstanding service in the local community for her work with local charities and groups.

David Bland – Non Executive Director
David joined the Trust in August 2010 and brings extensive senior level experience, particularly in running complex multi-site service businesses. He has a strong mix of strategic and operational skills developed during many years of international consultancy work.

From his time in the hospitality industry with Bass plc and Intercontinental Hotels Group plc, David brings a real understanding of how to deliver excellent and consistent customer service.

More recently, David has been working with a number of private equity-backed companies, as well as acting as a mentor to several young people starting businesses with the Prince's Trust.

Jonathan Fellows – Non Executive Director
Jonathan held executive roles on the boards of several large publicly listed companies before spending eight years successfully leading and growing private equity backed businesses.

He has extensive experience of raising finance, particularly for major capital projects, as well as developing business strategy and improving customer service, PR and communications.

Jonathan is a Fellow of the Chartered Association of Certified Accountants, a member of the Association of Corporate Treasurers and Chair of the Trust Audit Committee.

Richard Miner – Associate Non Executive Director
Richard is a Chartered Accountant by profession and has worked for many years with entrepreneurial and growing businesses, having held senior positions in both practice and industry. He was previously a Non Executive Director at NHS Birmingham East and North where he chaired the Audit Committee and the World Class Commissioning Programme Board.

Richard is a member of the Finance and Performance and Audit Committees as well as taking non-executive responsibility for Adult Community Services. From May 2012 Richard's role will change from Associate Non Executive Director to Non Executive Director and he will chair the Charitable Funds Working Group.

Kathryn Williets – Non Executive Director
Kathryn joined the Trust as a Non Executive Director in May 2004, bringing with her a background in criminal, family and childcare law. She qualified at the Bar in 1989 and then re-qualified as a solicitor in 1994. She holds a teaching qualification and has taught in a range of legal subjects. Kathryn is a member of the Law Society.

Kathryn is currently a sole practitioner providing agency services to other solicitors' firms, and to Local Authorities, in the areas of childcare and family law. She lives in Halesowen. She spent some years involved in school governance, and is a former Chair of the Governing Body at Manor Way Primary School.

During the process to achieve Foundation Trust status, Kathryn delivered presentations to stakeholders, partners and the public. As a member of the Trust Board, Kathryn is interested in public and patient issues, especially those surrounding elderly care. She is also keen to contribute to audit and governance policies implemented by the Trust. She chairs the Charitable Funds working group. She is the Trust lead on issues of patient safety and security management.

Kathryn's term of office with Trust ends on 30th April 2012 and she has decided to step down from the Board at this point. The Trust thanks Kathryn for her support and dedication during her eight years' service.

Executive Directors

Paula Clark – Chief Executive
Paula joined the Trust as Chief Executive on 1st October 2009 from Burton Hospitals NHS Foundation Trust.

During her four years as Chief Executive of Burton Hospitals, she led the trust through turn-round and on to Foundation Trust status in 2008.

Paula has worked in the NHS for the past 21 years, with 13 years at Chief Executive level.

Her career in the NHS has spanned a wide range of sectors, including Chief Executive of Erewash Primary Care Trust and senior roles at Southern Derbyshire Health Authority, Nottingham City Hospital and Derbyshire Ambulance Service. Before joining the NHS, Paula worked in sales and marketing in the pharmaceutical industry and was a member of the Chartered Institute of Marketing. She was also a lecturer in Marketing and Business Studies at Clarendon College, in Nottingham, and led their public relations function.

Paul Assinder – Director of Finance and Information
Paul brings to the Trust Board 32 years of experience in financial management and audit in large commercial and NHS organisations. With the last 21 years of his career at Finance Director level, Paul has significant experience of Board level challenges. This has included negotiating a major Private Finance Initiative deal to a financial close.

Today, as the Director of Finance and Information for The Dudley Group, one of his roles is to develop and implement the financial aspects of the Trust's strategy. While championing the highest financial standards, audit and governance standards, Paul is also interested in developing clinical performance and accountability frameworks. He is leading the Trust's Service Line Performance Management Initiative.

Qualified as a chartered and certified accountant, with a degree in Economics and Management, Paul has written widely and lectured on NHS finance matters.

He is a member of a wide range of professional bodies and networks and is a trustee of the Healthcare Financial Management Association.

Richard Beeken – Director of Operations and Transformation
Richard joined the Trust in June 2010 from South Staffordshire and Shropshire Healthcare NHS Foundation Trust where he spent two-and-a-half years as Chief Operating Officer.

He has held a variety of senior positions within the NHS since graduating from the NHS Management Training Scheme. This is his third Executive Director post.
He has worked as Divisional Manager of Surgical Services at Royal Wolverhampton Hospitals and Chief Operating Officer at Birmingham Children's Hospital before moving to South Staffordshire and Shropshire Healthcare NHS Foundation Trust in 2007.

Richard is responsible for service delivery in our clinical services, delivered through our clinical directorate structure, as well as leading on the Trust-wide Transformation programme which aims to deliver efficiency and quality gains in the future through effective service redesign. Richard is also the executive responsible for Facilities and Estates through the management of the PFI contract.

Paul Harrison – Medical Director
As Medical Director and Consultant Haematologist, Paul has a varied role with both clinical and managerial responsibilities.

His medical background as a Haematologist has given him wide clinical experience and he is a Fellow of both the Royal College of Physicians and the Royal College of Pathologists. He is particularly interested in medical education and has served as Regional Specialty Advisor for both the Royal College of Physicians and the Royal College of Pathologists.

He has previously chaired both the Regional Training Committee and the Haematology Specialty Advisory Committee and was also previously an examiner for the Royal College of Pathologists. Paul currently sits on the Royal College of Physicians' Regional Advisers and Specialty Representatives Group and is a CPD Approver for the Royal College of Physicians. He is called upon to lecture and advise on a variety of clinical, managerial and professional topics and has previously been a member of the HRG Expert Working Group.

He previously undertook the role of Lead Cancer Clinician during which time he successfully expanded cancer services while maintaining financial balance, ensuring the Trust met cancer waiting time targets.

Key operational achievements have involved the establishment of new services in Dudley. These include a nurse-led open access deep vein thrombosis diagnostic/treatment service and a peripheral blood stem cell transplantation programme. He also reconfigured working practices in the Haematology department to develop a fully integrated team-based approach by medical staff.

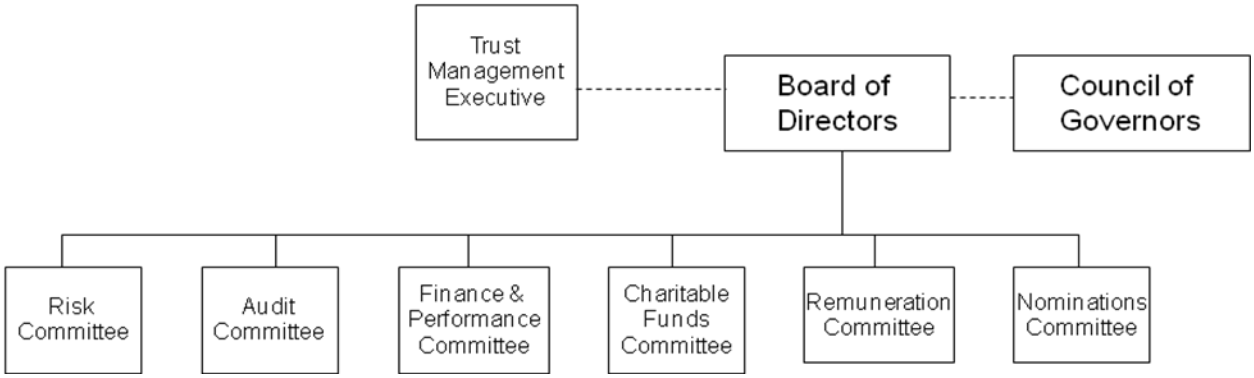
Denise McMahon – Nursing Director
A nurse for 30 years, Denise started her nurse training in 1978 at Walsall Manor Hospital having been a nurse cadet for two years.

Denise was a senior nurse in medicine and then a general manager for medicine and surgery until she became Deputy Nurse Director in 1997. Two years later, she moved to the Royal Orthopaedic Hospital, in Birmingham, as Director of Nursing and Operations and then on to Kettering General in 2001 as Director of Nursing and Midwifery.

In addition to her corporate responsibilities as Director of Nursing, specific responsibilities include professional leadership for the nursing and midwifery strategy and Director of Infection Prevention and Control, a role in which she has considerable experience. She also holds the Director lead role for Governance. Denise is passionate about patient care and has continued to do clinical shifts throughout her career.

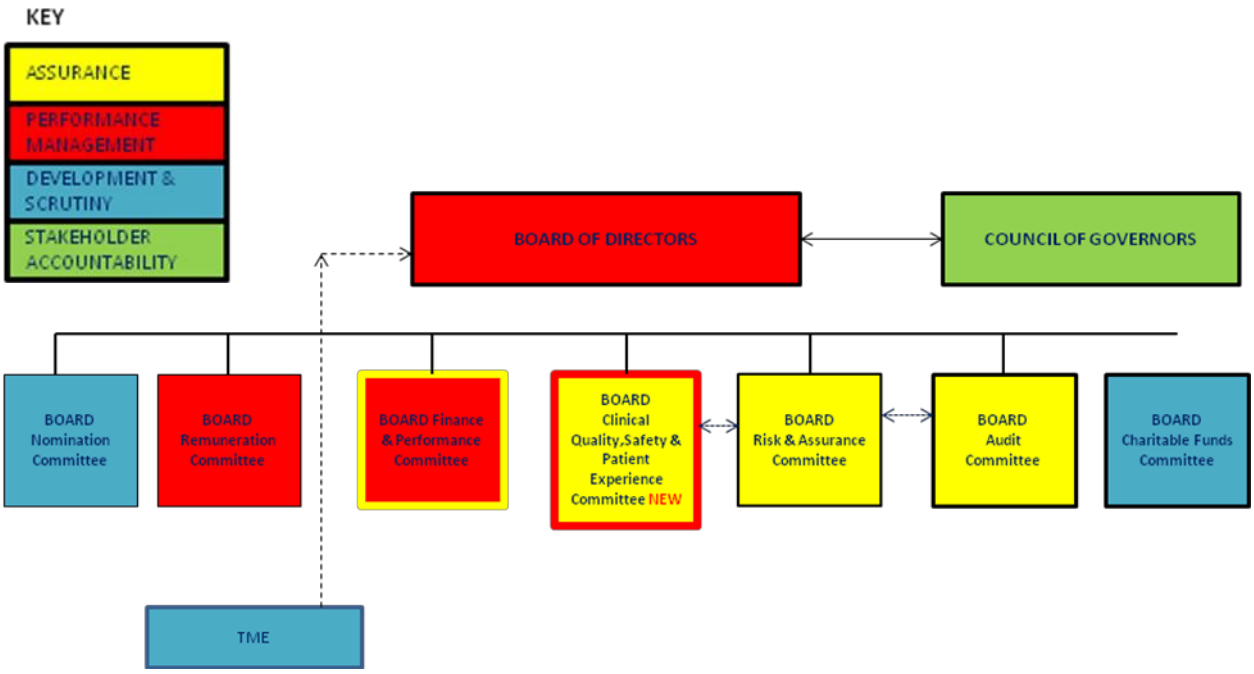
Board of Directors Committees

Structure 2011/12



In January 2012 the Board of Directors reviewed their Committee structure and recognising the broadening Quality Agenda, established a new Clinical Quality, Safety and Patient Experience Committee to provide dedicated time and appropriate resource to this. At the same time the role of the Risk Committee was expanded to include assurance and now has responsibility for the risk, control and governance processes which have been established across the Trust. The Terms of Reference for the remaining Committees were reviewed and updated to reflect changes to membership and to the supporting working groups. Changes came into effect on the 1st April 2012 for the 2012/13 year.

Structure 2012/13



Board and committee meetings attendance

		Attendance at Board of Directors out of 11
John Edwards	Chair	11
David Badger	Non Executive Director/ Deputy Chair/ Senior Independent Director	10
Ann Becke	Non Executive Director	7
Jonathan Fellows	Non Executive Director	10
Kathryn Williets	Non Executive Director	10
David Bland	Non Executive Director	11
Richard Miner	Associate Non Executive Director	11
Paula Clark	Chief Executive	10
Paul Assinder	Director of Finance and Information	9
Paul Harrison	Medical Director	11
Denise McMahon	Nursing Director	9
Richard Beeken	Director of Operations and Transformation	11

Audit Committee

The Audit Committee provides the Trust Board with an objective view of the financial systems used by the Trust and makes sure the statutory obligations, legal requirements and codes of conduct are followed.

The Audit Committee has met four times during the year and has reviewed its effectiveness and reported this to the Board of Directors. The Committee has fully discharged its responsibilities for reviewing the effectiveness of systems of internal control and governance.

Audit Committee membership		**Attendance out of 4**
Jonathan Fellows	Non Executive Director (Committee Chair)	4
David Bland	Non Executive Director	1
David Badger	Non Executive Director	3
Kathryn Williets	Non Executive Director	3
Ann Becke	Non Executive Director	3
In attendance		
Paula Clark	Chief Executive	3
Paul Assinder	Director of Finance and Information	4
Denise McMahon	Nursing Director	3
Deloitte LLP	External auditors representative	4
RSM Tenon	Internal auditors representative	4
Richard Miner	Associate Non Executive Director	3

Independence of external auditor
The Trust has a policy in place for the approval of additional services by the external auditor to ensure that the independence of the external auditor is not compromised where work outside the audit code has been purchased.

Nomination Committee
The Trust's Nomination Committee meetings are called on an ad hoc basis when an appointment needs to be made. The Committee operates to review and evaluate the Board structure and expertise, as well as to agree a job description and person specification for the appointments of the Chief Executive and Executive Directors. The Committee also identifies and nominates suitable candidates for such vacancies and recommends its proposed appointment for Chief Executive to the Council of Governors. One meeting was held during 2011/12.

Nomination Committee membership		**Attendance out of 1**
John Edwards	Chairman (Committee Chair)	1
Jonathan Fellows	Non Executive Director	1
David Bland	Non Executive Director	1
David Badger	Non Executive Director	1
Kathryn Williets	Non Executive Director	1
Ann Becke	Non Executive Director	1
In attendance		
Paula Clark	Chief Executive	1
Paul Assinder	Director of Finance and Information	1
Annette Reeves	Head of Human Resources	1
Richard Miner	Associate Non Executive Director	1

Sustainability Report

The Trust takes its sustainability responsibilities very seriously and the Sustainability Development Unit sets in its 'NHS Carbon Reduction Strategy' the contributions the NHS can make to reduce its carbon impact. The Trust supports the view that it should measure and progressively reduce its own carbon footprint in order to save resources and contribute to reducing the impact of its activities on the environment.

We work very closely in this matter with our Private Finance Initiative (PFI) partner, Summit Healthcare, who has a responsibility under the PFI contract to purchase utility resources and manage their effective use and also to dispose of waste that is created by the Trust and its partners. The Trust has a Sustainable Development Group comprising senior technical, financial and procurement management personnel, drawn from the Trust and its PFI partner, whose responsibilities are directly linked to the environmental agenda.

Target areas at present are the procurement process of the Trust, the segregation of waste materials and the effective use of energy.

Our Strategy
The Trust's overall sustainability strategy has been developed in the context of having re-developed the hospitals as part of a major PFI including installing energy efficient new plant in modern healthcare facilities. Supporting the district general hospital at Russells Hall are two outpatient centres that help minimise travel distances for patients.

The Trust's strategy can be considered under six headings:

- Building Energy Management
- Travel
- Procurement
- IT
- Waste/recycling
- Raising awareness

<u>Building Energy Management</u>
During the year, a new Energy Group was set up aligning the sustainability agenda for energy with the PFI contract efficiency process to reduce costs. Tenders will be evaluated for a major energy reduction company to advise the Trust on the way forward.

Travel
The Trust will continue to work with its 'Green Travel Plan' designed to reduce car journeys by 10 per cent over a five-year period (base line year is 2010) and evaluate the recent car park charges and restrictions on parking for staff.

Procurement
The Trust will continue to follow good practice in the procurement of sustainable products by following the Office of Government list of Sustainability Minimum Mandatory Standards 'Quick Wins'. The Trust Board have approved a Trust wide 'Sustainable Procurement Policy.'

IT
The Trust will continue to purchase IT equipment (through Siemens Plc) from market leaders in the manufacture of environmentally responsible equipment.

Waste/recycling
The Trust has set up a waste/recycling group to improve its arrangements for controlling waste and recycling. This Committee reports to the Sustainable Development Group on a regular basis. Recent initiatives include the following:

- Cardboard recycling has increased to approximately three tonnes per week
- Batteries are collected from various wards and departments to enable recycling
- Sharps are dealt with by a system called 'Sharpsmart' reducing the amount of plastic incinerated by utilising a re-usable container and is regularly audited
- Much clinical waste is recycled following 'alternative treatments'

Raising awareness
The Sustainable Development Group will work with the communications manager to raise awareness about the sustainability agenda among staff and the Trust's stakeholders.

Governance
The Trust's Sustainable Development Group is responsible through the Trust Management Executive to the Trust Board of Directors. The group is chaired by the Trust's Deputy Director of Operations. An annual energy and carbon reduction report to the Trust Board will monitor and show how the Trust and its PFI Partners are progressing.

Summary of Performance
There are a number of contributing factors which relate to the efficiency and effectiveness of using energy and other utility services in the Trust at the present time:

(a) The increased demand for cooling facilities within clinical areas of the estate. Large areas of the hospital are ventilated by natural ventilation only

(b) The increased use of modern computer technology and the tendency for staff to leave equipment on standby when not in use

(c) The use of the hydrotherapy pool facilities

(d) Though there are areas of the buildings that have movement sensors fitted to the lighting systems, there are significant other areas where the lighting is left on. This needs to be managed and controlled by those who use the facilities

Area	Measure	Non-Financial data (applicable metric)	Non-Financial data (applicable metric)	Financial data (£)	Financial data (£)
		2010/11	**2011/12**	**2010/11**	**2011/12**
Greenhouse Gas Emissions **kwh**	Electricity (kwh) Gas (kwh) Oil (kwh)	16,353,056 kwh 57,101,132 kwh 2,927,778 kwh	17,682,611 kwh 56,689,651 kwh 1,551,731 kwh	£1,082,520 £1,159,368 £ 128,770	£1,380,741 £1,389,880 £ 87,438
Waste Minimisation and Management	Absolute values for total amount of waste produced by the Trust (tonnes) Methods of disposal	1774.32 tonnes Landfill = 484.54 tonnes Recycled = 189.33 tonnes Treated waste = 1,100.45 tonnes	1516.80 Tonnes Landfill = 396 tonnes Recycled = 210 tonnes Sharps Waste = 34.80 tonnes Treated waste = 876 tonnes	£434,520.18 £34,523.47 £2,794.76 £397,201.95	£ 447,036 £ 35,640 £ 6,300 £ 102,000 £ 303,096
Finite Resources	Water (metre cubed)	187,929 M^3	173,257 M^3	£367,638*	£145,330

Area	Measure	Non-Financial data (applicable metric)	Non-Financial data (applicable metric)	Financial data (£)	Financial data (£)
		2010/11	2011/12	2010/11	2011/12
Emissions EUETS (Tonnes of $CO^{2)}$	Tonnes	11,064	10,191		
Electricity (Tonnes of $CO^{2)}$	Tonnes	8,825	**		

***** Figures include sewage charge

** Figures unavailable at the time of audit

Electricity generated on site from CHP is approximately 28%.

Regulatory Ratings

The Trust set the 2011/12 regulatory ratings plan based on the annual risk assessment of the coming financial year 2011/12. Analysis for each area of rating compared with that expected in the annual plan is summarised below:

Financial risk rating
The Trust planned for a rating of '3' in the annual plan. The Trust entered the Financial Year with a challenging cost improvement programme. This was also on the back of a reduction in the amount of income the Trust would receive as a result of changes to the Payment by Results (PBR) system and local commissioning intentions. The Trust's overall performance for the year showed an Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) margin of £20.6m, 7.2 per cent, equivalent to £1m below plan and net surplus at £627k, £127k above plan. Although the Trust encountered a difficult 2011/12 financially we were still able to deliver a rating of '3' on our final outturn.

Governance risk rating
The Trust planned for a rating of 'Green' in the annual plan. During the year the Trust exceeded its annual C. diff target of 77 with reported cases of 113. The majority of the cases occurred in the first half of the financial year. The Trust was compliant with this target in Quarter 4 with lower reported cases than plan. The CQC have stated that the Trust is compliant with all essential standards of quality and safety but it has a single 'major' concern and an associated compliance action outstanding against CQC outcome 8 (cleanliness and infection control). This relates exclusively to excess C. diff numbers in the first half of 2011/12 and have caused the Trust to continue to have a final governance rating of 'Amber-Red'. The Trust is confident that this rating will increase to 'Amber-Green' in Quarter 1 of 2012/13 given the current achievement of the C. diff target.

Mandatory services
The Trust planned for a rating of 'Green' in the annual plan. The Trust made no changes to the range of services provided, nor to mandatory assets, during the year. A rating of 'Green' was maintained throughout all quarters.

Ratings for 2011/12

2011/12	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Amber-Red	Amber-Red	Amber-Red	Amber-Red
Mandatory services	Green	Green	Green	Green	Green

Ratings for 2010/11

2010/11	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	3	3	3	3	3
Governance risk rating	Amber-Green	Red	Red	Amber-Green	Amber-Green
Mandatory services	Green	Green	Green	Green	Green

Financial performance

In line with the rest of the NHS, the Trust has faced a challenging year financially in 2011/12. Total income has increased by 1.9 per cent, to £284.8 million, above the previous year, representing a real terms reduction to overall funding.

The Trust recorded an Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA) of £20.6 million which equates to 7.2 per cent of turnover.

In overall terms the Trust has achieved an overall Financial Risk Rating of 3 by Monitor.

The key financial impact experienced by the Trust continues to be linked to the new payment rules regarding a 30 per cent marginal payment for non-elective admissions over a specified emergency activity threshold. Continued growth in non-elective work resulted in the opening of additional beds and the knock-on cancellation of elective work. The increased stepped costs required to deliver this additional work is not appropriately funded under this particular regime, resulting in estimated lost income of approximately £4.2m. The impact of other specific finance rule changes, including the non-payment for a non-elective re-admission within 30 days were successfully mitigated via a partnership approach with Dudley PCT.

Table 1 highlights the impact of the above, showing the significant increase in expenditure over plan that exceeded the level of income growth. Although EBITDA was lower than plan the overall surplus was higher by £127k. This was predominantly due to a profit on sale of surplus residential properties and a lower PDC dividend liability than planned.

Table 1: Trust Financial Performance 2011/12

	Plan	Actual	Variance
	£000's	£000's	£000's
Income	279,438	284,825	5,387
Expenditure	(257,839)	(264,233)	(6,394)
EBITDA	**21,599**	**20,592**	**(1,007)**
Net Surplus	**500**	**627**	**127**
EBITDA Margin	7.7%	7.2%	(0.5%)
EBITDA % Plan Achieved	87.9%	95.8%	7.9%
Return on Capital Employed	5.4%	4.9%	(0.5%)
IS Surplus Margin	0.4%	0.2%	(0.2%)
Liquidity Days	37.3	40.7	3.4

Income and Expenditure
The table below compares the original planned income and expenditure with the outturn position for 2011/12.

	Plan	Actual	Variance	Notes
	£000's	£000's	£000's	
Activity Income	264,423	268,359	3,936	**1**
Other Clinical Income	1,759	1,626	(133)	
Other Operating Income	13,256	14,840	1,584	**2**
Total Income	**279,438**	**284,825**	**5,387**	
Pay Spend	(161,736)	(166,696)	(4,960)	**3**
Non-Pay Spend	(96,103)	(97,537)	(1,434)	**4**
Total Expenditure	**(257,839)**	**(264,233)**	**(6,394)**	
EBITDA	**21,599**	**20,592**	**(1,007)**	**5**
Retained Surplus	**500**	**627**	**127**	

1. Activity Income
The Trust signed Acute Care contracts totalling £240.4m for 2011/12 including £3.5m for specific quality improvements. The main PCT Acute contracts are held with Dudley (£176.7m), Sandwell (£33.1m), South Staffordshire (£9.1m) and Specialised Services (£11.0m). In addition the Trust is now responsible for running adult community services across the Dudley Borough, resulting in additional contract income of £21.3m, including £0.5m for specific quality improvements.

The activity plan was based upon signed contracts with PCTs that is income secured rather than 'at risk'. Whilst the start point for plans in 2011/12 was based on a more realistic level of modelled activity, it also contained a level of deflation to take account of the impact of PCT commissioning intentions. This reflects the aim of the PCT to de-commission activity deemed to be inappropriate in the current financially challenged environment. This was particularly relevant for non-elective admissions (previous year outturn equated to 56,117 spells but the plan was reduced to 48,542 spells. However, it should be noted that a high proportion of this reduction was linked to alternative methods of recording activity).

	Annual Plan	Outturn	Variance	Growth (%)
Accident & Emergency attendances	96,523	98,438	1,915	2.0%
Elective spells	46,224	48,441	2,217	4.8%
Non-elective spells	48,542	54,042	5,500	11.3%
Outpatient attendances/ procedures	510,246	515,241	4,995	1.0%

In undertaking additional activity over and above the plan, the Trust has earned additional income under NHS tariff, commensurate with the extra work. The majority

of this additional work is paid for at the full tariff but as a result of current rules, there is an element of non-elective work that is only funded at a marginal rate of 30 per cent. The impact of this change penalises the Trust by an estimated £4.2m. In addition, further new rules regarding the non-payment for a non-elective re-admission within 30 days of the original attendance could have resulted in a further loss of income of £4.2m. However, a partnership approach with Dudley PCT enabled this potential loss to be fully mitigated.

An additional one-off sum of £1.6m was also funded to enable improved performance of key targets (including waiting times in A&E and waiting times for operations) over the winter period. This enabled the continued achievement of these important targets.

2. Other Operating Income

The Trust successfully attracted other operating income in excess of planned levels, notably for training and education, research and development and for the provision of pharmacy services. The Trust remained well within the private patient income cap.

3. Pay Spend

Pay costs exceeded the budget plan by £4.960 million. Similar to the previous year, this was a direct impact of the significant increase in work, including the opening of additional beds for longer time periods and temporary off-site provision for patients that were medically fit for discharge but not quite able to return home.

During the year, employed staff increased from 3,798 to 3,893* Whole Time Equivalents, including further recruitment of trainee nurses to the Trust's successful development programme. The Trust has actively sought to reduce vacancies during the year, particularly for nurses via successful recruitment days. It has also developed a successful in-house staff bank (commenced in 2010/11) that is able to fill at least 95 per cent of unmet nursing shifts without recourse to external agency provision.

The corollary of these changes, coupled with a concerted effort to eliminate premium rate working, is a significant reduction in both agency and waiting list/overtime expenditure. Agency costs are sometimes necessary to ensure safe staffing levels in wards but the costs are significantly higher than contracted or bank staff. Due to the increased contracted staffing levels and success of the staff bank, total agency costs have reduced from £10.173 million expended in 2010/11 to £3.208 million expended in 2011/12. The nursing element has reduced from £3.455 million spent in 2010/11 to £0.455 million spent in 2011/12. For agency spend on Medical staff, the reduction is equally positive from spend of £6.037 million in 2010/11 to £2.588 million in 2011/12.

*see note on page 24

4. Non-Pay Spend

Additional non-pay spending has occurred as a direct result of additional activity with significant unplanned spends occurring on high cost drugs, various clinical supplies, surgical instruments, patient appliances, dialysis and dressings. In addition, non-pay spend has also increased on computer equipment, additional cleaning linked to greater infection control and legal expenses.

5. EBITDA

EBITDA for the year as a whole fell below plan linked to the additional costs of managing non-elective pressures and the corresponding reduced level of income. The reductions in agency spend and other premium costs enabled the Trust to remain profitable overall resulting in a retained surplus of £0.627 million (representing a figure that is £0.127m in excess of the original plan).

Capital

In 2011/12 the Trust invested £8.3 million on new facilities and equipment. The replacement and upgrade of the Endoscope Decontamination facility at Russells Hall and Corbett Hospitals was the largest scheme during 2011/12, at £2.4m. Increased clinical diagnostic activity required the Trust to have a larger decontamination facility as well as alterations to ensure compliance with latest regulatory requirements. The Trust also replaced £2.2m worth of imaging equipment during the year. This forms part of the PFI contract and is paid through the annual amount paid to the relevant PFI provider.

Investment 2011/12	**Amount**
	£000's
Endoscope Decontamination Area	2,381
Imaging Equipment Replacement	2,227
Other Medical Equipment	1,603
Day Case Theatre Upgrade	549
Information Technology	308
Imaging Equipment Enabling Works	282
Other Works including PFI Lifecycle	984
Total	**8,334**

Cashflow

The Trust ended the year with a healthy cash balance of £36.3 million, all held within the Government Banking Service. This will be used to support our planned capital expenditure over the next three years.

During 2011/12 the Trust operated with a Prudential Borrowing Limit (PBL) set for the year by Monitor of £158.7 million of long-term borrowing. The Trust maintained, but did not utilise, a committed working capital facility with Barclays Bank of £10 million.

During 2011/12 the Trust continued its policy of paying all local suppliers at the earliest opportunity to support the local economy during these difficult economic times. The Trust continues to perform strongly against the best practice payment

policy target of 95 per cent compliance. During 2011/12 the Trust paid 99 per cent of non-NHS invoices in value terms and 98 per cent in quantity terms.

Better Payment Code of Practice
The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is the later.

	2011/12		2010/11	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	45,113	107,060	47,468	113,042
Total non-NHS trade invoices paid within target	44,199	105,930	46,760	112,508
Percentage of non-NHS trade invoices paid within target	98%	99%	99%	100%

Audit
So far as the directors are aware, there is no relevant audit information of which the auditor is unaware. The directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. This guidance discusses how public sector organisations should charge for information.

Countering Fraud and Corruption
The Trust takes its responsibility towards countering fraud and corruption in the NHS very seriously.

The Trust's Fraud and Corruption Policy lays down its absolute commitment to maintaining an honest, open and well-intended atmosphere within the Trust. This commitment is the cornerstone of an anti-fraud culture, championing the deterrence and prevention of fraud and the rigorous investigation of any cases of fraud or corruption. Where fraud is proven, the Board will apply all available sanctions i.e. disciplinary/criminal action, and use of the civil law to recover funds.

Accounts

For the Period 1st April 2011 to 31st March 2012

Foreword to the Accounts

These accounts for the period 1 April 2011 to 31 March 2012 have been prepared by The Dudley Group NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, has, with the approval of the Treasury, directed.

Signed

Paula Clark
Chief Executive

Date: 15th May 2012

Statement of Accounting Officer's Responsibilities for The Dudley Group NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed The Dudley Group NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Dudley Group NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed

Paula Clark
Chief Executive

Date: 15th May 2012

Statement of Directors' Responsibilities In Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Signed Date: 15th May 2012

Paula Clark
Chief Executive

Signed Date: 15th May 2012

Paul Assinder
Director of Finance

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Dudley Group NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Dudley Group NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Nursing Director has Board level responsibility for the Trust's risk management policies and processes. The Board of Directors has established a Risk Committee, Chaired by a Non Executive Director which meets monthly to review corporate and directorate specific risks and associated mitigation plans and oversees the effective operation of the Trust's risk register. It is in place to challenge the levels of assurance throughout the organisation and to ensure the effective management and mitigation of risks. Additionally, each Directorate of the Trust operates independent Risk Management Groups that report to the Risk Committee, focusing on risks at an operational level.

The Trust has a comprehensive induction and training programme, supplemented by e-learning training packages and ad hoc learning opportunities for staff. Collectively these cover a wide range of governance and risk management topics for both clinical and non clinical staff in all disciplines and at all levels in the organisation.

Additionally, training can be provided by the Governance team on the wider risk management and governance agenda. Good practice is disseminated through the existing Matrons forums, directorate risk groups and via the Board Committee reporting structure.

The risk and control framework

The Trust's Risk Management Strategy and Policy which is reviewed annually provides guidance on the identification and assessment of risk and on the development and implementation of action plans. The Directorates undertake continuous risk assessments to maintain risk registers and to implement agreed

action plans. Risks are assessed by using a 5x5 risk matrix where the total score is an indicator of the seriousness of the risk and the overall risk rating. Action plans to address or manage risks are recorded in the risk register and managed at Directorate and/or Board level. Regular reports to the Risk Committee confirm the progress made.

The Board of Directors focus on the corporate risks taking assurance from the Risk and Audit Committees. Papers received at the Board and at Board Committees identify the risks to the achievement of Trust objectives and provide a link to the risk register. The Trust uses a dedicated action monitoring system to record and monitor all risks across the organisation including the current and mitigated risk scores and progress against identified action plans.

In addition to the operational risk registers (reported to Risk Committee) the Directors are currently managing 27 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (5 risks in total). These are clinically based and operational in nature, arising from the desire to maintain high quality clinical standards and deliver a safe and affordable service:

- The management of avoidable pressure ulcers in the community
- Staffing levels in Maternity
- Coding of patient care
- Staffing resources and capacity
- Management of patient admissions and discharges

Positive assurance to date confirms the effectiveness of the management and control of these risks. Action plans are in place, or being developed, to address any perceived gaps in control or assurance.

The Board Assurance Framework identifies the risks to the achievement of the Trust's objectives and the independent assurance mechanisms that relate to the effectiveness of the Trust's system of internal control. This is informed by partnership working across the health care region and through working with the Primary Care Trusts, Governors, community wide Safeguarding Boards and other stakeholders.

The Trust informs and engages with its key stakeholders in relation to risk through a number of forums which include a regular joint contract/clinical quality review meeting with the Trust's host commissioners and the sharing of performance reports including key risks with the Trust's Governors. Key stakeholders include Dudley PCT, our PFI partners Summit Healthcare (Dudley) Ltd, voluntary groups, the Council of Governors, the FT Members, patient groups, patients, the local community and the Local Authority Overview and Scrutiny Committee.

The Trust has also introduced a number of arrangements to monitor the quality governance arrangements and improvements in quality. These include the use of performance dashboards, a clinical audit programme, the review and introduction of Quality Care Indicators, Nursing Care Indicators and robust monitoring against local and national targets for Healthcare Associated Infections (HCAI).

Nursing Care Indicator Audits measure the quality of care given to patients and the monthly audits of key nursing interventions and associated documentation are published, monitored and reported to the Board of Directors by the Nursing Director. This is supported by the implementation of real time surveys capturing the views of patients and using these to make improvements. The Trust also continues to monitor the hospital standardised mortality ratio (HSMR) to ensure it is consistent with national levels.

Regular reports to the Board on risks to compliance with the Care Quality Commission Essential Standards of Quality and Safety, and on the progress against key quality priorities, provide assurance that priorities are actively managed and progressed at operational level. Additionally, Matrons and Heads of Service attend the Board on rotation to discuss quality issues. Internal Audit also provides an independent opinion on the adequacy of the arrangements for ensuring compliance with the Care Quality Standards.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

Information risks are managed and controlled through the risk management process. The Trust has a Caldicott and Information Governance Group (CIGG) which reports to the Risk Committee. The Trust uses the NHS Connecting for Health Information Governance Toolkit and has also been through an extensive audit process which indicated that the Trust was operating just below Level 2 in some areas of information Governance. The Trust had an action plan in place to ensure that Level 2 was achieved in all areas in early 2011/12. The Deputy Medical Director is the Trust's Caldicott Guardian and the Director of Finance and Information has Board level responsibility for Information Governance. The Trust has encryption requirements in place for all sensitive and clinical information leaving the Trust and continually reviews the physical security of IT equipment. Instituted improvements have been continued in 2011/12.

The Trust has achieved Level 1 for both the General Risk Management and Maternity Standards covered by the National Health Service Litigation Scheme (NHSLA) and continues to review and improve the risk management arrangements in these areas.

Each level of management, including the Board, reviews the risks and controls for which it is responsible. I, together with the Board monitor the progress against actions to minimise or mitigate risks in accordance with the Risk Management Strategy.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality and diversity and human rights legislation are complied with.

The Foundation Trust (in partnership with our PFI Provider) has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources
The Trust produces detailed Annual Plans incorporating both service and quality initiatives and reflecting service, operational requirements and financial targets in respect of income and expenditure and capital investments. These include the Trust's plan for improving productivity and efficiency in order to minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. The Plan incorporates projections for the next two years which facilitates forward planning in the Trust. Financial plans are approved by the Board of Directors, supported by the Finance and Performance Committee prior to submission to Monitor, the independent regulator.

The in-year resource utilisation is monitored by the Board and its committees via a series of detailed reports covering finance, activity, capacity, human resource management and risk. Clinical risk assessments are conducted on individual savings proposals that may impact on the provision or delivery of clinical services. Monthly performance reviews assess each directorate's performance across a full range of financial and quality matrices, which in turn forms the basis of the monthly integrated performance report to the Finance and Performance Committee. Quarterly reports are submitted to Monitor from which a financial and governance risk rating is assigned. The Trust received a financial risk rating of 3 from Monitor for the 2011/12 financial year.

The key processes embedded within the Trust to ensure that resources are used economically, efficiently and effectively, centre around a robust budget setting and control system which includes activity related budgets and periodic reviews during the year which are considered by Executive Directors and the Board of Directors. The budgetary control system is complemented by Standing Financial Instructions, a Scheme of Delegation and Financial Approval Limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis. The Finance and Performance Committee and Management Executive Meeting also receive a monthly report showing the Trust's performance against CQUIN, Monitor and CQC targets.

As Accounting Officer, I have overall accountability for delivery of the Annual Plan and am supported by the Executive Directors with delegated accountability and responsibility for delivery of specific targets and performance objectives. These are formally reviewed and monitored monthly by the Board of Directors and its Committees. Independent assurance on the use of resources is provided through the

Trust‘s Internal Audit programme, Audit Committee and external agencies such as Monitor, External Audit and the CQC.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust Boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Board of Directors has taken the following measures to ensure that the Quality Report presents a balanced view and has appropriate controls in place to ensure the accuracy of data.

The Executive and Non Executive Directors have a collective responsibility as a Board to ensure that the governance arrangements supporting the Quality Accounts and Report provide adequate and appropriate information and assurances relating to the Trust's quality objectives. Board sponsors are nominated for all quality priorities providing visible board leadership of specific quality initiatives.

Whilst the Chief Executive has overall responsibility for the quality of care provided to patients the implementation and co-ordination of the quality framework is delegated to the Nursing and Medical Directors who have joint responsibility for reporting to the Board of Directors on the development and progress of the quality framework and for ensuring that the Quality Strategy is implemented and evaluated effectively.

Building on the framework adopted in previous years, the Trust’s strategy comprises a number of Trust-wide “Quality Goals”, to address the three quality themes of Patient Safety, Clinical Outcomes and Patient Experience.

The development of the Quality Report is led by the Nursing Director with the full support of the Board of Directors and the Council of Governors. Executive Directors are accountable and have overall responsibility for ensuring that their Directorates implement the Strategy and achieve the agreed quality key performance indicators. The Quality Strategy defines the processes and responsibilities for implementation including indicators to monitor progress.

The systems and processes which support the development of the quality accounts focus on engagement activities with public, patients and staff and utilising the many media/data capture opportunities available.

The Trust reviewed its quality priorities in February 2012 when Executive Directors discussed a number of potential changes to the priorities for 2012/13. A Listening into Action (LiA) event was organised with Governors, staff and the public to look at the potential changes and agree a final list. The Board agreed to retain the existing key metrics on Patient Experience, Patient Safety and Clinical Effectiveness in last year’s report.

The Trust also takes part in national audits and reviews clinical services accreditation schemes (e.g. laboratories, WMQRS) and related national quality improvement initiatives that provide data to make comparisons with other providers (e.g. CHKS). Additionally, all serious incidents, overall trends of incidents, complaints and claims provide comparative data to benchmark against other organisations or areas for organisation learning.

The Trust also works in partnership with others on quality improvement activities including LINKs (Local Involvement Network), Overview and Scrutiny Committee, Independent Complaints Advocacy Service (ICAS) and Local Commissioning Organisations.

In addition to the leadership provided by the Board of Directors, Clinical Directorate Management Teams, led by Clinical Directors and co-ordinated by General Managers, are accountable for, and ensure that a quality service is provided within their respective directorates and areas of responsibility. They are required to implement the Quality Strategy, providing safe, effective and personal care and ensure that patients have a positive experience and are treated with courtesy, respect and kindness. Clinical Directorate Management Teams develop specific objectives within their service plans to provide a quality service and action plans in response to local and national patient survey results and other quality indicators.

Training opportunities are available for clinical and non clinical staff and competency is monitored as part of the Trusts appraisal system. External reviewers provide independent opinions on the appropriateness and adequacy of training.

The Board of Directors ensures that quality improvement is central to all activities. This is achieved by routine monitoring, participation in national improvement campaigns, celebrating success with our staff awards and proactively seeking patient views on our services.

The Trust has robustly utilised existing reporting arrangements to monitor progress against the quality priorities and identify trends. Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.

A quarterly Quality Account Priorities Report is presented to the Board, confirming the progress made against each priority and sharing the results of local and national surveys on patient experience. Additionally, a number of different Key Performance Indicator reports and dashboards are available and used by a wide variety of staff groups to monitor quality on a day to day basis. The organisation's performance on key quality indicators is also benchmarked against national/international comparisons and against the organisation's performance over time, identifying areas for prioritisation.

The Board discussed the need to improve the monitoring and reporting systems associated with the Quality Account and established the Quality and Patient Experience Group to absorb the functions of the existing Patient Experience Group and oversee the management of other quality issues including the Quality Account.

The Group currently meets monthly and reports to the Risk Committee and has overall responsibility for ensuring that a clinically effective and personal service is provided to comply with both nationally recognised quality standards and local and internal standards that have been set.

In 2012/13 the Trust will enhance the existing arrangements further by establishing a formal Board Committee to manage the wider Quality agenda and focus on the key clinical priorities arising from the Quality Accounts and Report.

Review of effectiveness
As Accounting Officer, I have responsibility for reviewing the effectives of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by the comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Risk Committee and a plan to address weaknesses and ensure continuous improvement of the systems is in place.

The Assurance Framework and the Trust‘s risk management arrangements provide me with evidence that the controls to manage the risks to the Trust achieving its principal objectives have been reviewed and are effective. My review is also informed by the work of external and independent assessors and advisors including but not limited to:

- Care Quality Commission
- Monitor
- Health and Safety Executive
- NHS Litigation Authority (assessment of Risk Management Standards)
- Dr Foster and CHKS (clinical benchmarking organisations)
- Internal and External Audit
- Peer Reviews

During 2011/12, the work of the Internal Auditors and a review of the Board Assurance Framework and governance processes identified some perceived gaps in control which have been reported as part of the ongoing monitoring arrangements. These are considered to be operational in nature and are supported by action plans which address weaknesses and ensure continuous improvement of the systems in place:

- Staffing levels in Maternity and Safe Staff (physical resource and staffing capacity) – the Board continues to monitor the recruitment, skill mix and retention of staff across the Trust and specific plans to support the midwifery service
- Impact on admission of emergency patients (due to externally caused delayed discharge) – the Board monitors the continuing partnership arrangements to improve services for patients on discharge or transfer to the community
- Coding of Patient Care – the Trust is reviewing coding guidance /procedures in line with any national and local changes to ensure coding reflects activity accurately
- Increase in the number and grade of avoidable pressure ulcers in the Community – the Board continues to monitor the implementation of systems in the wider community

The Head of Internal Audit Opinion 2011/12 confirmed that: "Based on the work undertaken in 2011/12, significant assurance can be given that there is a sound system of internal control which is designed to meet the organisation's objectives, and that controls are being consistently applied in all the areas reviewed".

Whilst no significant issues were raised control weaknesses were identified in two audit reports – Professional Registration and CRB checking and Junior Doctors: Management of Planned absence. Follow up reviews undertaken by Internal Audit prior to the year end confirmed that good progress had been made in dealing with the initial recommendations and that the key control weaknesses had been addressed.

Additionally as part of a routine schedule of planned visits, the CQC undertook a review on 19th September 2011 to check the improvements made since an earlier visit in February 2011 and concerns about an increase in the number of people who had contracted *clostridium difficile*. They found that the Trust was meeting many of the required Outcomes and patients were very positive about the care they received. Whilst steps had been taken to reduce the numbers of *clostridium difficile* infections further actions were required to improve the systems and processes to manage and monitor the spread of this.

Following this visit, the CQC issued a report in December 2011 indicating:

"Whilst the trust has taken steps to reduce the numbers of *clostridium difficile* infections there are actions that should be taken to improve the systems to manage and monitor the prevention and control of infections."

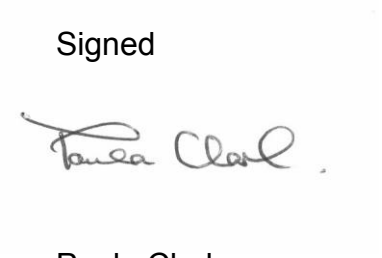
The Trust has worked with the CQC and developed further action plans, which have been shared with the CQC, to address the areas of concern. These continue to be monitored by the Trust Board. The level of infections reduced considerably in the latter part of the year and continues to be monitored closely.

Conclusion

The Assurance Framework and effectiveness of the systems of internal control in relation to the Quality Report are consistent with the Trust's overall system of internal control and the Board has been assured that the Quality Report presents a balanced

view and that the data is accurate. I believe that the Annual Governance Statement is a balanced reflection of the actual control position. No significant internal control issues have been identified.

Signed



Paula Clark
Chief Executive

Date 15th May 2012

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF THE DUDLEY GROUP NHS FOUNDATION TRUST

We have audited the financial statements of The Dudley Group NHS Foundation Trust for the year ended 31 March 2012 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement, the Statement of Changes in Taxpayers' Equity and the related notes 1 to 28. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of The Dudley Group NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Guis Miah (Senior Statutory Auditor)

for and on behalf of Deloitte LLP

Chartered Accountants and Statutory Auditor

Birmingham, United Kingdom

24 May 2012

Remuneration report

Remuneration Committee (unaudited information)
The Remuneration Committee is a sub group of the Board which determines the appropriate levels of remuneration for the Executive Directors and senior managers. The term Senior Managers refers to Chair, Executive and Non Executive Directors only.

Remuneration levels are normally determined by reference to such factors as those applying in equivalent organisations, changes in responsibility and salary increases agreed for other NHS staff.

No meetings of the Remuneration Committee were held during 2011/12.

Remuneration committee membership	
John Edwards	Chairman (Committee Chair)
David Badger	Non Executive Director
Ann Becke	Non Executive Director
David Bland	Non Executive Director
Jonathan Fellows	Non Executive Director
Richard Miner	Associate Non Executive Director

Remuneration for Executive Directors does not include any performance-related elements.

No significant financial awards or compensation have been made to past senior managers during the period of this report.

The terms and conditions for the Executive Directors and senior managers of the Trust are included in their individual contracts of employment which includes notice periods and any termination arrangements.

The Trust Board of Directors had a pay freeze in 2009/10 and this has continued through 2010/11 and 2011/12.

No payments have been made to third parties for services of a senior manager.

Salary and Pension entitlements of Senior Managers (audited information) 2011/12

A) Remuneration

Name and Title	Note	2011/12			2010/11		
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	* Benefits in Kind (Rounded to the nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	* Benefits in Kind (Rounded to the nearest £100)
		£000	£000	£00	£000	£000	£00
Paula Clark, Chief Executive		175-180			175-180		
Paul Assinder, Director of Finance & Information		140-145			140-145		
Paul Harrison, Medical Director		60-65	100-105		60-65	105-110	
Paul Brennan, Director of Operations	a				100-105		3,600
Richard Beeken, Director of Operations & Transformation	b	120-125			95-100		
Janine Clarke, Director of Human Resources	c				80-85		2,300
Denise McMahon, Nursing Director		120-125			120-125		
Ruth Serrell, Performance Director	d				25-30		
Roger Callender Associate Director	e				70-75		
Alfred Edwards, Chairman	f				25-30		400
John Edwards, Chairman	g	45-50		1,700	15-20		300
David Badger, Non Executive Director		15-20			15-20		
Kathryn Willietts, Non Executive Director		10-15		100	10-15		100
Ann Becke, Non Executive Director		10-15			10-15		100
Jonathon Fellows, Non Executive Director		10-15			10-15		
David Bland, Non Executive Director	h	10-15			5 - 10		300
Richard Miner, Associate Non Executive Director	i	10-15			5 - 10		
Aggregate Total		725 -785	100-105	1,800	960 -1,045	105-110	7,100

Note:-

* Benefits in kind relate to leased cars in respect of the Executive Directors and home to base travel reimbursement for Non Executive Directors

a Paul Brennan left 31 May 2010

b Richard Beeken commenced 15 June 2010

c Janine Clarke left 18 July 2010

d Ruth Serrell commenced 23 October 2009 and left on 1 July 2010

e Roger Callender left the position of Associate Director on 1 April 2011

f Alfred Edwards retired on 31 October 2010

g John Edwards commenced 1 November 2010

h David Bland commenced 1 August 2010

i Richard Miner commenced 1 October 2010

The Trust is required to disclose the relationship between the remuneration of the highest paid Director and the median remuneration of the other Trust employees.
The banded remuneration of the highest paid Director of the Trust for 2011/12 is £175,000 - £180,000 (2010/11 £175,000 - £180,000). This was 7.9 times (2010/11 7.9 times)
The median remuneration of the workforce, which was £20,000 - £25,000 (2010/11 £20,000 - £25,000).

On 1st April 2011 the number of staff increased by 642 following the transfer of Adult Community Services from Dudley PCT.

In 2011/12, there were no (2010/11 0) employees who received remuneration in excess of the highest paid Director.

Total remuneration includes salary, non consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

B) Pension Benefits

Name and Title	Note	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2011 To nearest £1,000	Real Increase in Cash Equivalent Transfer Value To nearest £1,000	Cash Equivalent Transfer Value at 31 March 2012 To nearest £1,000
		£000	£000	£000	£000	£000	£000	£000
Paula Clark, Chief Executive		0 - 2.5	2.5 - 5.0	40 - 45	125 - 130	740	23	763
Paul Assinder, Finance Director		0 - 2.5	2.5 - 5.0	50 - 55	150-155	895	28	923
Richard Beeken, Director of Operations & Transformation		0 - 2.5	0 - 2.5	25 - 30	75 - 80	264	8	272
Paul Harrison, Medical Director	1	0 - 2.5	2.5 - 5.0	50 - 55	155 - 160	752	23	775
Denise McMahon, Nursing Director		0 - 2.5	2.5 - 5.0	50 - 55	155 - 160	832	26	858

Note:-

1 Medical Director figures shown include accrued benefits and contributions in respect of full salary, which will include both management and medical contributions.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed

Paula Clark
Chief Executive Date 15th May 2012

The Dudley Group NHS Foundation Trust

Statement Of Comprehensive Income

For The Year Ended 31 March 2012

	Note	Year Ended 31 March 2012 £'000	Year Ended 31 March 2011 £'000
Operating Income from operations	3 & 4	285,312	260,231
Operating Expenses of operations	5	(273,406)	(249,430)
OPERATING SURPLUS / (DEFICIT)		**11,906**	**10,801**
FINANCE COSTS			
Finance income	9	433	347
Finance expense - financial liabilities	10	(9,769)	(9,206)
PDC Dividends payable		(1,943)	(1,785)
NET FINANCE COSTS		**(11,279)**	**(10,644)**
Corporation tax expense		0	0
Surplus/(Deficit) from operations		**627**	**157**
SURPLUS/(DEFICIT) FOR THE YEAR		**627**	**157**
Other comprehensive income			
Impairments		(2)	(193)
Revaluations		16,937	29
Asset disposals		0	0
Other recognised gains and losses		0	0
Other reserve movements		0	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**17,562**	**(7)**
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**17,562**	**(7)**

The notes on pages 5 to 37 form part of these accounts.
All income and expenditure is derived from continuing operations.

There are no Minority Interests in the Trust, therefore the surplus for the year of £627,000 (2010/11 £157,000) and the Total Comprehensive Income of £17,562,000 (2010/11 Expense of £7,000) is wholly attributable to the Trust.

The Dudley Group NHS Foundation Trust

Statement Of Financial Position As At 31 March 2012

	Note	31 March 2012	31 March 2011	1 April 2010
Non-current assets		£'000	£'000	£'000
Intangible assets	11	576	838	1,111
Property, plant and equipment	12	219,000	203,193	203,410
Investment Property		0	0	0
Other Investments		0	0	0
Trade and other receivables	14	8,733	7,826	6,627
Other Financial assets		0	0	0
Other assets		0	0	0
Total non-current assets		228,309	211,857	211,148
Current assets				
Inventories	13	2,837	3,183	2,949
Trade and other receivables	14	6,247	6,131	8,858
Other financial assets	25.7	0	0	10,000
Non-current assets for sale and assets in disposal groups	12.8	0	1,078	0
Cash and cash equivalents	20	36,346	33,441	26,925
Total current assets		45,430	43,833	48,732
Current liabilities				
Trade and other payables	15	(15,093)	(13,717)	(13,575)
Borrowings	19	(4,897)	(4,231)	(4,065)
Other financial liabilities		0	0	0
Provisions	17	(706)	(613)	(834)
Other liabilities	16	(2,048)	(1,040)	(1,242)
Liabilities in disposal groups		0	0	0
Total current liabilities		(22,744)	(19,601)	(19,716)
Total assets less current liabilities		**250,995**	**236,089**	**240,164**
Non-current liabilities				
Trade and other payables		0	0	0
Borrowings	19	(151,365)	(154,020)	(158,089)
Other financial liabilities		0	0	0
Provisions		0	0	0
Other liabilities		0	0	0
Total non-current liabilities		(151,365)	(154,020)	(158,089)
Total assets employed		**99,630**	**82,069**	**82,075**
Financed by Taxpayers' equity				
Public Dividend Capital		20,927	20,927	20,927
Revaluation reserve		52,709	37,160	37,423
Available for sale investments reserve		0	0	0
Other reserves		0	0	0
Merger Reserve		0	0	0
Income and expenditure reserve		25,994	23,982	23,725
Total Taxpayers' equity		**99,630**	**82,069**	**82,075**

The financial statements were approved by the Board of Directors and authorised for issue on their behalf by:

Signed …… Date: 15th May 2012

Paula Clark, Chief Executive

The Dudley Group NHS Foundation Trust

Statement of Changes in Taxpayers Equity

For The Year Ended 31 March 2012

	Public Dividend Capital £'000	Revaluation Reserve £'000	Income and Expenditure Reserve £'000	Total £'000
Taxpayers' Equity at 1 April 2010	**20,927**	**37,423**	**23,725**	**82,075**
Surplus / (Deficit) for the year	0	0	157	157
Transfers between reserves	0	(99)	99	0
Impairments	0	(193)	0	(193)
Revaluations	0	29	0	29
Other recognised gains/losses	0	0	0	0
Other reserve movements	0	0	1	1
Taxpayers' Equity at 31 March 2011	**20,927**	**37,160**	**23,982**	**82,069**
Surplus / (Deficit) for the year	0	0	627	627
Transfers between reserves	0	(1,386)	1,386	0
Impairments	0	(2)	0	(2)
Revaluations	0	16,937	0	16,937
Other recognised gains/losses	0	0	0	0
Other reserve movements	0	0	(1)	(1)
Taxpayers' Equity at 31 March 2012	**20,927**	**52,709**	**25,994**	**99,630**

The Dudley Group NHS Foundation Trust

Statement of Cash Flows

For The Year Ended 31 March 2012

	31 March 2012 £'000	31 March 2011 £'000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	**11,906**	**10,801**
Operating surplus/(deficit) of discontinued operations	0	0
Operating surplus/(deficit)	**11,906**	**10,801**
Non-cash income and expense:		
Depreciation and amortisation	8,727	8,868
Impairments	340	0
Reversals of impairments	0	0
Amortisation of PFI credit	0	0
(Increase)/Decrease in Trade and Other Receivables	(1,241)	1,722
(Increase)/Decrease in Other Assets	0	0
(Increase)/Decrease in Inventories	346	(234)
Increase/(Decrease) in Trade and Other Payables	524	(661)
Increase/(Decrease) in Other Liabilities	1,008	(202)
Increase/(Decrease) in Provisions	93	(221)
Tax (paid) / received	539	197
Movements in operating cash flow of discontinued operations	0	0
Movements in operating cash flow in respect of Transforming Community Services transaction	0	0
Other movements in operating cash flows	(291)	(8)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	21,951	20,262
Cash flows from investing activities		
Interest received	435	400
Purchase of financial assets	(171,000)	(80,000)
Sales of financial assets	171,000	90,000
Purchase of intangible assets	(31)	(99)
Sales of intangible assets	0	0
Purchase of Property, Plant and Equipment	(5,763)	(8,646)
Sales of Property, Plant and Equipment	2,026	10
Net cash generated from/(used in) investing activities	(3,333)	1,665
Cash flows from financing activities		
Loans received	0	0
Loans repaid	0	0
Capital element of finance lease rental payments	0	0
Capital element of PFI Obligations	(4,216)	(4,153)
Interest paid	0	0
Interest element of finance lease	0	0
Interest element of PFI Obligations	(9,769)	(9,206)
PDC Dividend paid	(1,728)	(2,052)
Cash flows from (used in) other financing activities	0	0
Net cash generated from/(used in) financing activities	(15,713)	(15,411)
Increase/(decrease) in cash and cash equivalents	**2,905**	**6,516**
Cash and Cash equivalents at 1 April	33,441	26,925
Cash and Cash equivalents at 31 March	**36,346**	**33,441**

Accounting Policies and Other Information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2011/12 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Income is recognised in the period in which services are provided, for patients in whose treatment straddles the year end this means income is apportioned across financial years on the basis of length of stay. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

2 Expenditure on Employee Benefits

Short-term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The NHS Pension scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period 1 April 1999 to 31 March 2004 which was published in December 2007 and is available on the NHS Pensions Agency Website.
The notional deficit of the scheme was £3.3 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2008, employees' pay contributions will be on a tiered scale from 5% to 8.5% of their pensionable pay.

3 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

4 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and;
  - has an individual cost of at least £5,000; or
  - the items form a group of assets which collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under the same managerial control; or
  - form part of the initial equipping and setting up cost of a new building or refurbishment of a ward or unit, and the items collectively have a cost of at least £5,000.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

For property assets the frequency of revaluations will be at least every five years, in line with Monitor's view.

The fair value of land and buildings are determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of modern equivalent cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets under construction are valued at cost and are subsequently revalued by professional valuers when they are brought into use if factors indicate that the value of the asset differs materially from its carrying value. Otherwise, the asset should only be revalued on the next occasion when all assets are revalued.

Subsequent expenditure

Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the income statement in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits expected to be obtained from use of an item of property, plant and equipment and where the cost of the item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates its non-current assets on a straight line basis over the expected life of the assets after allowing for the residual value. Useful lives are determined on a case by case basis. The typical lives for the following assets are:

Asset Category	Useful Life (years)
Buildings	As per valuer's estimate
Engineering Plant & Equipment	5 - 15
Medical Equipment	7 - 10
Transport Equipment	7
Information Technology	5 - 8
Furniture & Fittings	5 - 10

Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as ‘Held for Sale’ ceases to be depreciated upon reclassification.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, Government Grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual issued by Monitor, are accounted for as 'on-balance sheet' by the Trust. The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a lifecycle element, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The lifecycle element is established on the lifecycle plan contained within the financial model. Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively. Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

5 Intangible Assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the license and their useful lives.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation and impairment

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Asset Category	Useful Life (years)
Software Licences	5

6 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is credited to income at the same time, unless the grant has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grant, in which case, the grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

8 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

9 Financial Instruments and Financial Liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. Regular way purchases or sales are recognised and de-recognised, as applicable, using the settlement date. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure' or Loans and receivables. Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.
Available for sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available for sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in ' Finance Costs' in the Statement of Comprehensive Income.

Other Financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

10 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

11 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% (2010/11: 2.9%) in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 17, but is not recognised in the Trust accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 22, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

13 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

14 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

15 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the statement of financial position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

16 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 26 to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

17 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

18 Charitable Funds

The Trust is not required to apply IAS 27 in 2011/12 following dispensation obtained by Monitor. However, this only applies to the consolidation of NHS Charitable Funds.

19 Critical accounting judgements and key sources of estimation and uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Accounting for PFI
- Application of IFRIC 4 Determining whether an Arrangement contains a Lease
- Application of IFRIC12 Service Concession Arrangements

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

- Valuation of Non- Current Assets
- Provisions
- Settlement of Over Performance with Healthcare Purchasers

20 Accounting Standards that have been issued but have not yet been adopted

There are currently no standards or interpretations adopted by the European Union that are not included in these financial statements.

21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

2 Segmental Analysis

The Board as 'Chief Operating Decision Maker' has determined that the Trust operates in one material segment, which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The Trust has identified segments in line with the thresholds in IFRS 8, applying the requirement of the ARM to consider expenditure instead of income as income is not analysed between segments in our monthly finance report to the Trust Board. Following a significance test of the expenditure segments the Trust found that there were six significant operating segments subject to the external reporting requirements of IFRS 8. Applying the aggregation criteria to the Trust's six significant operating segments found that in all cases the segments had similar economic characteristics, the nature of the services are similar, the nature of the production process are similar, the type or class of customer for the services are similar, the methods used to provide the services are similar and the nature of the regulatory environment is similar.

The Trust's significant operating segments satisfy all of the criteria listed for an aggregation to be deemed appropriate. The six significant operating segments of the Trust are all active in the same business – the provision of healthcare, and all operate within the same economic environment – the United Kingdom. Given that the purpose of disclosing segmental information is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments, reporting a single segment of "Healthcare" would be consistent with the core principle of IFRS 8, as it would show the singular nature of both the business activity and the economic environment of the Trust.

Income from activities (medical treatment of patients) is analysed by customer type in note 3 to the accounts on page 14. Other operating income is analysed in note 4 to the accounts on page 15 and materially consists of revenues from healthcare, research and development, medical education, and the provision of services to other NHS bodies. Total income by individual customers within the whole of HM Government and considered material, is disclosed in the related parties transactions note 23 to the accounts on page 33.

	Year Ended 31 March 2012		Year Ended 31 March 2011	
	£'000	%	£'000	%
Trust Income *	284,825		260,231	
Expenditure - aggregated healthcare segment	(249,369)	87.7%	(222,230)	85.4%
Expenditure - other **	(34,829)	12.3%	(37,844)	14.6%
Total Expenditure	(284,198)	100.0%	(260,074)	100.0%
Operating Surplus	627		157	

* Trust income was not split into individual Directorates in the monthly Finance Report to the board during 2011-12 and 2010-11.

** Other Expenditure is made up of Corporate Directorates, Depreciation, Impairments, PFI Finance Lease Interest and Interest Receivable.

3 Revenue from Activities

3.1 Income By Source	Year Ended 31 March 2012 £'000	Year Ended 31 March 2011 £'000
NHS Foundation Trusts	0	0
NHS Trusts	14	16
Strategic Health Authorities	133	0
Primary Care Trusts	268,427	244,372
Local Authorities	238	7
Department of Health - grants	0	0
Department of Health - other	0	0
NHS Other	0	0
Non NHS: Private patients	50	68
Non-NHS: Overseas patients (non-reciprocal)	20	57
NHS injury scheme (was RTA)	995	1,482
Non NHS: Other	133	89
Total income from activities	**270,010**	**246,091**

This income is also analysed by income type below:

3.2 Revenue from Activities	Year Ended 31 March 2012	Year Ended 31 March 2011
Acute Trusts		
Elective	51,294	50,966
Non Elective	85,680	87,621
Outpatient	49,095	46,320
A&E	9,483	8,495
Other NHS Clinical Income	49,146	47,821
Community Trusts		
Income from PCT's	21,040	0
Income not from PCT's	234	0
Income at Tariff	**265,972**	**241,223**
Private Patients	50	68
Other non-protected clinical income	3,988	4,800
Total income from activities	**270,010**	**246,091**

Income from Community Trusts is in respect of Adult Community Services which transferred to the Trust on 1 April 2012

3.3 Income from Mandatory and Non-Mandatory Services	Year Ended 31 March 2012 £'000	Year Ended 31 March 2011 £'000
NHS Clinical Income	268,574	244,388
Non-Mandatory / Non-Protected Income	1,436	1,703
Income from Activities	270,010	246,091
Other Operating Income	15,302	14,140
Total Income	285,312	260,231

As an NHS Foundation Trust, the majority of income in respect of patient care is received under Payment By Results (PBR), which is intended to reimburse Trusts based on the actual activity delivered using the National Tariff of procedure prices.

The Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide (protected services). All of the income from activities before private patient income shown above is derived from the provision of those services.

Other NHS Clinical Income comprises the following services pathology; rehabilitation; community support services; radiology; renal services; patient transport services; and high cost drugs/devices/appliances.

3.3 Private Patient Income

	2011/12 £'000	2010/11 £'000	Base Year £'000
Private Patient Income	50	68	119
Total Patient Related Income	269,960	245,989	134,515
Proportion (as percentage)	0.02%	0.03%	0.09%

Section 44 of the 2006 Act requires that the proportion of the private patient income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03. The note above shows that the Trust continues to be compliant.

4 Other Operating Revenue

	Year ended 31 March 2012 £'000	Year ended 31 March 2011 £'000
Research and development	393	1,402
Education and training	7,370	7,797
Charitable and other contributions to expenditure	89	19
Non-patient care services to other bodies	1,714	1,783
Profit on disposal of fixed asset investments	0	0
Profit on disposal of intangible fixed assets	0	0
Profit on disposal of land and buildings	0	0
Profit on disposal of other tangible fixed assets	5	0
Gain on disposal of assets held for sale	341	0
Reversal of impairments of assets held for sale	0	0
Amortisation of PFI deferred credits		
Main scheme	0	0
Additional lifecycle assets received	0	0
Income in respect of Staff Costs	1,926	1,294
Other	3,464	1,845
Total other operating income	**15,302**	**14,140**

Other income is derived from Staff Recharges £1,926,000 (2010/11 £1,294,000); Pharmacy Drugs £1,002,000 (2010/11 £931,000); and numerous other small amounts.

5 Operating Expenditure	Year ended 31 March 2012	Restated Year ended 31 March 2011
5.1 Operating Expenses	£'000	£'000
Services from NHS Foundation Trusts	130	84
Services from NHS Trusts	155	170
Services from PCT's	0	0
Services from other NHS Bodies	100	93
Purchase of healthcare from non NHS bodies	15	31
Employee Expenses - Executive directors	779	1,016
Employee Expenses - Non-executive directors	142	131
Employee Expenses - Staff	166,836	150,711
Drug costs	26,091	22,991
Supplies and services - clinical (excluding drug costs)	20,304	20,148
Supplies and services - general	1,763	982
Establishment	2,458	2,250
Research and development	0	0
Transport	2,263	2,286
Premises	3,439	3,134
Increase / (decrease) in bad debt provision	51	101
Other impairment of financial assets	0	0
Depreciation on property, plant and equipment	8,434	8,496
Amortisation on intangible assets	293	372
Impairments of property, plant and equipment	340	0
Impairments of intangible assets	0	0
Audit fees		
audit service - statutory audit	67	58
audit services - audit related regulatory reporting	18	16
Other auditor's remuneration		
further assurance services	0	0
other services	0	0
Clinical negligence	5,644	5,373
Loss on disposal of investments	0	0
Loss on disposal of intangible fixed assets	0	0
Loss on disposal of land and buildings	3	0
Loss on disposal of other property, plant and equipment	52	10
Loss on disposal of assets held for sale	0	0
Legal fees	0	0
Consultancy costs	639	1,253
Training, courses and conferences	0	0
Patient travel	0	0
Car parking & Security	0	0
Redundancy	4	0
Early retirements	0	0
Hospitality	0	0
Publishing	0	0
Insurance	0	0
Other services, eg external payroll	0	0
Losses, ex gratia & special payments	0	0
Other	33,386	29,724
TOTAL	**273,406**	**249,430**

Other expenditure includes £27,088,000 (2010/11 £26,118,000) in relation to payments to the Trust's PFI Partner for services provided and numerous other small amounts.

5.2 The Late Payment of Commercial Debts (interest) Act 1998

During the year 2011/12 (2010/11 £ nil) the Trust was not charged interest for the late payment of commercial debts.

6 Operating Leases

6.1 Payments recognised as an expense	Year ended 31 March 2012 £'000	Year ended 31 March 2011 £'000
Minimum lease payments	94	42
Contingent rents	0	0
Sub-lease payments	0	0
	94	42
Total future minimum lease payments Payable:		
Not more than one year	64	30
Between one and five years	151	55
After 5 years	39	0
Total	254	85

7 Directors' Remuneration and other benefits

	Year ended 31 March 2012 £'000	Year ended 31 March 2011 £'000
Aggregate Remuneration	892	1,162
Employer Contributions to a pension scheme	103	120
	995	1,282

8 Employee Expenses and Numbers

8.1 Employee Costs

	Year Ended 31 March 2012			Year Ended 31 March 2011		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	134,282	127,926	6,356	117,917	114,425	3,492
Social security costs	10,745	10,303	442	9,047	8,809	238
Pension costs - defined contribution plans						
Employer's contributions to NHS Pensions	15,423	15,149	274	13,191	13,024	167
Termination benefits	4	0	4	0	0	0
Agency/contract staff	7,165	0	7,165	11,572	0	11,572
Total	167,619	153,378	14,241	151,727	136,258	15,469

8.2 Average Number of Persons Employed

	Year Ended 31 March 2012			Year Ended 31 March 2011		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	450	418	32	435	406	29
Administration and estates	716	668	48	680	656	24
Healthcare assistants and other support staff	827	827	0	638	638	0
Nursing, midwifery and health visiting staff	1,280	1,093	187	1,141	1,014	127
Nursing, midwifery and health visiting learners	11	11	0	11	11	0
Scientific, therapeutic and technical staff	348	343	5	431	426	5
Bank and agency staff	25	0	25	137	0	137
Total	3,657	3,360	297	3,473	3,151	322

8.3 Employee Benefits

Employees benefits include payment of salaries/wages and pension contributions. There were no other employee benefits paid in 2011/12 (2010/11 nil).

8.4 Retirements due to Ill-health

During the period 2011/12 there were 4 (in 2010/11 there were 4) early retirements from the Trust on the grounds of ill-health.
The estimated additional pension liabilities of these ill-health retirements will be £390,149 (2010/11 £334,838).
The cost of these ill-health retirements will be borne by the Pensions Scheme, and therefore there is no liability or provision in the Trust accounts.

8.5 Sickness Absence

The detail of staff sickness / absence from work for the year are:

	2011/12	2010/11
Absence Full Time Equivalent (FTE)	51,509	48,631
Available Employee Time (FTE) for the year	1,409,519	1,214,786
Sickness Rate	3.65%	4.00%

8.6 Exit Packages

The Trust's expenditure includes 1 payment of £4,000 (2010/11 nil) relating to staff exit packages.

9 Finance Income	Year ended 31 March 2012 £'000	Year ended 31 March 2011 £'000
Interest on bank accounts	433	347
Interest on available for sale financial assets	0	0
Interest on held-to-maturity financial assets	0	0
	433	347

10 Finance Costs - Interest Expense	Year ended 31 March 2012 £'000	Year ended 31 March 2011 £'000
Finance Costs in PFI obligations		
Main Finance Costs	6,255	6,348
Contingent Finance Costs	3,514	2,858
	9,769	9,206

11 Intangible Assets

11.1 2011/12

	Computer Software	Total
	£'000	£'000
Gross Cost as at 1 April 2011	1,831	1,831
Additions Purchased	31	31
Additions Donated	0	0
Disposals	0	0
Gross Cost as at 31 March 2012	1,862	1,862
Amortisation as at 1 April 2011	993	993
Provided during the Year	293	293
Disposals	0	0
Amortisation as at 31 March 2012	1,286	1,286
Net Book Value		
Purchased at 1 April 2011	838	838
Donated at 1 April 2011	0	0
Total at 1 April 2011	838	838
Net Book Value		
Purchased at 31 March 2012	576	576
Donated at 31 March 2012	0	0
Total at 31 March 2012	576	576

11.2 2010/11

	Computer Software	Total
	£'000	£'000
Gross Cost as at 1 April 2010	1,732	1,732
Additions Purchased	99	99
Additions Donated	0	0
Disposals	0	0
Gross Cost as at 31 March 2011	1,831	1,831
Amortisation as at 1 April 2010	621	621
Provided during the Year	372	372
Disposals	0	0
Amortisation as at 31 March 2011	993	993
Net Book Value		
Purchased at 1 April 2010	1,111	1,111
Donated at 1 April 2010	0	0
Total at 1 April 2010	1,111	1,111
Net Book Value		
Purchased at 31 March 2011	838	838
Donated at 31 March 2011	0	0
Total at 31 March 2011	838	838

12 Tangible Assets

12.1 2011/12

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2011	228,978	25,990	169,640	512	906	29,756	223	1,325	626
Additions - purchased	8,214	0	2,515	0	1,245	4,237	0	217	0
Additions - donated	89	0	5	0	0	84	0	0	0
Impairments	(2)	0	(2)	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	679	0	(906)	203	0	24	0
Revaluations	7,590	(1,200)	8,865	(75)	0	0	0	0	0
Reclassified as held for sale	(627)	(190)	0	(437)	0	0	0	0	0
Disposals	(1,806)	0	0	0	0	(1,708)	(94)	(4)	0
Gross Cost at 31 March 2012	242,436	24,600	181,702	0	1,245	32,572	129	1,562	626
Accumulated depreciation at 1 April 2011	25,785	0	4,431	28	0	20,056	108	747	415
Provided during the year	8,434	0	4,576	0	0	3,564	18	197	79
Impairments	340	0	340	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	(9,347)	0	(9,347)	0	0	0	0	0	0
Reclassified as held for sale	(28)	0	0	(28)	0	0	0	0	0
Disposals	(1,748)	0	0	0	0	(1,654)	(94)	0	0
Accumulated depreciation at 31 March 2012	23,436	0	0	0	0	21,966	32	944	494
Net book value									
NBV - Owned at 1 April 2011	52,169	25,990	16,536	484	906	7,368	115	572	198
NBV - PFI at 1 April 2011	150,776	0	148,561	0	0	2,215	0	0	0
NBV - Donated at 1 April 2011	248	0	112	0	0	117	0	6	13
NBV total at 1 April 2011	203,193	25,990	165,209	484	906	9,700	115	578	211
NBV - Owned at 31 March 2012	49,758	24,600	17,010	0	1,245	6,072	97	613	121
NBV - PFI at 31 March 2012	169,089	0	164,687	0	0	4,402	0	0	0
NBV - Donated at 31 March 2012	153	0	5	0	0	132	0	5	11
NBV total at 31 March 2012	219,000	24,600	181,702	0	1,245	10,606	97	618	132

12 Tangible Assets

12.2 2010/11

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Cost at 1 April 2010	222,497	26,350	159,617	1,428	2,673	30,551	135	1,219	524
Additions - purchased	9,522	0	7,340	30	906	936	110	94	106
Additions - donated	19	0	0	0	0	0	0	7	12
Impairments	(193)	0	0	(193)	0	0	0	0	0
Reclassifications	0	0	2,654	0	(2,673)	14	0	5	0
Revaluations	29	0	29	0	0	0	0	0	0
Reclassified as held for sale	(1,113)	(360)	0	(753)	0	0	0	0	0
Disposals	(1,783)	0	0	0	0	(1,745)	(22)	0	(16)
Gross Cost at 31 March 2011	228,978	25,990	169,640	512	906	29,756	223	1,325	626
Accumulated depreciation at 1 April 2010	19,087	0	0	0	0	18,074	129	544	340
Provided during the year	8,496	0	4,431	63	0	3,713	1	203	85
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	(35)	0	0	(35)	0	0	0	0	0
Disposals	(1,763)	0	0	0	0	(1,731)	(22)	0	(10)
Accumulated depreciation at 31 March 2011	25,785	0	4,431	28	0	20,056	108	747	415
Net book value									
NBV - Owned at 1 April 2010	48,329	26,350	7,302	1,428	2,673	9,711	6	675	184
NBV - PFI at 1 April 2010	154,770	0	152,202	0	0	2,568	0	0	0
NBV - Donated at 1 April 2010	311	0	113	0	0	198	0	0	0
NBV total at 1 April 2010	203,410	26,350	159,617	1,428	2,673	12,477	6	675	184
NBV - Owned at 31 March 2011	52,169	25,990	16,536	484	906	7,368	115	572	198
NBV - PFI at 31 March 2011	150,776	0	148,561	0	0	2,215	0	0	0
NBV - Donated at 31 March 2011	248	0	112	0	0	117	0	6	13
NBV total at 31 March 2011	203,193	25,990	165,209	484	906	9,700	115	578	211

12 Tangible Assets

12.3 Analysis of Tangible Assets

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
Net Book Value	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NBV - Protected Assets at 31 March 2012	197,485	24,600	172,885	0	0	0	0	0	0
NBV - Unprotected Assets at 31 March 2012	21,515	0	8,817	0	1,245	10,606	97	618	132
	219,000	24,600	181,702	0	1,245	10,606	97	618	132
NBV - Protected Assets at 31 March 2011	191,493	25,800	165,209	484	0	0	0	0	0
NBV - Unprotected Assets at 31 March 2011	11,700	190	0	0	906	9,700	115	578	211
	203,193	25,990	165,209	484	906	9,700	115	578	211

Protected assets are land and buildings owned or leased by the Foundation Trust, and the disposal of which may affect the Trust's ability to provide it's mandatory goods and services.

12.4 Net Book Value of property, plant and equipment in the Revaluation Reserve at 31 March 2012

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
As at 1 April 2011	37,155	20,824	15,151	858	0	315	2	3	2
Movement in year	15,554	(1,654)	18,210	(858)	0	(138)	(2)	(3)	(1)
As at 31 March 2012	52,709	19,170	33,361	0	0	177	0	0	1

12.5 Net Book Value of property, plant and equipment in the Revaluation Reserve at 31 March 2011

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
As at 1 April 2011	37,389	20,885	15,092	990	0	414	2	3	3
Movement in year	(234)	(61)	59	(132)	0	(99)	0	0	(1)
As at 31 March 2012	37,155	20,824	15,151	858	0	315	2	3	2

12.6 Impairment Losses

The Trust carried out an impairment review of its non-current assets in March 2012. For land and buildings the Trust received a valuation report from the District Valuer prepared on a MEA basis. The valuation report was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as the terms are consistent with the requirements of HM Treasury, the National Health Service and Monitor. On application there was a fall in value of land and a general increase in value of buildings compared to the carrying value at 31st March 2012. In line with IFRS the Trust was able to offset the fall in value of land against the relevant revaluation balance held for the applicable assets. However for one element of the Trust's buildings there was no remaining revaluation balance and this led to a charge to the Statement of Comprehensive Income relating to the impairment loss.

Impairment of Assets	31 March 2012 £'000	31 March 2011 £'000
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Changes in market price	342	193
Reversal of impairments	0	0
TOTAL IMPAIRMENTS	342	193

12.7 Asset Valuations

The Trust received a MEA valuation from the District Valuer in March 2012. The updated valuations of the Trust's land, buildings and dwellings were applied to the Trust financial statements and enable the Trust to disclose an up to date position with regard to asset valuations. No significant assumptions were made as part of the valuation process as minimum capital expenditure had been applied to the land and buildings since the previous full revaluation exercise. If the Trust had not received this updated valuation the carrying values of land, buildings and dwellings would have been £25,800,000; £163,833,000 and £nil respectively.

12.8 Non Current Assets Held For Sale

	Total £'000	Property, Plant and Equipment £'000
NBV of Non Current Assets Held For Sale in disposal groups at 1 April 2011	1,078	1,078
Assets classified as available for sale during the year	599	599
Assets sold during the year	(1,677)	(1,677)
NBV of Non Current Assets Held For Sale in disposal groups at 31 March 2012	**0**	**0**
NBV of Non Current Assets Held For Sale in disposal groups at 1 April 2010		
Assets classified as available for sale during the year	1,078	1,078
Assets sold during the year	0	0
NBV of Non Current Assets Held For Sale in disposal groups at 31 March 2011	**1,078**	**1,078**

The Board took the decision to sell the housing stock in Ashdown Drive in 2010/11. At the time of the signing of the 2010/11 accounts four houses were part of an open housing market sale with the remainder sold at auction in April 2011.

12.9 Capital Commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements were £1,341,000 (31 March 2011 £3,333,000). This amount relates entirely to property, plant and equipment. There are no contracted capital commitments for intangible assets.

13 Inventories

13.1 Inventories	Year ended 31 March 2012 £'000	Year ended 31 March 2011 £'000
Drugs	1,733	1,649
Work in progress	0	0
Consumables	1,032	1,477
Energy	33	33
Inventories carried at fair value less costs to sell	0	0
Other	39	24
TOTAL Inventories	2,837	3,183

13.2 Inventories recognised in expenses	Year ended 31 March 2012 £'000	Year ended 31 March 2011 £'000
Inventories recognised in expenses	27,228	24,513
Write-down of inventories recognised as an expense	0	0
Reversal of any write down of inventories resulting in a reduction of recognised expenses	0	0
TOTAL Inventories recognised in expenses	27,228	24,513

14 Trade Receivables and Other Receivables

14.1 Trade Receivables and Other Receivables

	Year Ended 31 March 2012	Year Ended 31 March 2011
Current	£'000	£'000
NHS Receivables - Revenue	3,846	3,689
Other receivables with related parties	81	0
Provision for impaired receivables	(790)	(757)
Prepayments (non PFI)	706	643
PFI Prepayments		
Prepayments - Capital contributions	0	0
Prepayments - Lifecycle replacements	0	0
Accrued income	1,019	909
Corporation tax receivable	0	0
Finance Lease Receivables	0	0
PDC dividend receivable	374	589
Other receivables	1,011	1,058
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	6,247	6,131
Non Current		
Prepayments (non PFI)	3,661	3,923
PFI Prepayments		
Prepayments - Capital contributions	0	0
Prepayments - Lifecycle replacements	3,887	2,469
Other Receivables	1,185	1,434
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	8,733	7,826

Other current and non current receivables include the NHS Injury Scheme (was RTA).

14.2 Provision for impairment of receivables

	As at 31 March 2012 £'000	As at 31 March 2011 £'000
At 1 April	757	670
Increase in provision	167	117
Amounts utilised	(18)	(14)
Unused amounts reversed	(116)	(16)
At 31 March	790	757

14.3 Analysis of impaired receivables

	As at 31 March 2012 £'000	As at 31 March 2011 £'000
Ageing of impaired receivables		
0 - 30 Days	21	0
30 - 60 Days	0	0
60 - 90 Days	0	0
90 - 180 Days	0	0
over 180 Days (over 6 months)	17	752
Total	38	752
Ageing of non-impaired receivables past their due date		
0 - 30 Days	269	153
30 - 60 Days	15	138
60 - 90 Days	32	99
90 - 180 Days	30	196
over 180 Days (over 6 months)	22	738
Total	368	1,324

15 Trade and Other Payables

	As at 31 March 2012	As at 31 March 2011
Current	£'000	£'000
Receipts in advance	0	0
NHS payables - revenue	792	1,467
Amounts due to other related parties	1,975	1,679
Trade payables - capital	1,360	1,047
Other trade payables	0	0
Taxes payable	3,647	3,108
Other payables	4,386	4,450
Accruals	2,933	1,966
PDC dividend payable	0	0
Reclassified to liabilities held in disposal groups in year	0	0
TOTAL CURRENT TRADE & OTHER PAYABLES	15,093	13,717
Non-current		
Receipts in advance	0	0
NHS payables - revenue	0	0
Amounts due to other related parties	0	0
Trade payables - capital	0	0
Other trade payables	0	0
Taxes payable	0	0
Other payables	0	0
Accruals	0	0
TOTAL NON CURRENT TRADE & OTHER PAYABLES	0	0

Taxes payable consists of employment taxation only (Pay As You Earn and National Insurance contributions), owed to HM Revenue and Customs at the year end.

16 Other Liabilities	As at 31 March 2012 £'000	As at 31 March 2011 £'000	As at 1 April 2010 £'000
Current			
Deferred Income	2,048	1,040	1,242
Deferred PFI credits	0	0	0
Deferred Government Grant	0	0	0
Net Pension Scheme Liability	0	0	0
TOTAL OTHER CURRENT LIABILITIES	2,048	1,040	1,242
Non-current			
Deferred Income	0	0	0
Deferred PFI credits	0	0	0
Deferred Government Grant	0	0	0
Net Pension Scheme Liability	0	0	0
TOTAL OTHER NON CURRENT LIABILITIES	0	0	0

Where income has been received for a specific activity which is to be delivered in the following financial year, that income is deferred.

17 Provision for Liabilities and Charges

	Current		Non Current	
	31 March 2012	31 March 2011	31 March 2012	31 March 2011
	£'000	£'000	£'000	£'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Other legal claims	76	80	0	0
Agenda for Change	404	0	0	0
Other	226	533	0	0
Total	706	613	0	0

	Total	**Pensions - former directors**	**Pensions - other staff**	**Other legal claims**	**Agenda for Change**	**Other**
	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April 2011	613	0	0	80	0	533
Arising during the year	802	0	0	178	404	220
Utilised during the year	(470)	0	0	(97)	0	(373)
Reversed unused	(239)	0	0	(23)	0	(216)
At 31 March 2012	706	0	0	138	404	164
Expected timing of cashflows:						
- not later than one year;	706	0	0	138	404	164
- later than one year and not later than five years;	0	0	0	0	0	0
- later than five years.	0	0	0	0	0	0
TOTAL	706	0	0	138	404	164

Other Legal Claims include claims under Employers' and Public Liability.

The Carbon Reduction Commitment Scheme (CRC) is a mandatory cap and trade scheme for non-transport CO2 emissions. As the Trust is registered with the CRC scheme, it is required, with effect from 2011/12 to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. This liability is recognised within the Other category of this note.

Other provisions include assessed liabilities in respect of the balance outstanding for Middle Grade Doctors Pay Award, CRC Scheme, and other litigation.

The NHS Litigation Authority has included in its provisions at 31 March 2012 £55,401,000 (2010/11 £40,426,000) in respect of clinical negligence liabilities for the Trust.

18 Prudential Borrowing Limit

NHS Foundation Trusts are required to comply and remain within a prudential borrowing limit. This is made up of two elements:

* the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
* the amount of any working capital facility approved by Monitor.

As per Section 46 of the Act, the Trust has a Prudential Borrowing Limit of £174,700,000 in 2011/12 (2010/11 £178,200,000). The Trust has not borrowed in 2011/12 (2010/11 £ nil) and at 31 March 2012 its long term borrowing was £156,262,000 (2010/11 £158,251,000) in relation to the finance lease of the Trust PFI Scheme. The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £158.7M and
(ii) Approved Working Capital Facility not to exceed £16.0M

Financial Ratio	2011/12		2010/11	
	Actual	Plan	Actual	Plan
Maximum Debt / Capital Ratio	57.0%	62.0%	62.0%	62.0%
Minimum Dividend Cover	5.8x	5.0x	6.1x	5.7x
Minimum Interest Cover	2.2x	2.2x	2.2x	2.5x
Minimum Debt Service Cover	1.5x	1.5x	1.5x	1.7x
Maximum Debt Service to Revenue	4.9%	5.0%	5.1%	5.2%

The Trust has an approved working capital facility of £10.0M. The Trust had not utilised any of its working capital facility at 31 March 2012 (2010/11 £ nil).

Further information on the NHS Foundation Trust Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

There has been no necessity to make use of the Trust's Prudential Borrowing Limit or to use its overdraft facility. The decrease in the Trust's Prudential Limit to £158.7M (31 March 2011 £162.2M) is in relation to compliance with the International Financial Reporting Standards (IFRS) which require the assets and liabilities of the Trust's PFI Initiative scheme to be accounted for within its Statement of Financial Position, see note 24 to the accounts.

	2011/12	**2010/11**
	£'000	£'000
Total long term borrowing limit set by Monitor	158,700	162,200
Working capital facility agreed by Monitor	16,000	16,000
TOTAL PRUDENTIAL BORROWING LIMIT	**174,700**	**178,200**
Long term borrowing at 1 April	158,251	162,154
Net actual borrowing/(repayment) in year - long term	(1,989)	(3,903)
Long term borrowing at 31 March	156,262	158,251

19 Borrowings

	As at 31 March 2012	As at 31 March 2011
Current	£'000	£'000
Obligations under Private Finance Initiative contracts	4,897	4,231
Total Current borrowings	4,897	4,231
Non Current		
Obligations under Private Finance Initiative contracts	151,365	154,020
Total Other non Current Liabilities	151,365	154,020

20 Cash and Cash Equivalents

	As at 31 March 2012	As at 31 March 2011
	£'000	£'000
Cash and Cash Equivalents	36,346	33,441
Broken down into:		
Cash at commercial banks and in hand	3	10
Cash with the Government Banking Service	36,343	33,431
Other current investments	0	0
Cash and cash equivalents as in Statement of Financial Position	36,346	33,441
Bank overdraft	0	0
Cash and cash equivalents as in Statement of Cash Flows	36,346	33,441

Other current investments were instant access cash deposits held with UK Bank Institutions.

21 Events after the reporting period

There have not been any events after the reporting period.

22 Contingencies

The Trust does not have any contingencies in 2011/12. However, at 31 March 2011 the Trust had a possible obligation to award damages in relation to an employment tribunal to the value of £150,000. This has not been successful. The probability of the success of the claim was low and thus had been included as a contingent liability.
The Trust does not have contingent assets.

23 Related Party Transactions

The Dudley Group NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by Monitor, the Independent regulator for Foundation Trusts. Key management personnel, namely the Trust Board Directors and Non Executive Directors, are those persons having authority and responsibility for planning, directing and controlling the activities of the Trust. During the year none of the key management personnel have parties related to them that have undertaken any material transactions with The Dudley Group NHS Foundation Trust.

The table below details, on an aggregate basis, key management personnel compensation:

	31 March 2012	31 March 2011
Compensation	£ million	£ million
Salaries and short-term benefits	0.80	1.15
Post-employment benefits	0.70	1.00
	1.50	2.15

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services. The value of activity undertaken with these organisations was not material to the accounts. The Department of Health is also regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. These entities are listed below:

	Year ended 31 March 2012				Year ended 31 March 2011			
	Income	Expenditure	Receivable	Payable	Income	Expenditure	Receivable	Payable
	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million
Department of Health	-	-	-	-	-	-	0.60	-
West Midlands Strategic Health Authority	7.77	-	-	-	7.56	0.01	0.04	-
Birmingham East & North PCT	11.74	-	-	-	11.31	0.23	-	0.23
Dudley PCT	204.17	3.44	2.35	0.02	182.20	1.39	2.56	0.14
Royal Wolverhampton NHS Trust	0.32	1.00	-	-	-	1.07	-	-
Sandwell PCT	33.75	-	0.51	-	31.26	-	0.50	-
Sandwell and West Birmingham Hospitals	0.27	0.80	-	0.03	0.14	0.82	-	0.12
South Staffordshire PCT	9.38	-	0.19	-	9.30	-	0.16	-
University Hospital Birmingham FT	1.12	0.16	-	-	1.06	-	-	0.04
Wolverhampton City PCT	3.44	-	0.22	-	3.29	-	-	-
Worcestershire Acute Hospitals Trust	0.15	0.65	0.05	-	-	0.66	-	0.10
Worcestershire PCT	4.01	-	0.02	-	4.83	-	0.03	-

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. These entities are

	Year ended 31 March 2012				Year ended 31 March 2011			
	Income	Expenditure	Receivable	Payable	Income	Expenditure	Receivable	Payable
	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million
HM Revenue & Excise	-	-	-	-	-	-	-	-
NHS Blood and Transplant Agency	-	1.54	-	0.02	-	1.90	-	0.05
NHS Business Services Authority	-	-	-	0.19	-	4.19	-	0.31
NHS Litigation Authority	-	5.81	-	-	-	5.46	-	-
NHS Pensions	-	15.47	-	1.98	-	-	-	1.68
NHS Professionals	-	-	-	-	-	-	-	-
Dudley Metropolitan Borough Council	0.64	1.31	-	-	0.22	1.31	-	-

24 Private Finance Initiatives

24.1 PFI schemes on the Statement of Financial Position

The Dudley PFI project provided for the refurbishment and new building of major inpatient facilities at Russells Hall Hospital, the building of new facilities at Guest Hospital and Corbett Hospital. The Capital value of the scheme was £160.2m. The Project agreement runs for 40 years from May 2001 (except IT, which runs for 15 years from completion). The Dudley PFI is a combination of buildings (including hard Facilities Managed (FM) services) and a significant range of allied and clinical support services.
The standard Unitary Payment changes periodically as a consequence of:

- Inflation (based on RPI and reviewed annually)
- Deductions for poor performance (Deficiency points and financial penalties for poor performance or non-compliant incidents).
- Variations to the Project Agreement(PA) (agreed under Variations procedure in the PA)
- 50% of market testing or refinancing impact
- Energy tariff adjuster (the difference between actual energy tariff changes and the uplift that comes through RPI)
- Volume adjuster (computed by comparing actual in patient days against that in the schedule, with a tolerance of plus or minus 3%)

The Trust has the rights to use the specified assets for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.
The PFI transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual (ARM) issued by Monitor, and therefore the Trust is required to account for the PFI scheme 'on-balance sheet' and this means that the Trust treats the asset as if it were an asset of the Trust and the substance of the contract is that the Trust has a finance lease and payments comprise two elements, an imputed finance lease charge and service charges.

	As at 31 March 2012 £'000	As at 31 March 2011 £'000
Gross PFI Liabilities	166,727	168,006
of which liabilities are due		
- not later than one year;	15,362	13,986
- later than one year and not later than five years;	19,588	16,924
- later than five years.	131,777	137,096
Finance charges allocated to future periods	(10,465)	(9,755)
Net PFI liabilities	**156,262**	**158,251**
- not later than one year;	4,897	4,231
- later than one year and not later than five years;	19,588	16,924
- later than five years.	131,777	137,096

The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 March 2012 £'000	31 March 2011 £'000
Within one year	4,897	4,231
2nd to 5th years (inclusive)	19,588	16,924
Later than 5 Years	131,777	137,096
Total	**156,262**	**158,251**

Total length of the project (years)	36
Number of years to the end of the project	29

25 Financial Instruments and Related Disclosures

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Trust has identified are as follows:

25.1 Financial Risk

Because of the continuing service provider relationship that the Trust has with Primary Care Trusts (PCT's) and the way those PCT's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Finance and Performance Committee.

25.2. Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

25.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

25.4 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in note 13 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the end of the period.

25.5 Liquidity Risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability to draw funding from the Trusts £10,000,000 working capital facility minimises such risk. The working capital facility level has been derived by taking into consideration the forecast month end cash balances for the coming two years. NHS Foundation Trusts are committed to comply with the Prudential Borrowing Code made by Monitor, the Independent Regulator of Foundation Trusts, and further details of the Foundation Trusts compliance can be found at note 17 “Prudential Borrowing Limit.”

The Trust is therefore not exposed to significant liquidity risk.

25.6 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

25.7 Financial Assets By Category

The following table shows by category the Trust's financial assets and financial liabilities at 31 March 2012 and 31 March 2011.

Financial Assets	As at 31 March 2012		As at 31 March 2011	
	Total	Loans and Receivables	Total	Loans and Receivables
	£'000	£'000	£'000	£'000
NHS Trade and other receivables excluding non financial liabilities	3,846	3,846	3,689	3,689
Non NHS Trade and other receivables excluding non financial liabilities	431	431	330	330
Other Investments	0	0	0	0
Other Financial Assets	0	0	0	0
Non current assets held for sale and assets held in disposal group excluding non financial assets	0	0	0	0
Cash and cash equivalents (at bank and in hand)	36,346	36,346	33,441	33,441
	40,623	40,623	37,460	37,460

Other Financial Assets are fixed term cash investments with UK Bank Institutions

Financial Liabilities	As at 31 March 2012		As at 31 March 2011	
	Total	Other financial Assets	Total	Other financial Assets
	£'000	£'000	£'000	£'000
Borrowings excluding Finance lease and PFI liabilities	0	0	0	0
Obligations under finance leases	0	0	0	0
Obligations under Private Finance Initiative contracts	156,262	156,262	158,251	158,251
NHS Trade and other payables excluding non financial assets	2,953	2,953	3,158	3,158
Non NHS Trade and other payables excluding non financial assets	8,493	8,493	7,451	7,451
Other financial liabilities	0	0	0	0
Provisions under contract	706	706	613	613
Liabilities in disposal groups excluding non-financial assets	0	0	0	0
	168,414	168,414	169,473	169,473

26 Third Party Assets

The Trust did not hold any cash at bank or in hand at 31 March 2012 (31 March 2011 £7,924) which related to monies held by the Trust on behalf of patients. The previous year balance was excluded from cash at bank and in hand figures reported in the accounts.

27 Losses and Special Payments

NHS Foundation Trusts are required to record payments and other adjustments that arise as a result of losses and special payments on an accruals basis, excluding provisions for future losses. In the period reported for 2011/12 the Trust had 38 (2010/11 43) separate losses and special payments, totalling £75,000 (2010/11 £73,000). These were in relation to cash losses and ex-gratia payments to patients.

There were no clinical negligence, fraud, personal injury, compensation under legal obligations or fruitless payment cases where the net payment for the individual case exceeded £100,000.

28 Auditors' Liability

In accordance with the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the liability of the Trust Auditors, Deloitte LLP is restricted to £1,000,000 in respect of liability to pay damages for losses arising as a direct result of breach of contract or negligence in respect of services provided in connection with or arising from their letter of engagement dated 5 May 2010.

The Dudley Group NHS
NHS Foundation Trust

Quality Report
2011/12

www.dudleygroup.nhs.uk

Content

PART 3

ANNEX

Part 1: Chief Executive's Statement

I am delighted to introduce this Quality Report, the purpose of which is to give a detailed picture of the quality of care we provide for patients who have visited our hospitals and/or received our services in the community from April 2011 to the end of March 2012.

At the beginning of the year we set ourselves some challenging quality objectives. We wanted to set ourselves on a path to exceed our internally set quality targets by 2014 so that we would be recognised as the highest quality service provider in the region by patient groups, staff and other key stakeholders. We also wanted to ensure we were providing excellent care and services, making patients feel involved, valued and informed.

These objectives linked into both our guiding principle as a healthcare provider and indeed the reason for our existence; to provide high quality care for all of our patients. However, what is high quality care? We believe it is being able to answer 'yes' to the following three questions:

1 Patient Experience
Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

2 Patient Safety
Are patients safe in our hands?

3 Clinical Effectiveness
Do patients receive a good standard of clinical care?

We are working towards answering these questions positively and being able to demonstrate it transparently. We believe the quality of care is made up of these three elements but they cannot be measured in just one way. Therefore we use a number of measures, all of which add together to give an overall picture of what the organisation is achieving and where it still needs to improve.

In Part two of this document we have outlined our priority quality measures and charted their progress throughout the year. A summary of current and previous priorities can be seen in the table on page 6; more information on each current priority can be found on the page numbers listed in the table. This further information includes progress made to date, as well as our new targets for 2012/13. This part of the report also includes sections required by law on such topics as clinical audit, research and development and data quality.

In Part three we have included other key quality projects and measures and specific examples of good practice on the three elements of quality listed above. Hopefully this will give a rounded view of what is happening across the whole of the Trust.

This is the first Quality Report that covers our new community adult services which joined us last April. Although some parts of the report are divided into hospital and community sections, we have deliberately not included a separate section on the community services. The reason for this is that we take the patient view that services should be seamless and integrated and many of our services cross the hospital and community boundary.

During 2011/12, nationally there has been a requirement to make substantial financial savings and a degree of uncertainty remains regarding the overall structure of the NHS. Despite these challenges, we believe the wide range of measures and checks detailed in this report indicate that the overall quality of care delivered at The Dudley Group is good and in line with that of other similar Trusts both locally and nationally.

Our Quality Priorities

As you read the report, you will see that we have performed well with our 2011/12 priorities related to patient experience feedback from our community services, inpatient MRSA infections, the time from admission that patients are having their hip operations and the large reduction in the numbers of hospital acquired pressure ulcers. For Clostridium difficile, we unfortunately breached our target but, following intensive work with assistance from outside partners, we have been back onto the individual monthly targets from November 2011 and this continues. We recognise there is some way to go to ensuring our inpatients' experience of our services matches that which we would all expect and we still have work to do to ensure we drive down the number of avoidable pressure ulcers acquired in the community. With regards to 2012/13, we have retained all of the topics from 2011/12 except for the time from admission to having a hip operation, as we are consistently performing well with this. In addition, we have included further priorities relating to nutrition and hydration, issues that we know are important to individual patients as well as local and national patient organisations.

Measuring Quality

The report shows that we are constantly monitoring the quality of our care in a variety of ways. We do this to assure patients and ourselves of where we are doing well and to learn where we need to change practice and improve our services. This year we have re-launched our vision and values to help steer us towards our goal to put the patient first, value our staff and improve customer care. Our new vision "Where People Matter" goes hand in hand with our new values: "Care, Respect and Responsibility" which together form a good basis for high quality care.

Although the report includes facts and figures to measure quality, we have also included a number of specific examples of awards, innovations and initiatives that Trust staff have achieved and put into practice throughout the year.

Recognising that our staff are our greatest asset, we have also started a new Patient and Customer Care Ambassador programme to enhance patient experience by helping to improve staff attitude and behaviour. Our aim is to give our patients, carers, families and visitors the best possible healthcare experience. To spearhead the change more than 30 staff have already completed the programme since it was piloted in October 2011.

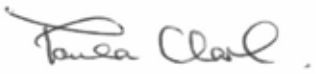
The ambassadors have been handpicked from staff across all wards and departments because they are known for their exemplary behaviour towards patients, their families, visitors and colleagues. They are now in the process of using their own experiences, both good and bad, to come up with a set of customer care standards as a promise to our patients to treat them with courtesy and respect at all times. In addition, while our patients acknowledge staff every day by the many compliments and letters we receive, we have developed a Roll of Honour which we publish on our Intranet which shows our appreciation of staff who give exceptional quality service and encourage others to copy their good customer care approach.

I hope you will find useful the information on the quality priorities which we have chosen to focus on, the ways in which we assure ourselves of our quality of care and a selection of the targets, both national and local.

We would appreciate any feedback you would like to give us on both the format and content of the report but also the priorities we have chosen. You can either phone the communications team on 01384 244404 or email communications@dgh.nhs.uk

I can confirm that, to the best of my knowledge, the information contained in this document is accurate.

Signed:



Paula Clark, Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Trust Board

2.1 Quality Improvement Priorities

2.1.1 Quality Priorities Summary

The table below gives a summary of the history of our quality priorities and also those we will be working towards in 2012/13.

Priority	2009/10	2010/11	2011/12	2012/13	Comments	More info
PATIENT EXPERIENCE Increase in the number of patients who report positively on their experience on a number of measures	√ Achieved	We improved on one measure with a slight decrease in another	**Priority 1** **Hospital:** Partially achieved **Community:** √ Achieved	**Priority 1**		P8 – 11
PRESSURE ULCERS Improve systems of reporting and reduce the occurrence of avoidable pressure ulcers	N/A	N/A	**Priority 2** **Hospital:** √ Achieved **Community:** Partially achieved	**Priority 2**		P12 – 14
INFECTION CONTROL Reduce our MRSA rate in line with national and local priorities Reduce our Clostridium Difficile rate in line with (or better than) local and national priorities	√ Achieved	√ Achieved	**Priority 3** √ Achieved x Not achieved	**Priority 3**		P15 – 17
HIP OPERATIONS Increase the number of patients who undergo surgery for hip fracture within 36 hours from admission (where clinically appropriate to do so)	N/A	√ Achieved	**Priority 4** √ Achieved	Not included as a priority	As the target was achieved for two consecutive years this priority has now been replaced for 2012/13	P7 – 8
NUTRITION Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission	N/A	N/A	N/A	**Priority 4**	A new priority for 2012/13	P18 – 19
HYDRATION Increase the number of patients who have fluid balance charts completed	N/A	N/A	N/A	**Priority 5**	A new priority for 2012/13	P18 – 19
CARDIAC ARRESTS Reduce the numbers of cardiac arrests	√ Achieved	√ Achieved	Not included as a priority	Not included as a priority	There was a dramatic improvement from 32 per month in 2008 to 13 per month by March 2011 and so this issue no longer remained a challenge for the Trust.	N/A

2.1.2 Choosing our Priorities for 2012/13

In February 2012, a 'Listening into Action' (LiA) workshop on the Quality Report, hosted by the Chief Executive and Director of Nursing, was held at Russells Hall Hospital Clinical Education Centre. There was an open invite to Trust Governors, members and representatives from patient groups. Fifty five people attended comprising 24 staff (three of which are Governors), five other Governors (four public, one appointed), 21 Foundation Trust members and five others from the following organisations: Dudley LINk, NHS Dudley, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC). The purpose of the day was to:

1. Provide an overview of the Trust's quality priorities (2011/12) and how they had progressed so far
2. Look at the quality priorities for 2012/13
3. Consider potential areas beyond 2012/13

Key clinical and non-clinical staff presented short talks on the existing four priorities:

- Patient Experience
- Infection Control
- Pressure Ulcers
- Hip Fractures

In addition, further presentations were made on two new potential priorities (Nutrition and Hydration) for 2012/13.

As the present target related to hip fractures had been achieved (see details across), we have decided to replace that with new topics for 2012/13. Therefore, there are now five areas for improvement for 2012/13 (the three other existing priorities from 2011/12 and the two new priorities). The workshop groups at the LiA event agreed that all five areas for improvement were of importance and so the Trust Board has agreed to have five priority areas in 2012/13.

Priority 4 for 2011/12. Increase the number of hip fracture patients who undergo hip fracture surgery within 36 hours from admission to the Emergency Department (where clinically appropriate to do so).

All of the developments for 2011/12 in this area for improvement, which were planned last year, have either been completed or are on-going. This has contributed to very good practice which has resulted in national recognition (see section 3.4.2).

Participants at the 'Listening into Action' workshop event as well as other Trust staff and Governors, have noted the success in achieving this target. For patients admitted between Apr 2011 – Mar 2012 (regional/national provisional figures correct at 8th May 2012):

- National average time to Surgery = 34.25 hours
- Regional average time to Surgery = 35.17 hours
- Trust average time to Surgery = 26.33 hours

The following two tables show the percentage of all of our patients who had hip surgery within 36 hours of admission (Table 1) and the percentage of those patients who had hip surgery within 36 hours of admission when it was clinically appropriate to do so (Table 2). We have shown two tables as some patients on admission are initially not well enough for surgery and need extensive treatment and therefore time to make them well enough for surgery to occur.

Table 1 – All patients having hip fracture surgery (Total: 460 patients of which 89.3 per cent were operated on <=36 hours)

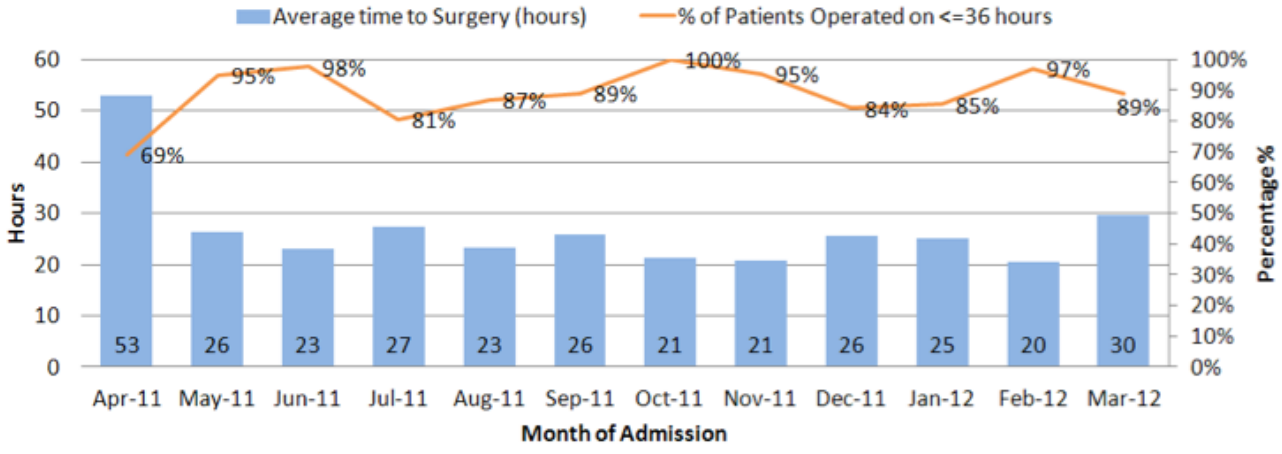
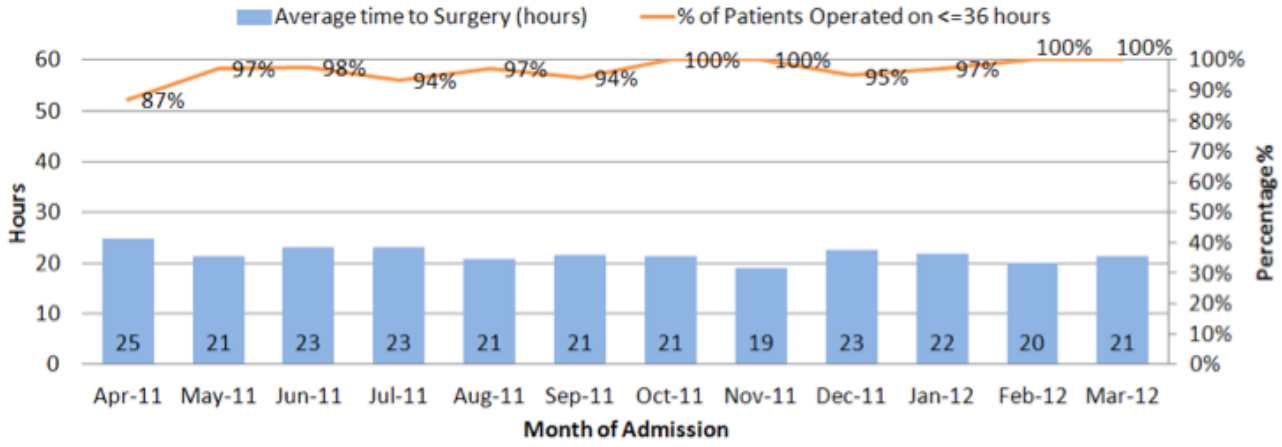


Table 2 – All patients having hip fracture surgery who were clinically well enough on admission for surgery (Total: 424 patients of which 96.9 per cent were operated on <=36 hours)



As Table 2 shows, the target has now been achieved, so we have decided to replace this priority with two new priorities for 2012/13 relating to nutrition and hydration. Already committed to making nutrition and hydration a priority during patients' stay in hospital, the Trust is endeavouring to develop and implement new strategies and monitoring systems to support this vital element of hospital care.

2.1.3 Our Priorities

Existing Priority 2011/12

PATIENT EXPERIENCE (3rd Priority Year)	
Priority 1 2011/12	
Hospital	Community
(a) Increase the number of patients who rate their overall care highly from 89.3 per cent in the 2010 national inpatient survey to 91 per cent. (b) Show an increase in patients who would recommend The Dudley Group's services to a friend or relative.	Increase the number of patients who rate their overall satisfaction with community services care and treatment from 94 per cent in the 2010/11 CQUIN (Commissioning for Quality and Innovation) patient experience survey to 96 per cent.

Patient Stories:

"Instruction on how to manage my condition was done sensitively and patiently."

"I did not enjoy the food on my recovery. I had very little appetite as the treatment affected my mouth, throat and intestines."

How we measure and record this priority

Hospital

The Trust takes part in the annual National Patient Survey programme which systematically gathers the views of patients about the care they have recently received. This priority is measured against results of the Inpatient Survey which takes place once a year and gives a 'snapshot' of care provided at that moment in time. We also undertake our own 'real-time' surveys to provide us with early identification of any problems throughout the year. We believe that listening to what patients tell us about their experiences is the best way for us to learn and improve.

We also measure our patient experience by listening to our Local Involvement Network (LINk) and other patient representative groups, feedback from patient concerns, complaints and compliments as well as feedback posted on NHS Choices.

Community
The Trust takes part in the Commissioning for Quality and Innovation (CQUIN) patient experience survey which systematically gathers the views of patients about the care they have recently received in the community. This usually takes place twice a year with the collection of baseline information early in the year and a repeat audit to measure our improvements. More information about the CQUIN scheme is available in section 2.2.4 on page 26.

Developments that occurred in 2011/12

In 2011/12 we refreshed our real-time surveys to improve the way we listen and make changes. Our enthusiastic team of volunteers carry out the surveys with patients in order to offer complete confidentiality. During the 2011/12 year we completed surveys with 1048 inpatients.

We also set up Patient Panels to provide a forum for patients to share their experiences to help us to improve our services. Panels have so far been held on:

- Inpatient mealtimes (November 2011)
- Accessibility (March 2012)

At the first Patient Panel we received feedback on the choice of food available, special dietary requirements, quality and flavour of food and communication relating to mealtimes. This subject has sparked great debate, and patient comments have been instrumental in the Board deciding to undertake a complete root and branch review of the way we deliver inpatient food services.

The Patient Panel on accessibility was well attended in March 2012 with patients sharing their experiences around wheelchair access, parking, hearing and low vision awareness. Action plans for improvement will be shared with the group and we look forward to working together to provide more accessible services.

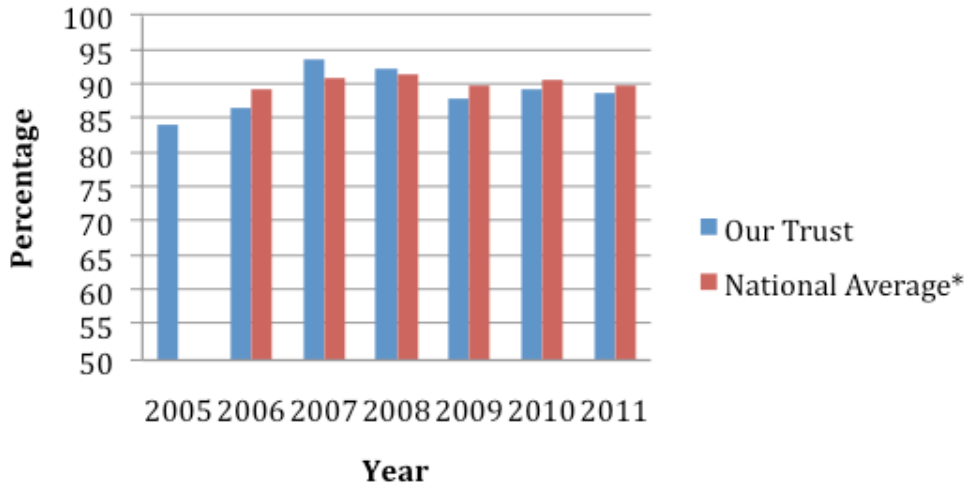
We also introduced a 'Health Hub' in the main reception at Russells Hall Hospital to provide patients, relatives, visitors and carers with as much information as possible to help reduce their potential anxieties and encourage them to be more informed about their care and treatment. During the year we also increased our range of patient information leaflets by 125.

Current status

Hospital
(a) The 2011 national Inpatient Survey results show that the number of patients who rate their overall care highly at The Dudley Group has decreased by 0.6 percent during the course of the year. This is in line with the average of 73 Trusts whose results were available for comparison, showing an average reduction of 0.8 per cent against this question.

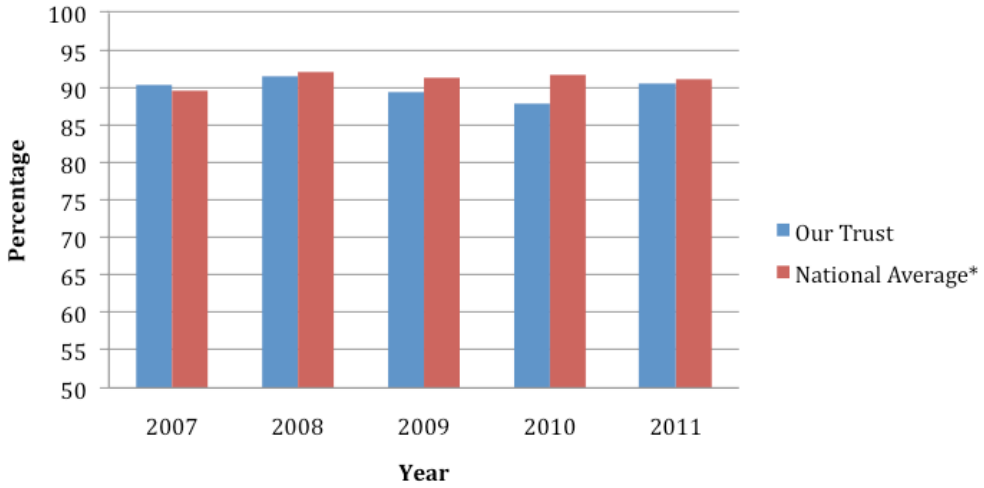
As indicated in the chart below, the results for this question have remained around 90 per cent for the last five years.

Patients rating overall care as good, very good or excellent



(b) In the 2011 National Inpatient Survey the Trust undertook the shorter core questionnaire (rather than the extended questionnaire) to try to encourage more participants to complete the survey. Unfortunately the recommendation question was not included in the core questionnaire; therefore the 'Our Trust' bar in the table below shows the results of our real-time surveys for 2011. Our real-time surveys represent the views of a much larger number of patients than the national survey and show an increase to 90.7 per cent of patients who would recommend the Trust to a friend or relative.

Patients who would recommend the Trust to a friend or relative



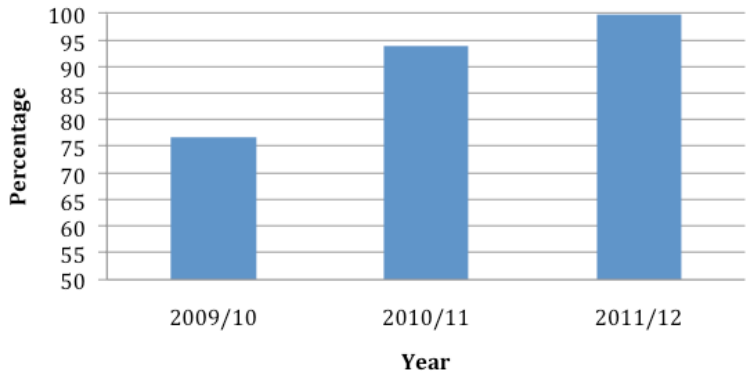
**National Average = Picker Institute Europe average. Picker undertook the inpatient survey for 73 hospital trusts in England in 2011*

Community

In line with the CQUIN requirements, a baseline survey was carried out in quarter two, with a follow up survey in quarter four to check for improvements. The surveys were undertaken with patients receiving care and treatment from the four services dictated by the CQUIN scheme: Continence, Diabetes, Virtual ward and Wound care (leg ulcer).

We are very pleased that patients surveyed are wholly satisfied with the care and treatment received, with the quarter two baseline of 99.56 per cent rising to 100 per cent in quarter four. This is testament to the hard work of community staff during their initial year in the Trust. Results from this and the two previous years are compared on the graph at the top of the next page.

Percentage of patients who are satisfied with the personal care and treatment received from the community services



New Priority 2012/13

PATIENT EXPERIENCE (4th Priority Year)	
Priority 1 2012/13	
Hospital	Community
(a) Increase the number of patients who receive enough assistance to eat their meals from 81 per cent to 85 per cent. (b) Increase the number of patients who receive enough information about ward routines from 57 per cent to 65 per cent.	(a) Increase the number of patients who use their Single Assessment Process folder to monitor their care from 75.3 per cent to 80 per cent. (b) Increase the number of patients who would know how to raise a concern about their care and treatment if they wished to do so from 80.8 per cent to 85 per cent.

Rationale for inclusion

Feedback at the Listening into Action workshop told us that patients and staff think that improving our patient experience is really important and should be retained as a quality priority. In previous years we have focused on overall measures of patient satisfaction and, while this is useful, in 2012/13 we want to try to make improvements to some specific issues that have scores which are lower than we would like.

Measuring this priority in 2012/13

Hospital

This will be measured using our ongoing real-time survey system to ensure we have up to the minute information and an early trigger system to highlight if progress is not being made either Trust-wide or in specific areas. This priority also forms part of our CQUIN scheme for 2012/13.

Community

This will be measured using an annual survey. The questions will be included alongside the existing CQUIN questions and will be asked of patients receiving care from the four services: Continence, Diabetes, Virtual ward, Wound care (leg ulcer).

Developments planned for 2012/13

- Consider feasibility of increasing employed nutritional support workers, continue utilising trained volunteer mealtime assistants, embedding of 15-minutes meal bell alert along with behind the bed boards identifying mealtime assistance requirements
- Introduce bedside folders to inform patients of ward routines
- Raise awareness with patient (or family/carer) of the use of the Single Assessment Process folder to keep them informed of the care provided and as a means of communication
- Ensure PALS leaflets are available for patients, refresh posters in clinic areas advising patients how to complain if they wish to, PALS advice to be documented as part of assessment

Board sponsor:
Denise McMahon, Director of Nursing

Operational lead:
Mandy Green, Communications Manager

Existing Priority 2011/12

PRESSURE ULCERS (1st Priority Year)	
Priority 2 2011/12	
Hospital	Community
Reduce avoidable stage three and four hospital acquired pressure ulcers through the year. This will mean by the final quarter of 2011/12 (Jan-Mar) the number for the last quarter of 2010/11 has been reduced by 50 per cent.	Ensure there is a reliable, accurate data collection system in place. For those patients on a district nurse caseload, avoidable stage three and four community acquired pressure ulcers are reduced through the year.

Patient Stories:

"Even once I was home I couldn't do the things that I usually do because the pressure ulcers were on my feet and I couldn't walk very well. It took a long time to heal."

How we measure and record this priority

Pressure ulcers (also called pressure sores and bed sores) are graded one to four with four being the most serious. It is vital that those treating the sores know what stage it is at and treat accordingly. It is also very important that the stage is recorded and treatment begins as soon as possible to prevent any complications and the problem becoming worse.

When a patient is identified as having a pressure ulcer this is noted on a weekly report on each ward and community service. This information is sent to the tissue viability team which maintains a Trustwide database of the details.

If pressure damage is noted within 72 hours (a time frame agreed by the Strategic Health Authority) of being admitted to hospital then this is considered to have developed before admission. The beginnings of an ulcer can be present but not visible for some time, therefore the patient may have been admitted to hospital already suffering from pressure damage.

Developments that occurred in 2011/12

Last year, we outlined a number of actions we intended to undertake during 2011/12. These have either been completed or are on-going. The key ones include:

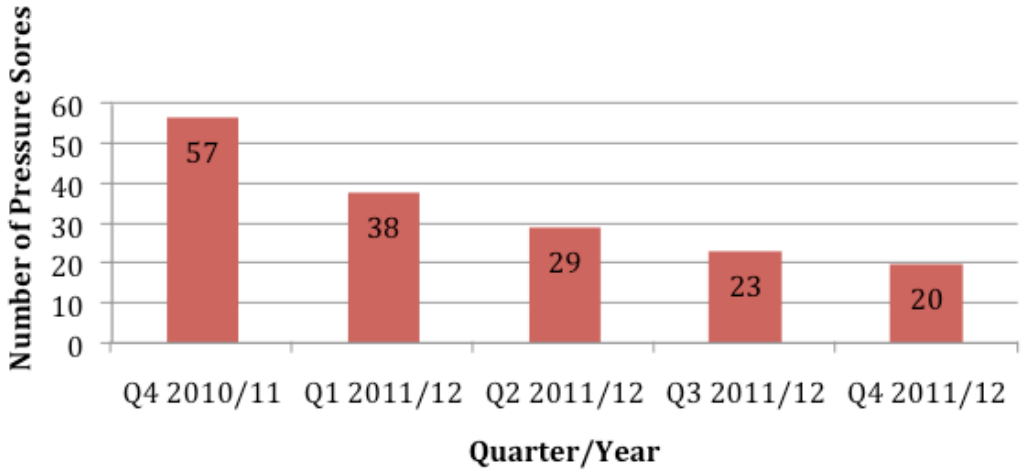
- The 'We love your skin' campaign which ran for three months and helped to raise awareness of pressure ulcer prevention.
- All wards have been issued with pressure ulcer prevention and management documents, which have been in use for over a year now. Compliance of the use of these documents is audited on a weekly basis. All wards are rated individually and there is a robust system in place to address any under achieving areas.
- All stage three and four pressure ulcers are reported as 'Serious Untoward Incidents' and are thoroughly investigated. This is done by a root cause analysis (a way of working out how and why the problem has happened) and from this actions are taken to prevent it happening again.Mandatory and induction training sessions continue for both hospital and community staff and a test has been added to ensure they know how to prevent, treat and manage pressure ulcers.

Current Status

Hospital

The graph below shows the number of stage three and four pressure ulcers that developed in the hospital from the fourth quarter of 2010/11 (January – March). It can be seen that to achieve the target of a reduction of 50 per cent the Trust needs to have reduced the numbers to 28-29 by the fourth quarter of 2011/12. This was achieved by the second quarter of the year.

Number of Stage three/four Pressure Ulcers Developed in Hospital

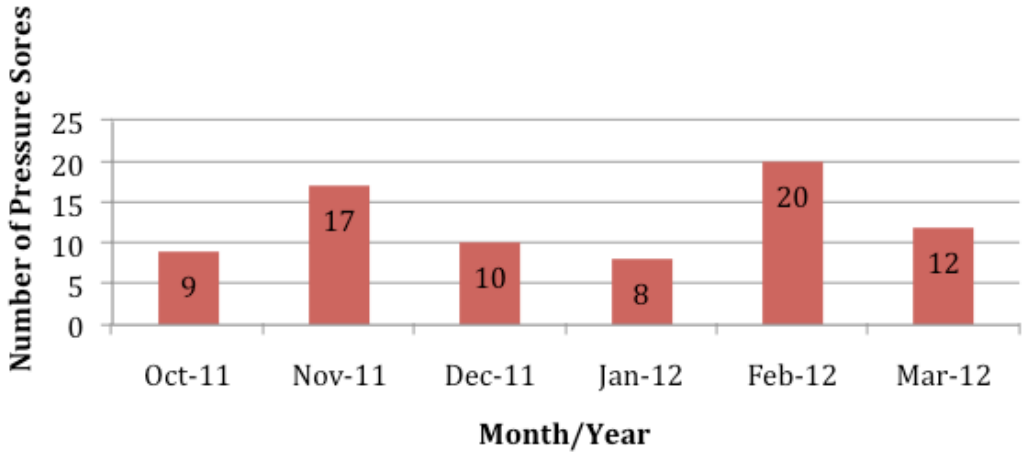


Community

A reliable system of reporting of pressure ulcers was put in place in community services in October 2011. This is now in line with the hospital system with all pressure ulcers being reported within 48 hours of development.

The number of ulcers do not seem to be decreasing (see graph overleaf). However, the new clear reporting system now in place has undoubtedly contributed to increased and more accurate reporting. Now district nurses report all pressure ulcers directly to the tissue viability department, rather than on the computer system which had connectivity problems when the Trust took over the community services.

Number of Grade three/four Pressure Ulcers Developed on District Nurse Caseload



It has also been seen through discussion of root cause analysis reports that there was a lack of knowledge in the community around pressure ulcer staging. This has led to a drive in education around pressure ulcers and again this has probably contributed to more accurate and increased reporting. Although the future cannot be fully predicted, it is probable that the numbers will level off as the new reporting system is used.

New Priority 2012/13

PRESSURE ULCERS (2nd Priority Year)	
Priority 2 2012/13	
Hospital	Community
Reduce avoidable stage three and four hospital acquired pressure ulcers, against activity, so that the number for 2011/12 has been reduced by 50 per cent in 2012/13.	Reduce avoidable stage three and four acquired pressure ulcers that occur on the district nurse caseload through the year, so that the number for the final quarter of 2011/12 has been reduced by 10 per cent at the second quarter of 2012/13 (Jul- Sep) and by 20 per cent at the final quarter of 2012/13 (Jan-Mar).

Rationale for inclusion

- Pressure ulcers are difficult to treat and slow to heal and prevention is therefore a priority
- Although the hospital achieved its target in 2011/12, the Trust realises there is still much to do and moving to a zero tolerance of pressure ulcers in hospital should be the aim.
- Feedback from our patients, staff, community groups and Governors indicates this should remain a target.

Developments planned for 2012/13

Actions being undertaken to achieve the Trust target include:

- Continue to embed the reliable reporting system with community nursing teams
- Train community staff to know what stage ulcers are at and treat accordingly
- Introduce a revised and improved version of the pressure ulcer prevention and management document
- Undertake a check of the use of the new document described above
- Undertake training of social services carers and carers within residential homes
- Improve the reporting of the incidence of pressure ulcers so that it is done electronically across the Trust rather than on paper as at present

Board Sponsor:
Denise McMahon, Director of Nursing

Operational Lead:
Lisa Turley, Tissue Viability Lead Nurse

Existing Priority 2011/12

INFECTION CONTROL (3rd Priority Year)
Priority 3 2011/12
Reduce our MRSA and Clostridium difficile (C. diff) rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than two post 48 hour cases; C.diff is no more than 77 post 48 hour cases.

Patient story

"Having C. diff makes you feel dirty and humiliated. You try to be clean but it feels out of control and very immediate. The nurses have been excellent and fastidiously wash their hands and change their aprons."

How we measure and record this priority

MRSA Bacteraemia and C. diff numbers are divided into pre and post 48 hours of admission cases. Only the post 48 hours cases are attributed to the Trust, meaning the patient acquired it in hospital. Pre 48 hours cases mean the patient was already developing the infection before they were admitted to hospital. The Trust, as part of the local health economy, has to record both pre and post 48 hours cases.

When our Pathology laboratory finds a positive result the information is fed into the HCAI (Health Care Acquired Infection) data system, a national data base. From there the data for all Trusts are collated and is sent to the Health Proctection Agency (HPA) for publication.

Developments that occured in 2011/12

Last year we outlined a number of actions we intended to undertake during 2011/12. These have either been completed or are on-going. The key ones include:

- Updating the policy and training for the taking of blood cultures. This has now happened.
- The development of a training video for the taking of blood cultures is nearly complete as are similar videos for aseptic technique, which prevents or minimises the risk of infection during clinical procedures, and cannulation, so making training more accessible.
- Disposable mops have been introduced across all areas of the Trust.
- Taking part in the National Patient Safety Agency (NPSA) prevention of central line infection in Critical Care Unit project and continue the Surgical Site Surveillance of non-mandatory procedures.
- In September 2011 we participated in the fourth national Prevalence Survey on hospital associated infections and the first national antimicrobial use and quality indicators in England. We are currently awaiting feedback to help us to identify target areas to watch in the future and decide on action.

Current Status

We have continued our good work to maintain consistently low levels of MRSA Bacteraemia (two in total). Unfortunately, we have not achieved our Clostridium difficile (C. diff) target this year, with numbers increasing generally across the West Midlands region.

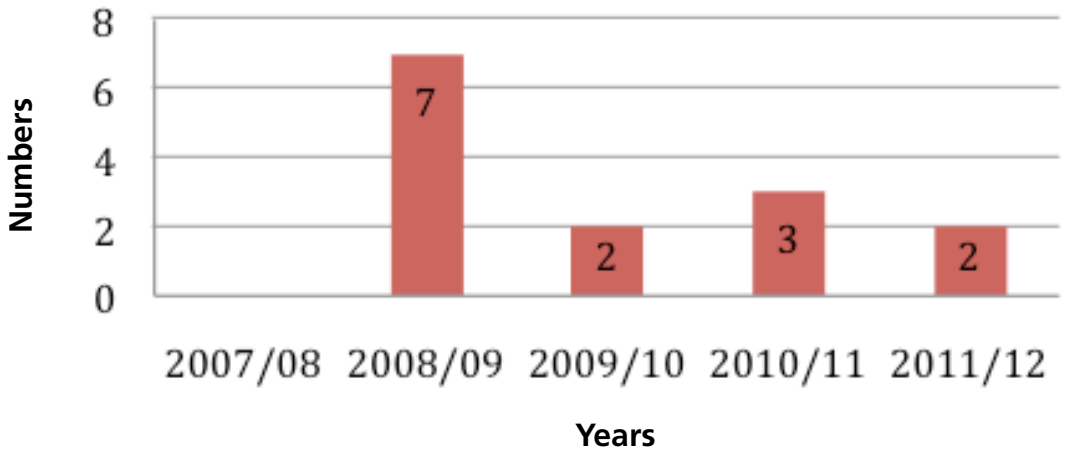
In May 2011, the Trust realised it was in danger of not meeting the C. diff target and so requested support from the Health Protection Agency (HPA), relevant PCT and SHA staff as well as independent

experts. Staff from these agencies investigated the situation and found that all the Trust procedures were appropriate. However, in certain cases these procedures were not always being used. Also in depth assessment (typing) of the strain of each case showed that cross infection was not happening in the hospital. An action plan was put into place and this is now monitored at a weekly meeting.

Actions taken include:
- Increased training
- More timely feedback on investigations of individual cases to the relevant clinicians to prevent reoccurrence
- A widespread awareness campaign

From November 2011, the Trust was back on track with its monthly targets and this continues to be the case up until the end of March 2012. The graph below shows the continued reduction of MRSA bacteraemia cases (post 48 hour, i.e. patients who acquired it whilst in hospital) from a total of seven in 2008/9 to a total of two in 2011/12.

Total MRSA cases per year

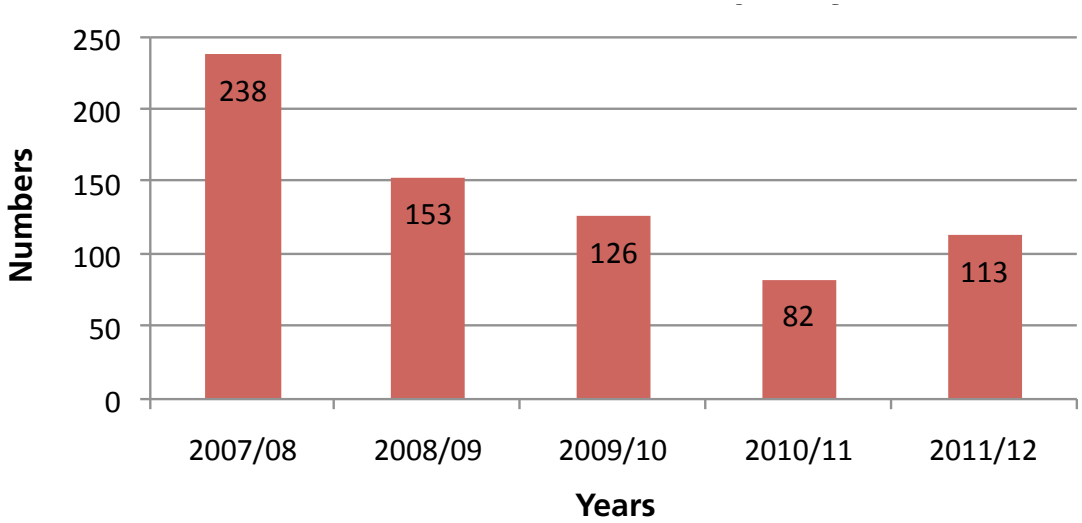


(In 2007/8 there was a total of 30 MRSA cases across the whole of Dudley both Trust and Community but separate post and pre-48 hours cases were not collected until 2008/9)

Current status C. diff

The graph below shows the total number of C. diff cases recorded as occuring more than 48 hours after admission, showing the reduction from a total of 238 in 2007/08 to a total of 113 in 2011/12.

Total C. diff cases per year



Priority for 2012/13

INFECTION CONTROL (4th Priority Year)

Priority 3 2012/13

To reduce our MRSA and Clostridium difficile (C.diff) rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than 2 post 48 hour cases; C.diff is no more than 77 post 48 hour cases.

Rationale for inclusion

- The drive to reduce healthcare associated infections, which includes MRSA Bacteraemia and C. diff, continues to become more challenging.
- To reduce infection remains a key aim across the NHS
- The Trust is conscious of not reaching the target for C. diff in 2011/12
- Feedback from our patients, staff, community groups and Governors indicates this should remain a target
- The Trust has been set by Department of Health the same targets for 2012/13 as those in 2011/12. This suggests that numbers have already been reduced to the minimal background level for C. diff.

Developments planned for 2012/13

Actions planned to achieve the above aims include:

- Introduce hydrogen peroxide 'fogging' for the environment when patients are discharged to reduce cross contamination
- Improve training support for anti-microbial (drugs that destroy disease-carrying micro-organisms) prescribing
- Review the details of the local cleaning contract in light of new national directives
- Agree competencies for the nursing element of cleaning the environment
- Agree and report competencies of contracted cleaning staff
- Improve information gathering including feedback and changes in practice regarding anti-microbial prescribing, bringing more senior medical input into the root cause analysis process
- Ensure more reliable investigations of individual infection cases with feedback and action plans to prevent or reduce it happening again
- Introduce the new testing algorithm introduced by the Department of Health
- Clarify the reporting regime as outlined by Department of Health guidelines
- The National Patient Safety Agency (NPSA) infection prevention project to be expanded and taken into the surgical and high dependency areas
- Review usage of protein pump inhibitors medication used for patients with stomach problems
- Monitor and record the time it takes to place patients into side rooms once an infection has been identified
- Appointment of an analyst to assist with the management of all the information required to keep an eye on and reduce infection rates
- Monitoring mortality rates when infections are involved

Board sponsor:
Denise McMahon, Nursing Director/Director of Infection Prevention and Control

Operational lead:
Dawn Westmoreland, Consultant Nurse, Infection Prevention and Control

New Priorities 2012/13

NUTRITION (1st Priority Year)

Priority 4 2012/13

Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission. By September 2012 at least 90 per cent of patients will have the risk assessment completed and this will continue for the rest of the year.

HYDRATION (1st Priority Year)

Priority 5 2012/13

Increase the number of patients who have fluid balance charts fully completed. By September 2012 at least 70 per cent of patients will have a fluid balance chart fully completed and this will rise to at least 90 per cent by the end of the year (March 2013).

How we will measure and record this priority

Every month 10 observation charts are checked at random on every ward as part of the wider Nursing Indicator assessments (in effect, 200 charts are audited in total per month). Each ward and the whole Trust is RAG (Red/Amber/Green) rated with a 'Green' given for a 90 per cent or greater score, an 'Amber' for 89-70 per cent scores and a 'Red' for scores 69 per cent or less.

Rationale for inclusion

- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The results of poor nutrition and hydration are well documented and include a) increased risk of infection, b) poor skin integrity, c) delayed wound healing, d) decreased muscle strength, e) depression and f) premature death. Put simply poor nutrition and hydration cause harm.
- A number of national reports, including those from Age UK and the CQC (Care Quality Commission), have questioned the state of practice with nutrition and hydration across hospitals generally.

A strong starting point for good nutritional care is that on admission every patient should be assessed on their nutritional status. The 'Malnutrition Universal Screening Tool' ('MUST'), in use for a number of years at the Trust, has been designed to help identify adults who are underweight and those at risk of malnutrition. It is a quick and simple procedure which enables us to take action and provide appropriate nutritional advice on admission.

In the last year, the importance of MUST has been highlighted by Dudley Council's Health and Adult Social Care Scrutiny Committee (HASC) during its Dignity in Care review of the Trust and by the CQC at one of its inspections.

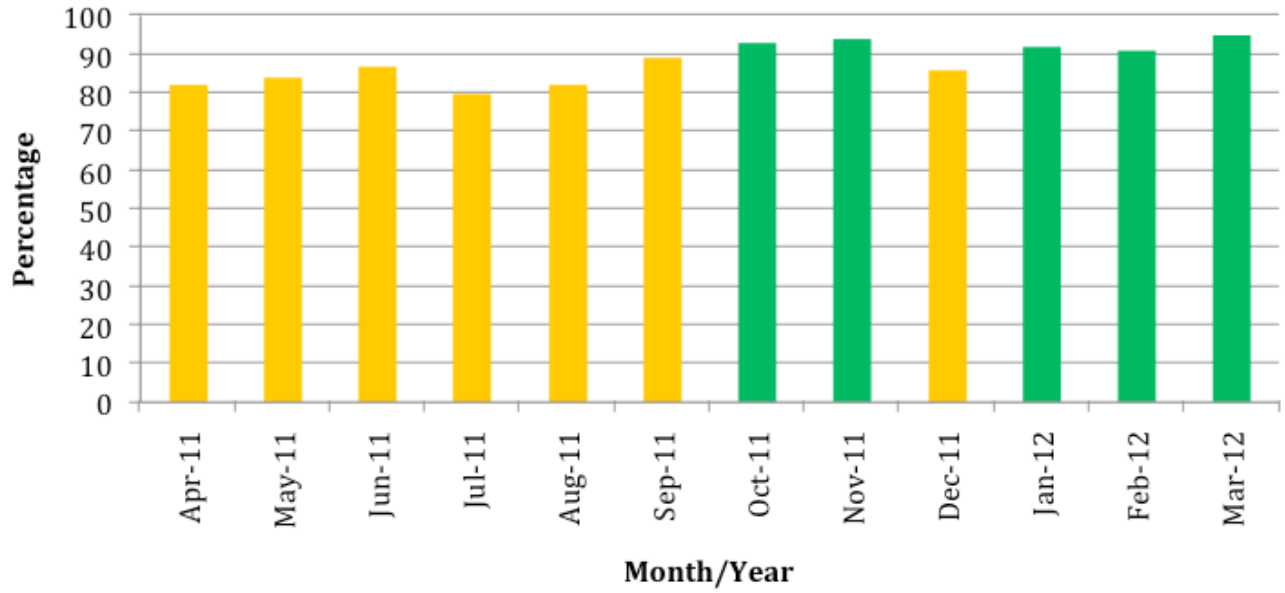
Improving hydration brings well-being and better quality of life for patients and can often mean reduced use of medication and prevention of illness. For the best hydration of the patient, the need for accurate recording of fluid input and output cannot be underestimated.

Current status

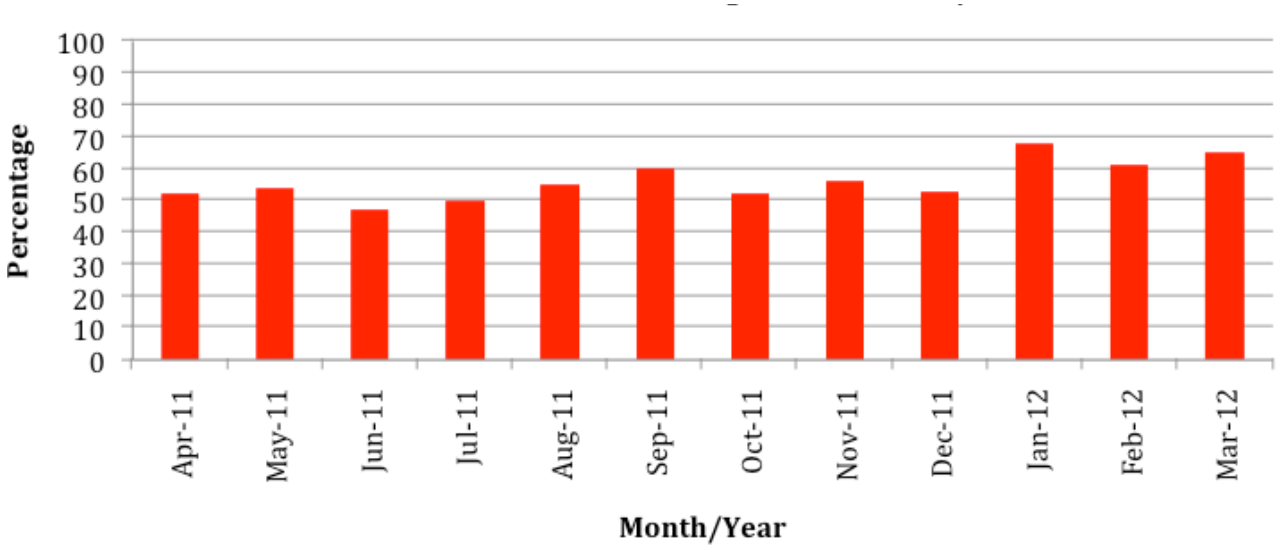
- Patients' needs are constantly assessed and where necessary information on bed boards is available so staff know the nutrition and hydration needs of each patient and can give special care
- The 15 minutes dinner bell prepares patients and staff for meal times
- A wide choice of food is available, including a vegetarian option and foods to meet religious, cultural and dietary needs
- 'Protected Meal Times' has been introduced meaning no interruptions with non-urgent treatments during mealtimes. This results in a more relaxed atmosphere which aids consumption and digestion
- Along with beverages served mid morning, mid afternoon and in the evening, extra snacks and drinks are also available
- A water jug, fruit juices and hot drinks are available to patients so that they stay hydrated and meet the recommended consumption of eight glasses of fluid per day

The graph below shows the overall Trust results for 2011/12:

MUST charts completed on admission 2011/12



Fluid balance charts completed 2011/12



Developments planned for 2012/13

- Nutrition steering group to review indicators quarterly and drive changes from any required action points
- Continue audit of MUST and education to be delivered in targeted areas
- Develop screen saver to promote MUST screening on admission to Trust
- Essence of Care Link nurses re enlisted
- Fluid balance charts redesigned and to be introduced
- New fluid balance charts to include new lunch time evaluation requiring trained nurse signature
- Education package for fluid balance developed to be delivered in all ward areas
- Competency document for fluid balance developed for all staff to sign
- New fluid balance criterion to be included in the Nursing Care Indicator (NCI) audit

Board Sponsor:
Denise McMahon, Director of Nursing

Operational Leads:
Dr S. Cooper, Consultant Gastroenterologist
Sheree Randall, Matron
Karen Broadhouse, Quality Project Lead

2.2 Statements of assurance from the Trust Board

2.2.1 Review of Services

During 2011/12 the Trust provided and/or sub-contracted 59 NHS services. The Trust reviewed all the data available to them on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2011/12 represents 99.4 per cent of the total income generated from the provision of NHS services by the Trust for 2011/12.

The above reviews were undertaken in a number of ways. With regards to patient safety, the Trust Executive and Non Executive Directors have been undertaking Patient Safety Leadership Walkrounds (see Section 3.3.2). Also covering patient safety, but including clinincal effectiveness, are the morbidity and mortality reviews undertaken by the Chairman, Chief Executive, Medical Director and the Non Executive Director who is chair of the Audit Committee. External input is provided by the Acting Medical Director of NHS Dudley. These occur on an 18-month rolling programme, covering all services.

Each service presents information from a variety of sources including:

- Internal audits
- National audits
- Peer review visits
- Activity and outcome figures such as readmission rates, day case rates and standardised mortality rates (see page 38 for more detail on our hospital mortality figures)

We also monitor safety, clinical effectiveness and patient experience through a variety of other methods:

- Nursing Care Indicators (NCI) – these are monthly reports of key nursing actions and their documentation. The results are published, monitored and reported to Trust Board monthly by the Director of Nursing.
- 'Productive' series – part of our Transformation programme looks at 'releasing time to care' by making work changes in theatres, the wards and the community. This results in clinical staff having more time directly with patients.

- The Outpatient Executive Group – oversees the action plan resulting from the National Outpatient Survey and other key working changes such as changes to clinic templates to help reduce waiting times.
- Ongoing patient surveys that give a basic feel for our patients' experiences in real-time so that we can quickly identify any problems and correct them.
- Patient Panels on specific topics also help us to get to the bottom of any hot topics such as inpatient mealtimes and accessibility. Our next Patient Panel will focus on carers.
- Every other month, senior medical staff attend the Trust Board to provide a report and presentation on performance and quality issues within their specialty areas.
- Every other month, a matron attends the Trust Board to provide a report and presentation on nursing and quality issues across the whole Trust.
- The Trust has an electronic dashboard of indicators for Directors, senior managers and clinicians for monitoring performance. The electronic dash board is essentially an online centre of vital information for staff. As a result of the information available here staff are able to give the right services and best possible care to patients.
- The Trust works with its local commissioners scrutinising the Trust's quality of care at joint monthly Clinical Quality Review meetings
- This year, the Midlands and East NHS has introduced a Quality Dashboard comparing all Trusts on a number of quality indicators, some of which are discussed in this report. The Trust has taken notice of the contents of this new initiative and has contributed to making the contents more robust.
- External assessments, which included the following key ones this year:
    - NHS Dudley continued its series of Appreciative Enquiry Visits by reviewing the arrangements for pressure ulcer prevention and management at the Trust. NHS Dudley staff were accompanied by patient/public representatives to interview staff and visit wards to look at practice and talk with patients. The results of the visit were very positive and an action plan was drawn up for the minor points of concern raised.
    - In May 2011, the West Midlands Quality Review Service looked at the Trust in conjunction with the local health community on the following services: a) Mental Health b) Learning Disability c) Vulnerable Adults in Acute Hospitals and d) Dementia. The results of the review were positive and an action plan has been drawn up and commenced.
    - In Nov/Dec 2011 a Joint CQC and Ofsted Inspection of safeguarding and looked after children services across the whole of Dudley took place. The Trust was a part of this inspection along with Dudley Metropolitan Borough Council, NHS Dudley and other local organisations. The Trust has drawn up an action plan, which has been approved by the CQC and started to put in place the relevant recommendations made.
    - In mid year, the Health and Adult Social Care Scrutiny Commitee (HASC) of Dudley Metropolitan Borough Council undertook a Dignity in Care Review of the Trust. In conclusion, the review stated: 'Members were impressed by the energy and commitment to Dignity practices'. A number of recommendations were made and the Trust is in the process of putting them in place.
    - The Trust had visits/inspections from the Local Supervisory Authority for Midwives (March 2011) and Clinical Pathology Accreditation (UK) Ltd accredited the Immunology Department (Jun 2011) and Histopathology and Cytology departments (April 2011). With regards to education and training, NHS West Midlands assessed the quality of training of pharmacists. The University of Birmingham College of Medical and Dental Sciences undertook a 'Follow On' Developmental Visit of the Undergraduate Teaching Academy (May 2011) and West Midlands Postgraduate Medical Education and Training Deanery inspected the paediatric department (July 2011), the Chemical Pathology department (Oct 2011) and the nephrology speciality (Jan 2012). NHS Quality Control North West assessed the Aseptic Preparation of Medicines (March 2011). Where recommendations were made, action plans have been put into place.

2.2.2 Participation in National Clinical Audits and Confidential Enquiries

During 2011/12, 43 national clinical audits and four national confidential enquiries covered NHS services that the Trust provides.

During that period the Trust participated in 40 (93 per cent) national clinical audits and four (100 per cent) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1. National clinical audits that the Trust was eligible to participate in during 2011/12

Name of Audit	Type of Care	Audit Participation	Submitted %
Perinatal mortality (MBRRACE-UK)	Peri-natal	Yes	100%
Neonatal intensive and special care (NNAP)	Neo-natal	Yes	100%
Paediatric pneumonia (British Thoracic Society)	Children	Yes	100%
Paediatric asthma (British Thoracic Society)	Children	Yes	100%
Pain management (College of Emergency Medicine)	Children	Yes	100%
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	Children	Yes	100%
Paediatric intensive care (PICANet)	Children	Yes	100%
Diabetes (RCPCH National Paediatric Diabetes Audit)	Children	Yes	100%
Emergency use of oxygen (British Thoracic Society)	Acute Care	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Acute Care	Yes	In progress
Non invasive ventilation (British Thoracic Society)	Acute Care	Yes	In progress
Pleural procedures (British Thoracic Society)	Acute Care	Yes	100%
Cardiac Arrest (National Cardiac Arrest Audit)	Acute Care	Yes	100%
Severe sepsis & septic shock (College of Emergency Medicine)	Acute Care	Yes	100%
Adult critical care (ICNARC CMPD)	Acute Care	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Acute Care	Yes	100%
Seizure management (National Audit of Seizure Management)	Acute Care	Yes	70%
Diabetes (National Adult Diabetes Audit)	Long term conditions	Yes	100%

Name of Audit	Type of Care	Audit Participation	Submitted %
Heavy menstrual bleeding (RCOG National audit)	Long term conditions	Yes	100%
Chronic pain (National Pain Audit)	Long term conditions	Yes	100%
Ulcerative colitis & Crohn's disease (UK IBD Audit)	Long term conditions	Yes	100%
Parkinson's disease (National Parkinson's Audit)	Long term conditions	Yes	100%
Adult asthma (British Thoracic Society)	Long term conditions	Yes	100%
Bronchiectasis (British Thoracic Society)	Long term conditions	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Elective procedures	Yes	96%
Elective surgery (National PROMs Programme)	Elective procedures	Yes	85.2%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Elective procedures	Yes	100%
Carotid interventions (Carotid Intervention Audit)	Elective procedures	Yes	100%
Acute Myocardial Infarction & other ACS (MINAP)	Cardiovascular disease	Yes	100%
Heart failure (Heart Failure Audit)	Cardiovascular disease	Yes	100%
Acute Stroke (SINAP)	Cardiovascular disease	No	
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Cardiovascular disease	Yes	100%
Renal replacement therapy (Renal Registry)	Renal disease	Yes	100%
Lung cancer (National Lung Cancer Audit)	Cancer	Yes	100%
Bowel cancer (National Bowel Cancer Audit Programme)	Cancer	Yes	100%
Head & neck cancer (DAHNO)	Cancer	Yes	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	Cancer	Yes	100%
Hip fracture (National Hip Fracture Database)	Trauma	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Trauma	Yes	48% (participation commenced Oct 2011)
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Blood transfusion	Yes	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	Blood transfusion	Yes	1st Stage 60% 2nd stage In progress
Risk factors (National Health promotion in Hospitals Audit)	Health promotion	No	
Care of dying in hospital (NCDAH)	End of life	No	

Table 2. National confidential enquiries that the Trust was eligible to participate in during 2011/12

Name of Enquiry		Enquiry Participation	% of cases submitted
Cardiac arrest procedures	NCEPOD	Yes	100%
*Bariatric Surgery	NCEPOD	Yes	100%
Surgery in Children	NCEPOD	Yes	100%
Peri-operative Care	NCEPOD	Yes	100%

**The Trust does not perform Bariatric Surgery but has participated in the study of patients who have been admitted as an emergency following Bariatric surgery elsewhere.*

As well as the national audits from the Department of Health standard list, in Table 1 above, the Trust has also taken part in these further national audits:

Table 3. Additional National Audits that the Trust has participated in during 2011/12

Name of Audit	Type of Care	Audit Participation
RCPCH Decreased Conscious Level Audit	Children	Yes
National Audit of Services for People with Multiple Sclerosis	Long term condition	Yes
CEM Consultant Sign-off in the ED	Acute care	Yes
Ionising Radiation (Medical Exposure) Regulations (IR(ME)R 200	Radiology	Yes
National Audit of Back Pain by NHS Occupational Services	Health promotion	Yes

The reports of six national clinical audits were reviewed by the provider in 2011/12 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

- Variable rate insulin infusion introduced
- New blood sugar testing and insulin charts introduced
- New Diabetic Ketoacidosis (DKA) and Hyperosmolar Nonketotic Coma (HONK) guidelines produced
- Introduction of falls link nurses in ward areas and link nurse meetings
- Production of falls prevention leaflets for outpatients areas
- Review of the Medical Emergency Team (MET) and cardiac arrest calls to ensure track and triggers are used correctly (in conjunction with new guidance on completion of observations)
- Develop a clear standard of care and treatment for all end of life patients
- Mental health awareness training made mandatory for all clinical staff who come into contact with people with dementia
- Expansion of the Acute Confusion Care Team
- Appointment of a Band 6 Registered Mental Nurse (RMN)
- Updated departmental guidelines in line with national guidance for the management of Paediatric Pneumonia
- Patients' smoking status checked at every review and referral to smoking cessation services offered
- Patients offered Computed Tomography (CT) calcium scoring to assess coronary heart disease risk
- Development of a patient information booklet which explains the importance of cascade screening for early detection and treatment of familial hypercholesterolaemia. This has been developed to improve the screening process and increase the identification of patients with the disease
- Promoting increased use of the patient information booklet which explains familial hypercholesterolaemia and the importance of lifestyle changes and treatment to reduce cholesterol levels

Local Clinical Audit

The reports of 70 completed local clinical audits were reviewed by the Trust in 2011/12 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- New referral form introduced to replace GP referral letter to standardise information relating to patients attending the Emergency Assessment Unit
- New consultant obstetric anaesthetist commenced September 2011
- Consent forms for caesarean sections currently being revised by the consultants
- Changes introduced to medical ward round frequency to ensure all patients are seen by a consultant within 72 hours
- Following carpal tunnel decompression, referral to hand therapy in early post-operative phase to help with the common problems such as scar pain
- Inclusion of information sheets for semi-elective trauma cases in junior doctor induction pack
- Introduction of a standard referral proforma for spinal trauma patients
- Development of specific sleep study parameters that are most predictive of sleep apnea
- Production of guidelines for the management of elderly women with breast cancer
- Provision of training for two additional breast care nurses to deliver quality information at pre-operative assessment
- Increase use of ultrasound for acute surgical admissions
- Pre-operative scoring of the risk factors in cataract surgery to ensure allocation of the theatre slots according to the severity of the risks
- Setting of clearly documented post operative targets in all cases following strabismus surgery
- Introduction of a pharmacist in Post Operative Assessment Clinic (POAC) to achieve 100 per cent improvement in care and documentation
- Further education for prescribers and nursing staff regarding risks of oxygen
- Review of current allocation of audiologists
- Introduction of a structured day case patient journey to resolve excessive pre-operative starvation times and prolonged stay
- Triage staff to inform the lead midwife coordinator when waiting times increase so that extra resource may be provided to deal with women in a timely manner
- Specific fatigue/breathlessness sessions developed by the community Macmillan specialist team
- Arrangement of shadowing opportunities for therapists with the independent living team
- Utilisation of a checklist to identify patients suitable for cardiac resynchronisation therapy (CRT) and as a prompt for evidence-based medication
- Proton Pump Inhibitors (PPI) indication review to be undertaken on and during admission to acute medical ward
- In the elective pre-operative setting, echocardiography requests are to be made at least three weeks prior to operation date to allow adequate allocation of resources

2.2.3 Research and Development

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 972. Commercial studies were 6.2 per cent of the total.

The Trust has participated in large multicentre trials in the fields of cancer, cardiology (heart) and musculoskeletal (body movement) medicine, undertaking both academic and commercial studies. The Dermatology Department has also begun commercial research during 2011/12 by taking advantage of the services of a research nurse employed by the Birmingham and Black Country Comprehensive Local Research Network (BBC CLRN) and the Clinical Research Unit's laboratory facilities.

In 2011 a professorship was awarded to Mrs Carmichael, Consultant in Breast Surgery, by the University of Aston for research work relating to breast cancer.

We have three clinical research fellows, one funded by the Trust, another funded by Arthritis Research UK and an oncology (cancer) clinical research fellow funded by BBC CLRN. Two rheumatology staff have also submitted grant applications.

Some of the improvements in clinical practice brought about by participating in clinical trials and other research studies are:

- All newly diagnosed patients with breast cancer are now routinely advised about the beneficial effect of regular exercise in breast cancer management

- Patients suffering from some acute leukaemias and lymphomas are now treated with a chemotherapy treatment whose success is based on the results of clinical trials.
- Patients awaiting joint replacement are advised on exercise and diet before surgery. In some cases weight reduction stops joint pain completely and surgery is not required.

Trust publications, including conference posters, increased to over 100 during the calendar year 2011, the greatest contribution coming from the rheumatology department providing new knowledge on lipids and platelet function in rheumatoid arthritis.

2.2.4 Commissioning for Quality and Innovation Payment (CQUIN) framework

A proportion of the Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

This is a quality increase that applies over and above the standard contract. The sum is variable based on 1.5 per cent of our activity outturn and depends on achieving quality improvement and goals. The estimated value in 2011/12 was £3.75m as part of our contracts with Primary Care Trusts (PCTs) for acute and community services, and with specialised services commissioners. We have not yet agreed the final settlement figure for 2011/12 as some targets depend upon information yet to be received. However, for the purpose of the year end accounts, we have assumed 84 per cent achievement of both the PCT and specialised services schemes. This would equal approx £3.15m.

CQUIN report 2011/12

There is one CQUIN (Commissioning for Quality and Innovation) scheme per contract, made up of several goals. Goals for venous-thromboembolism (a blood clot in a vein) and responsiveness to personal needs are nationally determined, and the remainder are locally agreed.

We have rated the CQUIN for 2011/12 on a red amber green (RAG) basis dependent on achievement to date. We will fall short of meeting the goal for hospital patient experience and we have actions in place to ensure the quality of care in this areas is improved and it is a quality priority for 2012/13.

Primary Care Trust CQUIN

Hospital – summary of goals

Goal no.	Description of goal	Quality Domain
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Tissue Viability – Pressure Ulcers	Safety and Effectiveness
4	Medicines Management – Antimicrobial Stewardship	Safety
5	Smoking and Alcohol	Effectiveness
6	Mental Health	Effectiveness and Patient Experience

Community – Summary of goals

Goal no.	Description of goal	Quality Domain
1	To improve responsiveness to personal needs of patients	Patient Experience
2	To deliver shared pressure ulcer care across acute and community services	Safety and Effectiveness
3	Joint care planning for stroke patients	Safety, Effectiveness and Patient Experience
4	To ensure patients are successfully maintained out of hospital in their own home by the virtual ward service	Safety, Effectiveness and Patient Experience

Specialised Services CQUIN

Hospital – Summary of goals

Goal no.	Description of goal	Quality Domain
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Screening for Retinopathy of Prematurity in Neonates	Safety and Effectiveness
4	Audit of Neonatal Pathways	Safety and Effectiveness
5	Access to Renal Therapies	Effectiveness and Patient Experience
6	Organs for Transplant	Effectiveness

CQUIN report 2012/13

In 2012/13 the amount the Trust can earn from the CQUIN framework will increase to 2.5 per cent on top of the actual outturn value. The estimated value of this is £6.4m. As well as the mandated goals for venous-thromboembolism and responsiveness to personal needs being continued in 2012/13, there are additional compulsory goals of dementia screening and the NHS Safety Thermometer.

Primary Care Trust CQUIN

Hospital – Summary of goals

Goal no.	Description of goal	Quality Domain
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Patient Experience – Net Promoter	Patient Experience
4	Dementia screening, risk assessment and referral for specialist services	Safety and Effectiveness
5	NHS Safety Thermometer	Safety and Effectiveness
6	Tissue Viability – Pressure Ulcers	Safety and Effectiveness
7	Medicines Management – Antimicrobial Stewardship	Safety and Effectiveness
8	Alcohol & Smoking – Brief Advice	Safety and Effectiveness

Community – Summary of goals

Goal no.	Description of goal	Quality Domain
1	Patient Experience – Personal needs	Safety, Effectiveness, Patient Experience and Innovation
2	National NHS Safety Thermometer	Safety and Effectiveness
3	Tissue Viability – Pressure Ulcers	Safety and Effectiveness
4	Virtual Ward	Safety, Effectiveness and Patient experience
5	Making Every Contact Count (MECC)	Effectiveness

Specialised Services CQUIN

Hospital – Summary of goals

Goal no.	Description of goal	Quality Domain
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Dementia screening, risk assessment and referral for specialist services	Safety and Effectiveness
4	NHS Safety Thermometer	Safety and Effectiveness
5	Maintain the improvement from previous CQUINs	Effectiveness
6	Quality Dashboards	Effectiveness

2.2.5 Care Quality Commission (CQC) registration and reviews

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2011/12.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Following the January 2011 planned visit to inspect the 16 Essential Standards of Quality and Safety set out by the CQC, (which was noted in last year's Quality Account) we submitted an action plan to the CQC. The CQC revisited the Trust in September 2011 to check the progress of the required actions and these were all found to be successful. A further issue regarding infection control was noted in this second visit and was thought to need improvement and an action plan is now in place.

2.2.6 Quality of data

The Trust submitted records during 2011/12 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.2 per cent for admitted patient care; National average was 98.87 per cent
- 99.7 per cent for outpatient care; National average was 99 per cent
- 96.4 per cent for accident and emergency care, National average was 93.1 per cent

Which included the patient's valid General Practitioner Registration Code was:

- 100 per cent for admitted patient care; National average was 99.9 per cent
- 100 per cent for outpatient care; National average was 99.7 per cent
- 100 per cent for accident and emergency care. National average was 99.4 per cent

The Trust's Information Governance Assessment Report overall score for 2011/12 was 74 per cent and was graded 'Satisfactory'. The Trust will be taking the following actions to improve data quality:

- Improve the filing and date order of patient case notes
- Ensure electronic discharge summaries are complete and consistent with patient case notes
- Review the system of correcting admission and discharge errors that are made on the patient computerised administration system

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 7.2 per cent for diagnoses and 3 per cent for treatments with a 6.6 per cent error rate overall (the latest national overall figure in 2009/10 was 11 per cent). These results should not be extrapolated further than the Trust-wide and general medicine samples audited.

During 2011/12 there were 16 incidents relating to data loss. These included faxes and letters sent to incorrect and old addresses. Actions taken from these incidents included:

- Controls over faxing information tightened with a new policy widely circulated, posters placed by each machine and publicity distributed throughout the Trust
- Systems introduced to phone relevant departments before and after faxes are sent to check patient information is correct
- Systems put in place for staff to check the latest addresses rather than copying the address on previous letters
- Importance of data security and confidentiality reinforced at Trust induction for new staff
- Incidents publicised to all staff to raise awareness of this issue

Part 3: Other Quality Information

3.1 Introduction

The Trust has a number of different Key Performance Indicators (KPI) reports. These are available and used by a wide variety of staff groups monitoring quality on a day-to-day basis. The main tool for the reporting of the Trust's progress towards its goals is a web-based dashboard, available to all senior managers and clinicians. This dashboard currently contains over 130 targets, grouped under the headings of Quality, Performance, Workforce and Finance. In addition, constant monitoring of different aspects of the quality of care include weekly reports being sent to senior managers and clinicians which include: A&E, Referral to Treatment, Stroke and Cancer targets and monthly reports being sent to all wards, with a breakdown of performance by ward. These are based on Nursing Care Indicators, Ward Utilisation, Adverse Incidents, Governance and Workforce Indicators and Patient Experience scores.

To compare ourselves against other Trusts, we use CHKS Ltd, which is a leading UK provider of comparative healthcare information, as a Business Intelligence monitoring tool. Some senior managers have access to the West Midlands SHA comparative performance tables to enable the Trust to compare itself against other Trusts.

The following three sections of this report provide an overview, with both statistics and examples, of the quality of care at the Trust, using the three elements of quality as outlined in the initial Chief Executive's Statement:

- **Patient Experience** – does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?
- **Patient Safety** – are patients safe in our hands?
- **Clinical Effectiveness** – do patients receive a good standard of clinical care?

The final section includes general quality measures which have remained the same for 2011/12 as the Trust Board and our stakeholders believe these take into consideration both national and local targets which will be important to patients and give a further perspective of the Trust's quality of care.

3.2 Patient Experience

Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

3.2.1 Introduction

This section shows how we gained a picture of patients' views of the Trust and examples of changes made based on those views.

3.2.2 Trustwide Initiatives

a. Real-time surveys

During the 2011/12 year we refreshed our real-time survey system from a paper to an electronic system. Using bespoke inhouse software allows us to have full control over the questions that we include and ensures that changes can take place as and when required.

We endeavour to visit every ward twice per week to listen to patients' experiences and gain their views on the quality of our care. A built in trigger system means that, should a patient raise a concern, we can quickly take action to improve the rest of their stay with us.

b. Patient Panels

Patient Panels were also set up this year to provide patients with a forum to help to make improvements in specific areas by sharing their experiences with us.

By using these forums to focus on specific topics we hope to really get to the bottom on where any issues lie. The aim is to find out what it feels like to be on the receiving end of our services; what is good, what matters most and where opportunities exist for improvements to be made.

We have held two Patient Panels during 2011/12 and aim to continue these forums in 2012/13. For more information on the 2011/12 Patient Panels see page 9.

c. Patient and Customer Care Ambassadors

Recognising that our staff are our greatest asset, we have also started a new Patient and Customer Care Ambassador programme to enhance patient experience by helping to improve staff attitude and behaviour. Our aim is to give our patients, carers, families and visitors the best possible healthcare experience.

More than 30 staff have already completed the programme since it was piloted in October 2011.

d. Patient Stories

Hearing about a patient's experience directly from the patient is a very powerful learning tool for both our Board of Directors and the staff who are providing care. To this end we have started a programme of patient video stories that allow us to hear directly from the patient to learn valuable lessons for improvement.

3.2.3 National Survey Results

In 2011 we took part in two national patient surveys, one for inpatients and one for outpatients. The Trust chose Picker Institue Europe as our independent survey co-ordinator and participants were chosen by randomly selecting 850 patients for each survey from the sample months indicated in the table below.

Survey	Sample month	Number of responses
Outpatient survey	April 2011	401 (47.8%)
Inpatient survey	August 2011	443 (52.8%)

What the results of the surveys told us

Outpatient Survey

Things we are good at:
- Patients being given the name of who their appointment would be with
- Easy to find the way to the outpatient department
- Cleanliness of our facilities
- Consistency of seeing the same member of staff in the department
- Patients being told how to take new medications

Areas where improvements could be made:
- Better choice of appointment time
- Being able to find a convenient place to park
- Better explanation of why tests are needed
- Not all staff introduce themselves
- Better information on who to contact if worried about condition or treatment

Inpatient Survey

Things we are good at:
- Time from referral to being admitted
- Not having to share bay with members of the opposite sex
- Plenty of hand wash gels available
- Cleanliness of ward/room
- Privacy when being examined or treated

Areas where improvements could be made:
- Hospital food
- More involvement around discharge from hospital
- More information about what to do/not to do after leaving hospital
- Better patient involvement in decision making

Actions plans have been drawn up to make improvements in the areas identified.

3.2.4 Examples of Specific Patient Experience Initiatives

a. DVD for Hip and Knee Replacement Surgery

The Orthopaedic Department has developed a script for patient information/education to produce a DVD for future patients awaiting hip/knee replacement surgery. The purpose of the DVD is to inform and prepare patients for their planned surgery to improve recovery and reduce both complications and length of hospital stay.

b. Making patients' stays more comfortable

Patient comfort packs containing little essentials to help make stays in hospital more comfortable are being handed out to patients in the Emergency Assessment Unit (EAU). The packs are for people who come into hospital without any toiletries or without any family support. They contain a cleansing wipe, bar of soap, sachet of shampoo, comb/brush, toothbrush and toothpaste and have been introduced as part of the Trust's drive to improve patient experience.

c. Dignity boxes improve patients' comfort

Two clinical support workers have devised a 'dignity box' for patients with continence and mobility problems who visit outpatients by ambulance. The boxes have been produced as part of the staff's National Vocational Qualification (NVQ) level three in health and social care and contain everything a patient with continence problems might need to make their hospital visit more comfortable. Items in the box include body care wipes, pyjamas, a night gown, slippers and pads for bowel and bladder dysfunction. Until now, the department hasn't had a central place to store clothes and equipment and it could be embarrassing and uncomfortable for patients with continence problems to wait while staff collected everything that was needed. The dignity box makes life easier for patients and preserves their dignity and comfort when they visit outpatients.

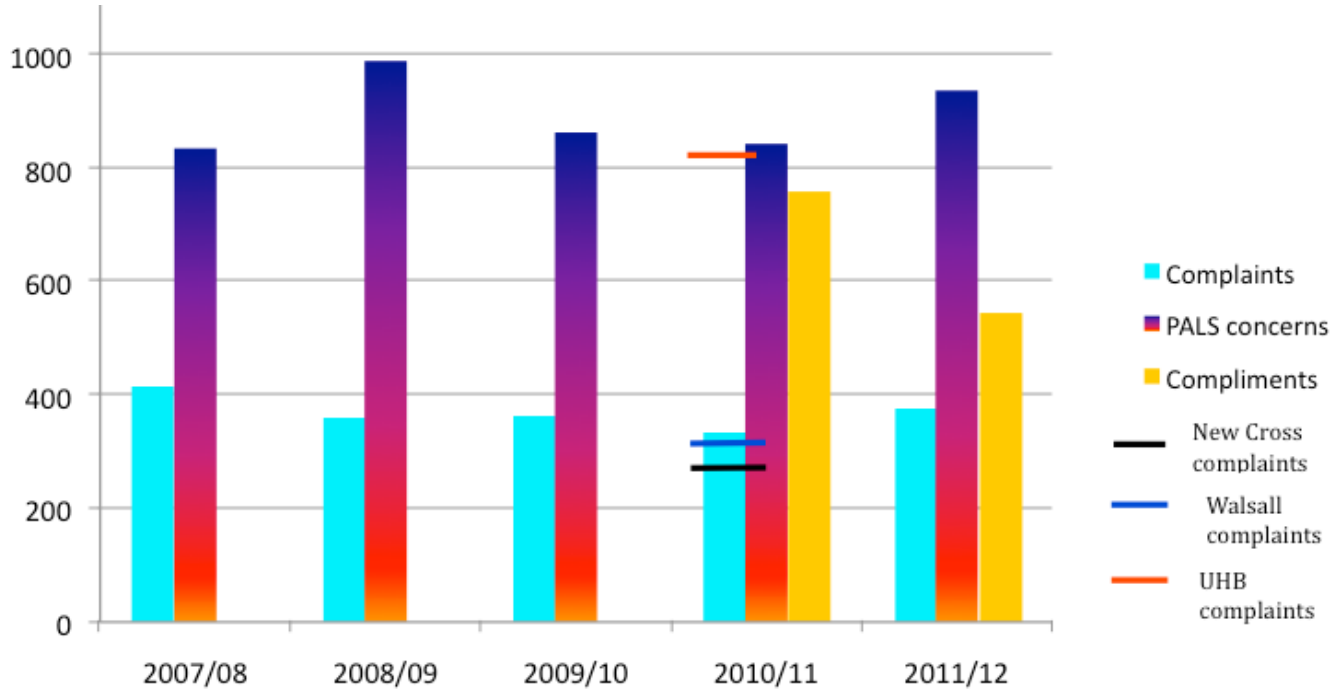
d. Outpatient satisfaction survey of breastcare patients

Patients were asked their views of their clinic visits and had to rate their experience on five subscales. Over 75 per cent of patients were satisfied overall and 95 per cent thought the medical staff warm and friendly. However, patients did not think enough time was spent with them and so the medical staff have stopped the task of dictating notes after each patient so enabling more time with each patient. The satisfaction scores have improved considerably.

3.2.5 Complaints and Compliments

This section contains tables of key complaint information together with examples of changes made as a result of complaints.

a) Total numbers of complaints (with local trust benchmarks), PALS concerns and compliments



b) Top 5 Complaints categories

Category	Year end 2010/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12	Year end 2011/12
All aspects of clinical treatment	221	70 (70%)	52 (53%)	58 (64%)	58 (64%)	238 (63%)
Attitude of staff	26	10 (10%)	8 (8%)	6 (6%)	12 (13%)	36 (10%)
Communication/ information to patient	23	5 (5%)	10 (10%)	7 (7%)	4 (4%)	26 (7%)
Admission, Discharge and Transfer	24	2 (2%)	5 (5%)	4 (4%)	8 (9%)	19 (5%)
OPD appointment/ cancellation	24	7 (7%)	14 (15%)	5 (5%)	3 (3%)	29 (8%)

c) Percentage of complaints against activity

Activity	Total yr ending 31/3/10	Total yr ending 31/3/11	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12	Total yr ending 31/3/12
Total patient activity	707462	714519	179588	184699	199883	189299	753469
% Complaints against activity	0.05%	0.05%	0.05%	0.05%	0.04%	(0.04%)	(0.05%)

d) Examples of changes implemented as a result of complaints

Emergency, Specialty Medicine & Elderly Care
- Direct line to district nursing service now available
- Review of staffing levels and increased ratio of care support workers and trained staff
- Nurses to check patients every two – four hours to ensure nursing needs (including meals and drinks) are met

Community Services and Integrated Care
- Explanation offered regarding signage in new Health Centre, which is outside of Trust's responsibility
- Failure to attend DNA (Did Not Attend) appointments explained to patient, who was asked to notify department if unable to attend appointments.
- Choose and Book system explained to patient

Surgery & Anaesthetics
- All medical staff reminded to ensure handwriting is legible
- Appointment system under review
- Additional clinics arranged
- New system of prescriptions in operation

Women and Children
- Women to be offered a wheelchair if they have difficulty in walking
- Matron raised awareness of staff attitude and good communication during patient interaction
- All staff reminded to answer call bells promptly
- Discharge checklist reviewed following stillbirth and information regarding community midwife visit now included
- Labelling on doors changed and teddy bear now used for rooms where babies are provided with treatment and care

3.2.6 PEAT Scores

Patient Environment Action Teams (PEAT) is an annual assessment of inpatient healthcare sites in England that have more than 10 beds.

It is carried out in accordance with guidance and includes Trust staff, PFI partners and an external validator. Patient representatives are also involved in the audit which is carried out on a single day once per year.

It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

Comparative PEAT assessment results 2009 to 2011

Year	Site Name	Environment Score	Food Score	Privacy & Dignity Score
2011	Russells Hall Hospital	Excellent	Good	Good
2010	Russells Hall Hospital	Excellent	Good	Good
2009	Russells Hall Hospital	Good	Good	Good

3.2.7 Patient Experience Measures:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12
% of patients that would recommend hospital to a relative/ friend	90.4%	91.5%	89.5%	88%	90.7%*
% of patients who would rate their overall care highly	93.8%	92%	88%	89.3%	88.7%
% of patients who felt they were treated with dignity and respect	97.4%	95.9%	94.6%	96%	95.3%

Data from national inpatient surveys conducted for CQC

** Data from our real-time surveys*

3.3 Patient Safety

Are patients safe in our hands?

3.3.1 Introduction

Ensuring patients are safe in hospital is achieved in many different ways from the quality of the training to the quality of equipment purchased. This section includes some examples of the ways we try to prevent things going wrong and what we do on those occasions when things unfortunately do not go to plan.

3.3.2 Patient Safety Walkrounds

For a number of years, the directors of the Trust have formally visited all of the departments to discuss with staff any concerns they have about patient safety in their areas. This year began with a schedule of at least three visits a month and included for the first time community departments, such as audiology, occupational therapy and physiotherapy at Brierley Hill Health and Social Care Centre. As well as making sure that directors get to know what front line staff are saying about patient safety, each visit results in an action plan.

Examples of changes that have happened this year after the walkrounds include:

- Purchase of both more monitoring equipment and beds for parents to sleep alongside children
- Improvements in the co-ordination and management of operating theatres
- Patients notes which were kept in an open carousel in a busy ambulatory care area now stored in a locked cupboard to prevent potential breaches in confidentiality
- Emergency nurses trained in specialised equipment rather than having to ask high dependency unit staff for advice and support. This reduces delays in treatment
- Purchase of further specialist equipment e.g. chairs, commodes, wheelchairs for larger patients
- Improved waste disposal in the renal (kidney) dialysis unit reducing the amount of waste in public areas
- Computer system amended to prevent inappropriate referrals eg between Audiology (hearing) and ENT (Ear, Nose and Throat) clinics
- System put in place to ensure confidentiality of key pad numbers when going into patient homes

3.3.3 Patient Safety Incidents

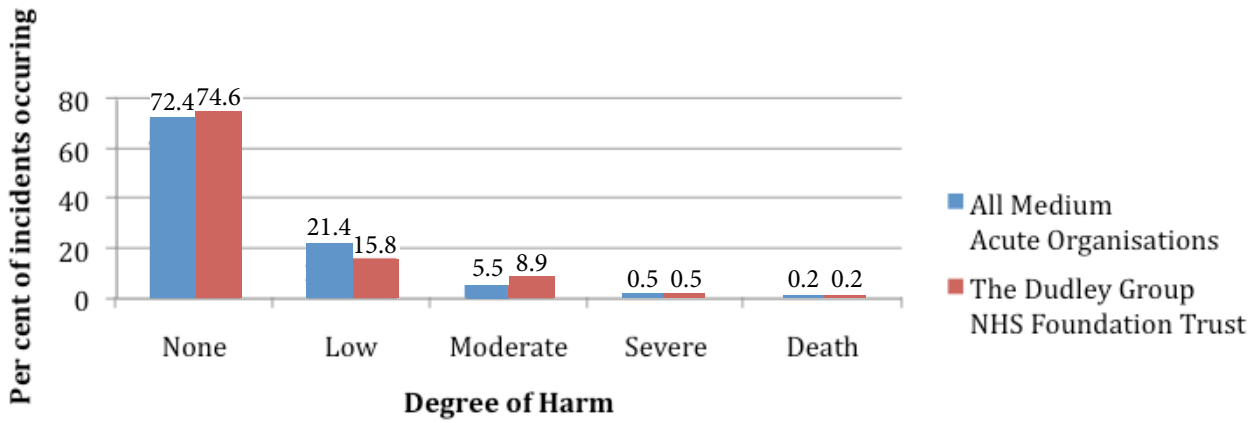
The Trust actively encourages its staff to report incidents, believing that to improve safety it needs to know what problems exist. This reflects the National Patient Safety Agency which has stated:

'Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are'.

The latest national comparative figures available are for the period 1 April 2011 to 30 September 2011. Organisations are compared against others of similar size. The Trust is the second highest reporter of incidents in its class of medium size acute Trusts.

With regards to the impact of the reported incidents it can be seen from the graph below, for the same period stated above, that the Trust is similar to other medium sized Trusts. Nationally across all Trusts 68 per cent of incidents are reported as no harm (Dudley Group 74.6 per cent) and under 1 per cent as severe harm or death (Dudley Group 0.7 per cent).

Incidents Reported by Degree of Harm for Medium Acute Trusts Organisations in England and Wales (Apr – Sep 2011)



In 2011/12 the Trust had no 'Never Events' (these are a special class of serious incident that generally are preventable). The Trust did have 302 'Serious Incidents' all of which underwent an internal investigation and, when relevant, action plans were initiated and changes made in practice. ('Serious Incidents' are a nationally agreed set of incidents which may not necessarily have resulted from error but need investigating to check the circumstances of its occurrence e.g. all child deaths are serious incidents even when this occurs as a result of serious illness or accident prior to admission).

Some examples of changes made in practice in response to the above incidents have been:

- Development of common management protocols for all patients in relation to laparoscopic colorectal surgery to ensure consistency of practice
- Robust method of introducing new guidelines and changes in practice which ensure all midwives are aware of new requirements in care and observations
- Improved monitoring and supervision of patients' wellbeing in the radiology department which includes the employment of a clinical support worker
- Introduction of an improved tracking system for medical photographs to ensure they can be located more easily when required for clinical and legal reasons
- Updated neonatal clinical guidelines which reflect the local Neonatal Network Guidelines
- Review of restraint policy to ensure clear guidance on approved restraint for healthcare settings and increased training on the needs of patients with mental health issues
- Introduction of screensavers on all computers across the Trust with key safety messages to raise awareness amongst staff and to help to prevent reoccurrence

3.3.4 Nursing Care Indicators (NCI)

Every month 10 nursing charts and other documents are checked at random on all general wards and departments at the Trust (in effect, 200 charts are audited in total per month) to ensure that nurses are undertaking activities that patients require and documenting that activity.

The initial themes looked at are:

- Patient observations (temperature, pulse, respirations etc)
- Pain management
- Manual handling and falls risk assessment
- Tissue viability – prevention of pressure ulcers
- Nutrition assessment and monitoring
- Medications and Prevention of infection.

In October 2011, the themes were expanded to include: ThinkGlucose programme to monitor diabetes and Bowel assessments.

The completion rates of each ward are fed back to the matrons and ward managers for action where necessary. Each ward and the whole Trust is RAG (Red/Amber/Green) rated with a 'Green' given for a 90 per cent or greater score, an 'Amber' for 89-70 per cent scores and a 'Red' for scores 69 per cent or less.

In the last year all aspects of care have improved across the Trust as shown below.

Average Trustwide scores for each NCI theme

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control
2010	77%	70%	71%	86%	68%	92%	95%
2011	83%	80%	79%	93%	77%	94%	97%
Difference	↑6%	↑10%	↑8%	↑7%	↑9%	↑2%	↑2%

The system has been expanded into the maternity, neonatal and paediatric units from 1st January 2012.

3.3.5 'Harm Free' Care and NHS Safety Thermometer

This year the Trust has signed up to 'Harm Free' care, a project being rolled out nationally to help teams eliminate four types of harm:

- Pressure ulcers
- Falls
- Urinary tract infections (in patients with a catheter)
- Venous thromboembolisms

Building on our existing improvements, 'Harm Free' care (meaning the absence of the above harms) can be measured using the NHS Safety Thermometer, so called as it provides a 'temperature check' on harm. This initiative will be reported on fully in next year's report.

3.3.6 Mortality

The different indices of mortality measure 'excess deaths' in different ways and the Trust now monitors the three most used figures:

1. SHMI (Summary Hospital Mortality Indicator)
2. RAMI (Risk Adjusted Mortality Index)
3. HSMR (Hospital Standardised Mortality Ratio)

At present, the Trust's SHMI is not outside the expected range.

To date, all internal investigations of outlier (off track) alerts generated from HSMR figures have confirmed no patient care problems and all alerts have been closed by the Care Quality Commission, which oversees these.

Recognising that whatever indices are used nationally, all mortality should be audited, the Trust continues to develop its internal mortality monitoring process. This includes monthly presentations to the Chairman, Chief Executive and Medical Director.

From 1st January 2012 a new database developed in-house is being used to ensure that the system of monitoring all deaths is undertaken in a more effective way. The Policy for Monitoring Inpatient Deaths has been changed, which will give more helpful and meaningful reporting in the future. This should also help individual departments to identify any patterns/problems more easily.

The Trust is also part of the new West Midlands Mortality Group where knowledge and experience is shared.

3.3.7 Examples of Specific Patient Safety Initiatives

a. Important change to barium enema requesting

We have changed the way barium (a liquid that coats the inside of the bowel to help gain a clear X-ray) enemas are requested both from our own staff and GPs to reduce the risk of harm from oral bowel cleansing solutions. Following a rapid response alert from the National Patient Safety Agency, all referring clinicians must ensure the patient is properly assessed to make certain it is clinically safe to undertake bowel preparation for a barium enema. The standard general X-ray request form has been replaced by a new Barium Enema Request form which includes a checklist that the clinician is asked to complete to ensure the patient is suitable for bowel preparation.

b. Red Stop Stickers help deliver high standards for infection control

Prolonged courses of antibiotics can cause increased risk of Clostridium difficile infections, increased resistance to antibiotics and increased risk of developing an allergy to the antibiotic.

Red stickers (to stop a course of antibiotics being prescribed) have been issued to all staff who don't include a date of duration and date of review on prescription charts when giving patients courses of antibiotics. The five-day red stop sticker initiative was part of our ongoing commitment to deliver high standards of infection control. Antibiotics need to be prescribed responsibly, appropriately and safely and the red stickers will remind prescribers to include all the relevant information on the prescription charts.

c. Protocol for care post-laparoscopic surgery

In response to a National Patient Safety Agency (NPSA) national alert the Trust produced a detailed protocol for care post-laparoscopic (key hole) surgery. For this type of surgery, there is an under-recognised risk that complications can remain undiagnosed until a life threatening condition such as circulatory collapse or septic shock develop. A multidisciplinary team produced clear standards for care post- abdominal, urological and gynaecological procedures.

These included:
- Expected observations
- Discharge criteria
- Information given on discharge
- Actions to take if patients telephoned later with problems

d. Purchase of and training in safer intravenous medicine equipment

Device models differ in their dials and settings which can lead to inaccurate measurement. This year the Trust has standardised intravenous infusion devices on a single model which includes enhanced safety features. A Trust-wide user training programme was put in place which teaches the safe operation of all ambulatory (portable) syringe drivers.

3.3.8 Patient Safety Measures:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12
Patients with MRSA infection/1,000 bed days*	N/A	0.07	0.04	0.01	0.01
Patients with C.diff infection/1,000 bed days*	1.45	0.97	0.9	0.51	0.70
Number of cases of Venous Thromboembolism (VTE) presenting within three months of hospital admission	49	48	48	35	143**

**Data source: Numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. NB MRSA/C. difficile figures may differ from data available on the HPA website due to Trust calculations using the most current Trust bed data.*

***Previous data collection of Hospital Acquired Thrombosis (HAT) was identified through clinical codes alone. We found that this information was not always a true reflection for a variety of reasons including the fact that the available clinical codes for thrombosis are confusing and, in practice, misleading. Also a majority of deep vein thrombosis (DVT) do not require readmission to hospital which results in further inaccuracies in data collection.To improve the accuracy of our data collection we now review all diagnostic tests for DVTs and pulmonary embolism (PE), cross referencing positive tests with past admissions. This methodology is only undertaken by relatively few hospitals as it is labour intensive, but is recognized as giving a more accurate figure for HAT. As a further check, we receive notification from the bereavement officer if PE was identified as the primary cause of death. As a result of amending our methods of identifying HAT, this year we have seen an increase in figures, but would stress that this is down to better identification of cases.*

3.4 Clinical Effectiveness

Do patients receive a good standard of clinical care?

3.4.1 Introduction

This section includes the various initiatives happening at the Trust to make sure patients receive a good standard of care and where we stand out compared to other organisations.

3.4.2 Examples of Awards received for Clinical Care

a. NHS Diabetes Care QiC (Quality in Care) award – Best emergency or inpatient care initiative

This award recognises the importance of providing specialised, tailored and safe care to people with diabetes while in hospital. The Trust's initiative 'ThinkGlucose' won this award. The project aims were:

- Increasing awareness of diabetes in inpatients.
- Specialists seen quickly with an early discharge/ follow-up plan to reduce the length of stay.
- Reducing prescription errors and improving patient care through updated guidelines.

The Trust achieved these aims with a reduction in insulin prescription errors, a drop in referrals to the wrong departments and an improvement in hypoglycaemia (low blood sugar) management. ThinkGlucose was seen to be a clear success, resulting in improved outcomes for patients with diabetes.

b. Wound Academy (Molnlycke) Scholarships

The Trust's Diabetes Foot Team was awarded a Highly Commended Team Award for its 'Putting Feet First' initiative, which provides foot education for patients and health care professionals. The team, comprising three podiatrists, focused on the care of wounds in the diabetic foot across primary and secondary care.

c. Fracture neck of femur service – high quality care recognized

The National Hip Fracture 2011 Report has praised the Trust as an example of good practice and for the high standard of care we give our patients.

The report said the Hip Fracture Suite's specialised service has delivered big reductions in long stay patients (from 34 to 23 days) and a steadily rising proportion of patients discharged directly home (from 50 per cent to 64 per cent).

In the same report Russells Hall Hospital has been the top performing among all the West Midland hospitals in the last three quarters of 2011.

d. Chronic Obstructive Pulmonary Disease (COPD)

The Chronic Obstructive Pulmonary Disease Local Enhanced Service (COPD LES) in Dudley won the 'Best Respiratory Initiative' at the National Vision Awards 2011.

The award was presented by Gyles Brandreth to community and hospital staff who attended on behalf of the Dudley Respiratory Group, at The International Convention Centre Birmingham in November 2011.

The COPD LES provides full training and support materials for all healthcare professionals from primary and secondary care, a comprehensive review for all patients with COPD in primary care, standby medication prescribed in both primary and secondary care and encouragement of self management by patients. The judges commented that the COPD LES was 'far reaching and had excellent engagement'.

e. Committed to Excellence Awards

These local awards, sponsored by the Trust's business partners, are now in their fifth year and recognise what staff do, day in day out, to give patients the very best care. One category is the Excellence in Patient Care award which was won this year by Amy Virdee, Clinical Support Worker on Ward C7. Amy has worked for The Dudley Group for more than 20 years and is gentle, caring, considerate and dedicated to her patients. She has very high standards and always encourages and challenges fellow staff to give excellent care.

3.4.3 Examples of Innovation

a. Gastric balloon used to facilitate life-saving surgery

For the first time in the Trust, a consultant gastroenterologist has inserted a gastric balloon to help a patient lose weight so he can receive life-saving heart surgery. The patient was being prepared for a gastric by-pass operation when a routine echocardiogram (heart ultrasound) revealed there was an aneurysm of the ascending aorta (a widening of the artery). Surgeons agreed the risk to the patient was too high for surgery unless he reduced weight significantly. The balloon was inserted as an endoscopic procedure and enabled the patient to lose eight stone. Once the gastric balloon was removed, surgery to repair the aneurysm was undertaken successfully a few days later.

b. National spotlight for bariatric surgery scoring system

Staff in the Biochemistry Department have developed a scoring system for the selection of patients who would benefit most from undergoing bariatric surgery. It has taken three years to develop and perfect the scoring system, which has recently been published nationally in the British Journal of Diabetes and Vascular Disease. The DUBASCO (Dudley Bariatric Surgery Comorbidity Score) identifies those patients who would benefit most from undergoing bariatric surgery (i.e. likely to develop diabetes, urgent need for surgery) but who may not necessarily be the heaviest.

c. Vertebroplasty available for patients with vertebral compression fractures

The Trust now offers a vertebroplasty (vertebral cement augmentation) service to patients with osteoporotic, traumatic vertebral compression fractures with persistent pain beyond six weeks. The multidisciplinary vertebral cement augmentation service provides appropriate patients with interventional (surgical and other) procedures in line with current best evidence and practice guidance. Each patient is assessed meticulously by a multidisciplinary team to provide an advanced

interventional service alongside a holistic approach to provide the ideal environment for improving patients' quality of life.

d. Fat gene test developed by biomedical scientist

A Senior Research Biomedical Scientist at the Trust has developed a quick method of identifying a gene mutation that has been linked to obesity. Patients attending the weight management clinic at Russells Hall Hospital will be invited to take part in a research study to find out if they have a gene mutation – commonly known as the fat gene. People with this gene mutation are on average 3.0 kg (6.6 pounds) heavier than those without it. People who would test positive for the gene may at least have some explanation as to why they tend to put on weight and may realise that they need to eat less and do more activity than others. This work has resulted in a prize at the Biomedical Science Congress which was held in Birmingham in September 2011.

e. Community Heart Failure Specialist Service

The Heart Failure Team has become one of the pilot sites for the British Heart Foundation (BHF) Intravenous Diuretics project. The aim is to improve the care of patients suffering with Heart Failure by delivering injectable diuretics in the home. The aim is to allow patients to be cared for and die at home preventing unnecessary admission to hospital.

3.4.4 Examples of Specific Clinical Effectiveness Initiatives

a. Dudley breast screening goes digital

A state-of-the-art digital screening unit now provides clearer, instant images to improve the diagnosis of breast cancer. Dudley Breast Screening Service's new unit opened in Sedgley and moves around sites across the borough as part of a three-yearly screening programme. The quality of images and the ability to digitally manipulate them on the computer screen makes it much more efficient than traditional films.

b. Open access service for sleep apnoea

We have now started an open access sleep apnoea (sleep disorder) assessment service for any patient who suffers from excessive snoring and or daytime sleepiness. Patients have two nights of Overnight Oximetry, an Epworth Sleepiness Scale questionnaire and Spirometry (breath measurement) is undertaken.

The results of these tests are then reviewed by a respiratory physician who then decides on an appropriate course of action. This new service increases the number of people we can see, reduces length of waiting time and speeds up the assessment and treatment.

c. Multi Disciplinary Team voice clinic aids rapid diagnosis for hoarse voice patients

The Ear, Nose and Throat (ENT) service has developed a multidisciplinary voice clinic with Speech and Language Therapy (SLT) to aid quicker diagnosis, treatment and resolution of symptoms for voice patients.

Voice patients are examined using a flexible nasendoscopy to see the larynx. Both patient and therapist can see internal images and this instant visual feedback helps direct their therapy and the patient also receives a resolution more quickly. The benefits of the clinic include earlier decision making and earlier treatment means less intervention. Another benefit is that patients with more complicated conditions receive input from both Ear, Nose and Throat (ENT) and Speech and Language Therapy (SLT) services.

d. Enhanced Recovery Programme

A number of specialties, including urology, general surgery and orthopaedics, have started this programme which is about improving patient outcomes and speeding up a patient's recovery after surgery. The Enhanced Recovery programme

focuses on making sure that patients take part in their own recovery process and aims to make sure that patients always receive evidence based care at the right time. The programme includes improved pre-operative assessment, planning and preparation before admission, and aims to reduce the physical stress of the operation. It also provides a structured approach to surgery from admission through to after surgery (peri-operative) management, including pain relief and early movement.

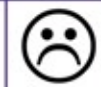
3.4.5 Clinical Effectiveness Measures:

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12
Trust Readmission Rate for Surgery Vs Peer group West Midlands SHA Source: CHKS Signpost	4.6% Vs 4.1%	3.9%* Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%	5.6% Vs 5.0%
Number of cardiac arrests Source: logged switchboard calls	397	250	170	145	119
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0	0

**3.8 per cent for 2008/09 in the 2009/10 quality report was April 2008 to February 2009 only*

3.5 Our performance against key national priorities across the domains of the NHS outcomes framework

National targets and regulatory requirements	Trust 2007/08	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2011/12	Target 2011/12	Trend/Comparison/ Target		
1. Preventing People from Dying Prematurely										
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	100%	100%	99.3%	99.8%	99.7%	98.41%**	96%	↓	☺	☺
All cancers: 31 day wait for second or subsequent treatment: surgery	N/A	N/A	N/A	99.6%	99.6%	97.58%**	94%	↔	☺	☺
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments	N/A	N/A	N/A	100%	100%	99.74%**	98%	↔	☺	☺
A maximum wait of 62 days from urgent referral to treatment of all cancers	100%	99.9%	86.5%	87%	88%	87.3%**	85%	↑	☺	☺
All cancers: 62 day wait for first treatment from consultant screening service	N/A	N/A	N/A	99.6%	96.6%	93.51%**	90%	↔	☺	☺
Proportion of high risk TIA patients investigated and treated within 24 hours of first contact with a health professional	N/A	N/A	N/A	76.11%	72.18%	70.19%**	60%	↓	☺	☺
3. Helping people to recover from episodes of ill health or following injury										
A maximum two-week wait for standard Rapid Access Chest Pain Clinics	99.98%	99.89%	99.90%	99.64%	99.89%	99.86%**	95%	↑	☺	☺
Genito-urinary medicine – percentage of patients offered an appointment within 48 hours	N/A	99.59%	99.83%	99.66%	99.18%	N/A	98%	↓	N/A	☺
Stroke patients spending 90% of their time on stroke unit	N/A	N/A	N/A	68.30%	76.8%	80.97%**	80%	↑	☹	☹
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	N/A	92.4%	95.8%	97.03%	95.7%	90.83%*	95%	↓	☺	☺
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	N/A	96.15%	99.1%	99.25% Apr-Jan	99.2%	97.3%*	90%	↓	☺	☺
Referral to treatment times for admitted patients	N/A	N/A	N/A	19.8 weeks	19 weeks	N/A	23 weeks	↑	N/A	☺
Referral to treatment times for non-admitted patients	N/A	N/A	N/A	12.1 weeks	9.6 weeks	N/A	18.3 weeks	↑	N/A	☺

4. Ensuring that people have a positive experience of care										
A/E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	98.1%	95.9%	98.1%	98.8%	97.27%	97.13%#	95%			
Percentage of patients who have operations cancelled for non-clinical reason to be offered another date within 28 days	100%	100%	100%	100%	100%	96.14%**	98.5%			
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	100%	100%	98%	96.8%	97.2%	95.77%**	93%			
Two week maximum wait for symptomatic breast patients	N/A	N/A	69%	98.2%	99%	95.61%**	93%			
Percentage of patients waiting five weeks or less for diagnostic tests	N/A	99.73%	99.58%	98.34%	95.25%	98.27%*	100%			
Proportion of women receiving cervical cancer screening test results within two weeks	90%	90%	32.12%+	98.60%	99.9%	N/A	98%		N/A	
Mixed sex accommodation breach rate per 1000 FCEs	N/A	N/A	N/A	N/A	0	0.84***	0	N/A		
5. Treating and caring for people in a safe environment and protecting them from avoidable harm										
Clostridium difficile year on year reduction	N/A	154	126	81	113	N/A	No more than 77		N/A	
MRSA – number of post 48hour bacteraemia infections	N/A	7	2	3	2	N/A	No more than 2		N/A	
Screening all elective in-patients for MRSA	N/A	N/A	100%	100%	100%	100%**	100%			
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	In 2011/12 the Trust is compliant									

+The low figure for 09/10 is due to a national increase in women coming forward for screening following a very high profile celebrity death from cervical cancer.

N/A = Not available or not applicable

**Figures are up to end of Feb 2012*

***Figures are up to end of Dec 2011*

****Figures are up to end of Oct 2011*

#Figures are up to end of Sep 2011

KEY

Trend = Present position compared to last year 2010/11

Target = Position compared to allocated target

Comparison = Position compared to national figure

= Improvement

= Deterioration

= Same

= Better than target/national figure

= Worse than target/national figure

3.6 Glossary of Terms

A & E	Accident and Emergency (also ED – Emergency Dept.)
ADC	Action for Disabled People and Carers
Bed Days	Unit used to calculate the availability and use of beds over time
BBC CRLN	Birmingham and Black Country Comprehensive Local Research Network
BHF	British Heart Foundation
CQC	Care Quality Commission
COPD LES	Chronic Obstructive Pulmonary Disease Local Enhance Services
CHKS Ltd	A national company that works with Trusts and provides healthcare intelligence and quality improvement services
C. diff	Clostridium difficile
CQUIN	Commissioning for Quality and Innovation payment framework
CEM	College of Emergency Medicine
DAHNO	Data for Head and Neck Oncology
DNA	Did Not Attend
DUBASCO	Dudley Bariatric Surgery Co-morbidity Score
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
ENT	Ear, Nose and Throat
ED	Emergency Department (also Accident and Emergency Dept.)
FCE	Full Consultant Episode (measure of a stay in hospital)
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities
GP	General Practitioner
HASC	Health and Adult Social Care Select Committee
HAT	Hospital Acquired Thrombosis
HCAI	Healthcare Acquired Infection
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HQIP	Healthcare Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratios
IBD	Irritable Bowel Disease
ICNARC CMPD	Intensive Care National Audit & Research Centre Case Mix Programme Database
KPI	Key Performance Indicator
LiA	Listening in Action
LINk	Local Involvement Network
MBC	Metropolitan Borough Council
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MET	Medical Emergency Team
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRSA	Meticillin-resistant Staphylococcus aureus
MESS	Mandatory Enhanced Surveillance System

MUST	Malnutrition Universal Scoring Tool
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCI	Nursing Care Indicator
NCDAH	National Care of the Dying Audit in Hospitals
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NNAP	National Neonatal Audit Programme
NPSA	National Patient Safety Agency
NVQ	National Vocational Qualification
Ofsted	Office for Standards in Education, Children's Services and Skills
PALS	Patient Advice and Liaison Service
PE	Pulmonary Embolism
PEAT	Patient Environment Action Teams
PFI	Private Finance Initiative
PROMs	Patient Reported Outcome Measures
PCT	Primary Care Trust
RAG	Red/Amber/Green
RCOG	Royal college of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RAMI	Risk Adjusted Mortality Index
SHA	Strategic Health Authority
SHMI	Summary Hospital Mortality Indicator
SINAP	Stroke Improvement Audit Programme
SUS	Secondary Uses Service
SLT	Speech and Language Therapy
VSGBI	Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism

ANNEX

Comment from Dudley Clinical Commissioning Group

Commissioners continue to work closely with The Dudley Group Foundation Trust and recognise the commitment to quality demonstrated in this report. It is acknowledged that the Trust has sought to ensure that quality improvement has remained very much at the forefront of service provision in 2011/12 and has clearly set out equally challenging aims for 2012/13.

The Trust has recognised that whilst much has been done to reduce Health Care Associated Infection, there remains much to be further implemented, and commissioners welcome the strategies now in place to support the reduction in Clostridium difficile infection rates, including learning from best practice, the introduction of dual testing processes, and a commitment to support colleagues across the Health economy to support further reductions in other infection rates.

Similarly, the Clinical Commissioning Group recognise the learning implemented by the Trust in seeking a reduction in hospital mortality, implementing electronic patient notes across the Accident & Emergency service, and look forward to continuing to work with colleagues in providing support to further safety and effectiveness strategies across health care.

Comment from Dudley Local Involvement Network

Dudley LINk is pleased to contribute to this report for another year.

Patient Experience

Receiving feedback from our community through Service Watch, LINk has received observations about our hospitals from patients, their family members and carers. The majority of who give positive comments and rate our hospitals good or very good. Some examples of comments received are:

- Excellent – Couldn't fault it in any way – all the staff were really good
- Directions in the hospital have improved immensely; staff were caring, direct and to the point. Trying to work hard under the pressure of the number of people
- This totally professional team made me totally relaxed. They looked after me 100% Bless them all; what would have been a very stressful time turned out to be a very positive experience!! Please relate my comments to them – they deserve it 110%

On feeding these comments back to the hospitals we know that the comments of our community have been taken into account in identifying areas where services can be improved.

Pressure Ulcers

We know that the prevention and treatment of pressure ulcers are of concern to people and we are pleased to see that this is again being prioritised for both patients in our hospitals and also for those in our community who are susceptible to this condition.

Infection Control

Last year our hospitals made good inroads into reducing MRSA and Clostridium difficile rates. We know that staff have worked hard to reduce these rates but we also remind our community (as we did last year) of the importance of hand hygiene when visiting our hospitals.

Nutrition and Hydration

Some of the less favourable comments made to us by our community relate to these two issues and so it is good to see these being prioritised this year.

We also approve that New Patient Forum Groups have been formed and that hospital food is one of the topics being discussed by them. We recognise the importance that has been placed on improving nutrition and hygiene in line with recommendations.

Comment from the Dudley MBC Health and Adult Social Care Scrutiny Committee

The Committee reviewed the progress of the Trust against the 2011/12 quality improvement priorities at its last meeting of the municipal year held on 28th March 2012. This also provided the opportunity to comment on the priorities developed for 2012/13.

The considerable reduction in hospital acquired pressure ulcers was noted. Members welcomed the continued focus on nutrition as a quality improvement area, in the light of it's 2011/12 Dignity in Care Review, along with the introduction of a 24 hour 'nutritional assessment' target for new admissions. The Committee would want assurance that the appointment of nutritional workers would help realise this target across services and a resultant improvement in patient hydration and overall meal time experience. It was also felt consideration should be given to the inclusion of performance indicators on this theme in future quality reports to assist in quantifying improvement and evaluating trends.

The Committee was also encouraged by the Trust's participation in the 'Safety Thermometer' initiative as it provided a real opportunity to secure even greater reductions in pressure ulcers acquired whilst in hospital and whilst on the community district nurse caseload; the Committee will be monitoring this issue through scrutiny of the Trust's patient experience strategy in 2012/13.

Overall, the Committee agreed that planned priorities for improvement going into 2012/13 were representative of the quality of services provided and covered areas of importance to local communities.

Comment from the Trust's Council of Governors

The Council of Governors continues to acknowledge the Trust Board's commitment to robust clinical governance and supports its aim to achieve a continuous improvement in the quality of services, both clinical and non-clinical. The Council accepts that substantial progress has been made, especially through the Transformation Programme, although there are a number of issues where improvements still need to be achieved.

The Council notes the positive actions being taken to reduce the rates of MRSA and C. diff infections and support the Trusts own view that even one case is one too many. Governors received regular updates and slide presentations on the work being done to reduce hospital acquired infection rates and is assured that significant progress has been made in this area.

The Council has expressed some concerns over the 'inpatient experience' satisfaction levels, but again is supportive of the work being instigated by the Trust to achieve improvements. Surveys used in gathering the information capture only a limited number of patient views when compared to the total number of patients seen in a full year so it is pleasing that governors have taken part in ward walk-rounds taking the opportunity to speak to patients on a one-to-one basis. Governors participated in the Quality Priority Listening Event held in February and are fully supportive of the Trust's intention to prioritise and take steps to achieve improvements in the areas of nutrition and hydration as part of its work in 2012/13.

It is important to understand that the role of the Council is that of 'secondary governance' with the Trust Board responsible for 'primary governance'. The Trust Board and the Council have worked together in an open and transparent way. Without this it would be difficult to influence Trust strategy positively. The Council acknowledges that to achieve this the Board has consulted with Governors on a wide range of issues during the year either through the Council's own committee structure, consultative papers or direct at the meeting of the full Council. These consultations have provided an essential route by which the Governors can ensure the Trust's membership's views are brought to the board's attention. A good example is the paper written by a governor highlighting the rights of all patients to receive good quality hospital care. Supported by the Council it set out some expectations for quality:

- Good clinical care
- An efficient service which includes prompt responses and a good use of resources
- The provision and availability of suitable food
- A friendly welcoming environment in which patients and visitors feel important and cared for
- A clean hospital and a quiet, peaceful environment, especially at night
- Good communications – between staff, patients, visitors and any other appropriate persons.

Governors feel they have used their roles in a positive way to influence the strategy of the Trust and will continue to do so despite the major changes that lie ahead for the NHS as a whole. Despite this positive aspect the Council had concerns about its own effectiveness and outside consultants were appointed to carry out an in-depth review; the results of which were in the main reflective of the Council's own views. The Council played an important role working alongside the Trust's Board in reviewing, and where required, amending, the Trust Constitution and fully supports the reduction in numbers of Governors from 39 to 25. This review, along with a restructuring of the Council of Governors own committee structure, has enabled the Council to be more effective in carrying out its duties.

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12;

The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2011 to June 2012
- Papers relating to Quality reported to the Board over the period April 2011 to June 2012
- Feedback from the commissioners dated 02/05/2012
- Feedback from Governors dated 26/04/2012
- Feedback from LINks dated 26/04/2012
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/04/2012
- The National Patient Survey 24/04/2012
- The National Staff Survey March 2012
- The Head of Internal Audits annual opinion over the Trusts control environment dated 31/03/12

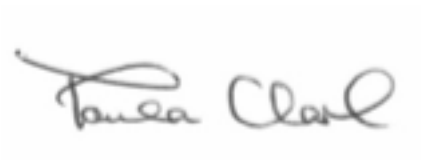
• CQC quality and risk profiles dated Apr/Jun/Jul/Aug/Oct/Dec 2011 and Feb/Mar 2012

o the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
o the performance information reported in the Quality Report is reliable and accurate. There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
o the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
o the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Date 15/05/2012 Chairman



Date 15/05/2012 Chief Executive

Independent Auditor's Assurance Report to the Council of Governors of the Dudley Group NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of the Dudley Group NHS Foundation Trust to perform an independent assurance engagement in respect of the Dudley Group NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of the Dudley Group NHS Foundation Trust as a body, to assist the Council of Governors in reporting the Dudley Group NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and the Dudley Group NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA
- 62 day cancer waits

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified below:
    - Board minutes for the period April 2011 to March 2012;
    - Papers relating to Quality reported to the Board over the period April 2011 to March 2012;
    - Feedback from the Commissioners dated 2 May 2012;
    - Feedback from LINks dated 26 April 2012;
    - Feedback from the Council of Governors dated 26 April 2012;
    - The Trust's 2011/12 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
    - The national patient survey 2011/12;
    - The 2011/12 local patient experience report. Due to the timings of our work we have reviewed quarters one, two and three for 2011/12;

- The national staff survey 2011/12;
- Care Quality Commission quality and risk profiles dated February 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment for the year ending 31/03/12.

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The nature, form and content required of Quality Reports are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by the Dudley Group NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in the detailed guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Deloitte LLP
Chartered Accountants
Birmingham
24th May 2012

Annual Report – glossary of abbreviations:

A&E	Accident and Emergency (often referred to as Emergency Department)
C. diff	*Clostridium difficile* (infection)
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DGH	The Dudley Group NHS Foundation Trust
EBITDA	Earnings Before Interest, Taxation, Depreciation and Amortisation
ED	Emergency Department
ENT	Ear, nose and throat
EPR	Electronic patient record
ERP	Enhanced recovery programme
ERS	Electoral reform service
FT	Foundation Trust
FTE	Full time equivalent
GI	Gastrointestinal
GP	General Practitioner
HR	Human Resources
IT	Information Technology
KF	Key finding
LIA	Listening into Action
LINk	Local Involvement Network
MBC	Metropolitan Borough Council
MDT	Multi-disciplinary team
MRI	Magnetic Resonance Imaging (MRI scan)
MRSA	Methicillin Resistant Staphylococcus Aureus (infection)

NBV	Net Book Value
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
PALS	Patient Advice and Liaison Service
PBL	Prudential Borrowing Limit
PBR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PFI	Private Finance Initiative
QIPP	Quality, Innovation, Productivity and Prevention programme
R&D	Research and Development
SHA	Strategic Health Authority
TIA	Transient Ischemic Attack
WTE	Whole Time Equivalent
VAR	Variance
VAT	Value Added Tax
YTD	Year to Date

A glossary of terms is also available on pages 46 and 47 of the Quality Report.

This leaflet can be made available in large print, audio version and in other languages, please call 0800 0730510

ਜੇਕਰ ਇਹ ਲੀਫ਼ਲੈੱਟ (ਛੋਟਾ ਇਸ਼ਤਿਹਾਰ) ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ (ਪੰਜਾਬੀ) ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰ ਕੇ ਪੇਸ਼ੰਟ ਇੱਨ੍ਹਫ਼ਰਮੇਸ਼ਨ ਕੋ-ਆੱਰਡੀਨੇਟਰ ਨਾਲ **0800 0730510** ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

यदि आपको यह दस्तावेज अपनी भाषा में चाहिये तो पेशन्ट इनफरमेशन को-आरडीनेटर को टैलीफ़ोन नम्बर **0800 0730510** पर फोन करें।

જો તમને આ પત્રિકા તમારી પોતાની ભાષા (ગુજરાતી)માં જોઈતી હોય, તો કૃપા કરીને પેશન્ટ ઈન્ફોર્મેશન કો-ઓર્ડિનેટરનો **0800 0730510** પર સંપર્ક કરો.

আপনি যদি এই প্রচারপত্রটি আপনার নিজের ভাষায় পেতে চান, তাহলে দয়া করে পেশেন্ট ইনফরমেশন কো-অর্ডিনেটারের সাথে **0800 0730510** এই নম্বরে যোগাযোগ করুন।

أذا كنت ترغب هذه الوريقة مترجمة بلغتك الاصلية (اللغة العربية) , فرجاء ا أتصل بمنسق المعلومات للمريض **Information Co-ordinator** على التلفون **0800 0730510**

حسب ضرورت اس لیف لٹ کو اپنی زبان (اُردو) میں حاصل کرنے کے لئے ، براہ مہربانی ٹیلیفون نمبر **0800 0730510** پر پیشنٹ انفرمیشن کو-اورڈینیٹر (مریضوں کے لئے معلومات کی فراہمی کے سلسلے میں افسر) کے ساتھ رابطہ قائم کریں۔