The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 7th December, 2017 at 8.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	8.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	8.30
3.	**Announcements**		J Ord	To Note	8.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 2 November 2017	Enclosure 1	J Ord	To Approve	8.30
	4.2 Action Sheet 2 November 2017	Enclosure 2	J Ord	To Action	8.35
5.	**Staff Story**		L Abbiss	To Note & Discuss	8.40
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	8.50
7.	**Safe and Caring**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Wulff	To note assurances & discuss any actions	9.00
	7.2 Chief Nurse Report – Infection Prevention and Control	Enclosure 5	S Jordan	To note its contents	9.10
	7.3 Nurse/Midwife Staffing Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	9.20
	7.4 Quality Account Update	Enclosure 7	S Jordan	To note assurances & discuss any actions	9.30
	7.5 Freedom to Speak up Guardians Report	Enclosure 8	D Eaves	To note assurances & discuss any actions	9.40

	7.6 Learning from Deaths Report	Enclosure 9	J Hobbs	To note assurances & discuss any actions	9.50
8	**Responsive and Effective**				
	8.1 Finance and Performance Committee Exception report	Enclosure 10	J Fellows	To note assurances & discuss any actions	10.00
	8.2 Integrated Performance Dashboard	Enclosure 11	M Woods	To note assurances & discuss any actions	10.10
	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 12	L Peaty	To note assurances & discuss any actions	10.20
	8.4 Research and Development Report	Enclosure 13	J Neilson	To note assurances & discuss any actions	10.30
	8.5 Audit Committee Exception Report	Enclosure 14	R Miner	To note assurances & discuss any actions	10.40
	8.6 Complaints Report	Enclosure 15	S Jordan	To note and discuss	10.50
9.	**Well Led**				
	9.1 Digital Trust Committee Exception Report	Enclosure 16	A Becke/ M Stanton	To note assurances & discuss any actions	11.00
	9.2 Workforce Committee Exception Report	Enclosure 17	J Atkins	To note assurances & discuss any actions	11.10
	9.3 Review of Trust Constitution	Enclosure 18	G Palethorpe	To Approve	11.20
	9.4 Guardian of Safe Working Report	Enclosure 19	B Elahi	To note assurances & discuss any actions	11.30
10.	**Any other Business**		J Ord		11.35
11.	**Date of Next Board of Directors Meeting** 9.00am 11 January, 2018 Clinical Education Centre		J Ord		11.35

12.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		11.35

Quorum: One Third of Total Board Members to include One Executive Director and One Non Executive Director

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 2nd November, 2017 at 9.00am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Julian Hobbs, Interim Medical Director
Siobhan Jordan, Chief Nurse
Paul Taylor, Director of Finance and Information
Ann Becke, Non Executive Director
Jonathan Fellows, Non Executive Director
Diane Wake, Chief Executive
Michael Woods, Interim Chief Operating Officer

In Attendance:

Helen Forrester, EA
Andrew McMenemy, Director of HR
Mark Stanton, Chief Information Officer
Liz Abbiss, Head of Communications
Glen Palethorpe, Director of Governance/Board Secretary
Natalie Younes, Director of Strategy and Business Development
Mark Hopkin, Associate Non Executive Director
Lisa Peaty, Deputy Director of Strategy and Business Development (Item 17/121.3)

17/112 Note of Apologies and Welcome
9.05am

The Chairman welcomed Michael Woods, Interim Chief Operating Officer to his first Board meeting. Julian Hobbs attended the meeting for the first time in his role as Interim Medical Director.

17/113 Declarations of Interest
9.06 am

The Clinical Lead for Pathology and MCP's standing declaration was noted and it was confirmed that this did not conflict with any items on the agenda requiring any decision.

Dr Mark Hopkin confirmed that he was a GP and Clinical Lead at the CCG and it was confirmed that this did not conflict with any items on the agenda requiring a decision.

There were no other declarations of interest.

17/114 Announcements
9.03 am

The Board noted that Richard Kirby had been appointed as Chief Executive of Birmingham Community Healthcare Trust and Dido Harding had been announced as Chair of NHSI. The announcement regarding the Chief Executive of NHSI was imminent.

17/115 Minutes of the previous Board meeting held on 12th October, 2017 (Enclosure 1)
9.08am

The minutes were amended at page 7 to read "Mr Atkins, Non Executive Director, asked about new nurses joining the Trust because of current registered nurse staffing levels." With this amendment the minutes of the previous meeting were agreed by the Board as a true and correct record of the meetings discussion and could be signed by the Chairman.

17/116 Action Sheet, 12th October, 2017 (Enclosure 2)
9.09am

17/116.1 Flu Jab

The Board noted that a communication had gone out via the Hub and mechanisms were in place to capture the information.

17/116.2 Medical Revalidation

The Board noted that within this action the wording should read "minimum number of appraisals per appraiser" and that this overall action was for a future meeting

All other items on the action sheet were either on the agenda, complete or for a future meeting.

17/117 Patient Story
9.11am

The Head of Communications presented the patient story.

The story related to a patient who had received surgery for a full knee replacement. The patient had a very positive story to tell about her experience and care received.

Dr Wulff, Non Executive Director, asked about patients attending at 7am for afternoon surgery. The Chief Executive confirmed that theatre scheduling was being picked up by the review being undertaken by Four Eyes which was considering better scheduling of patient attendances at the ward before their surgery.

The Interim Medical Director added that the patient needs to get up very early to arrive at 7am. If the process was more tailored to scheduling it would improve the outcome for patients.

The Chairman asked about timeframes for changes to become effective. The Chief Executive confirmed this will be taken at the January Clinical Quality, Safety, Patient Experience Committee.

The Interim Chief Operating Officer confirmed that the reason for bringing in patients so early is often to see the Anaesthetist, but the process could be fine-tuned.

The Chief Executive stated that the Trust also needs to look at the pre-operative process. The Interim Medical Director added that improving this process will also help manage any risk around the Montgomery ruling in relation to the level of consent and understanding by the patient as they will have more time to reflect on the risks of the procedure before the day of surgery.

The Chairman asked about cancellations of surgery and how frequently this happens. The Chief Executive confirmed that numbers are captured routinely and reported within the performance report and cancellations happen for various reasons.

Dr Hopkin, Associate Non Executive Director, commented that the patient was half way through her treatment and it was the next stage that he wished to better understand. The Board agreed that it would be useful to see a follow up story on the rehabilitation experience.

The Chairman and Board noted the positive story.

Update on the work around theatre scheduling and pre-operative process to the January Clinical Quality, Safety and Patient Experience Committee.

Follow up patient story to be presented to the Board.

17/118 Chief Executive's Overview Report (Enclosure 3)
9.28am

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

- Welcome to Karen Kelly who commences with the Trust as Chief Operating Officer on 1st January, 2018. The Interim Chief Operating Officer will work alongside Karen for a period of time.

- Healthcare Hero Awards: These continue to be well received within the organisation.

- Digital Trust: There was a successful launch event which was well supported by staff.

- Flu Jab: The Trust was achieving a 52% take up rate which is better than last year and a good start to this campaign.

- Staff Survey: 23% response rate. The Trust is continuing to encourage all staff to complete the survey.

- Black Country Alliance: It was recognised that not including Wolverhampton in the Alliance was not beneficial and therefore the Black Country Provider Partnership had been formed which is part of the STP. Mrs Becke, Non Executive Director, confirmed that at the time of setting up the Alliance, Wolverhampton reserved their right to be included and had been involved in certain projects. The Chairman confirmed that the Partnership would be overseen by the four Medical Directors and Chief Executives and Diane Wake will Chair the Partnership meetings. The Chairman asked for regular updates on progress to the Board.

The Chairman and Board noted the report.

Chief Executive to provide regular updates on the Black Country Partnership to the Board.

17/119 Safe and Caring

17/119.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
9.37am

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 4.

The Board noted the following key areas from the Committee meeting:

- Stage 4 Avoidable Pressure Ulcers: This had been an area of concern for the last 6 months and actions had been identified and were being undertaken. The Committee was updated on actions and will continue to monitor these.

- Ophthalmology: The Committee is looking to ensure that the appointment backlog is addressed by November and that the service can then sustain its delivery against the demand on the service.

- Maternity Services: The new Maternity Dashboard was tabled at the meeting, with the Committee providing feedback on where to make improvements to the document. The updated dashboard will be presented to the next meeting along with the continued updates on the Maternity Improvement Plan.

- The Committee noted the pressure on clinicians and competing demands and had asked the Executive Team to consider this risk and for it to be placed on the corporate risk register.

- Report on the Paediatric Service appointment delays is to come back to the Committee.

The Chief Nurse commented on complaints and that currently there was still a backlog in responses to complaints. It was anticipated that the position will have improved for the next meeting.

The Chairman and Board noted the report, assurances received, and items to come back to the Committee.

17/119.2 Chief Nurse Report – Infection Prevention and Control Update (Enclosure 5) 9.43am

The Chief Nurse presented her report, given as Enclosure 5.

The report had been reviewed and the Board noted that the next paper will provide further detail around the analysis of the various infections routinely monitored across the Trust.

Norovirus had been experienced on Ward B2 but had been managed extremely well to restrict spread.

The Chief Executive suggested that the Trust should use Neopoint testing to help with the early identification of Norovirus.

The Interim Chief Operating Officer suggested decanting the ward to undertake deep cleaning. The Chief Executive confirmed that she had concerns around the level of deep cleaning at the Trust and more work will be undertaken in this area linked to the updated cleaning policy.

Mrs Becke, Non Executive Director, raised C.Diff and her concern that 14 cases had been identified as lapses in care already this year. The Board noted that in all of these cases the common issue that resulted in them being attributed to the Trust was related to poor training compliance rather than poor actual practice. The Chief Nurse confirmed that all training was now up to date so those attributed in future would better reflect real lapses in specific care.

The Chairman and Board noted the report and the work around deep cleaning and the expected improvement in C.Diff lapses in care attributed to the Trust due to training compliance.

17/119.3 Monthly Nurse/Midwife Staffing Report (Enclosure 6) 9.53am

The Chief Nurse, presented the monthly Nurse/Midwife Staffing Report given as Enclosure 6.

The Board noted the following key issues:

- Staffing: The Trust was achieving safe staffing levels.
- The format of the report will change after the staffing reviews were fully completed.

Dr Wulff, Non Executive Director, asked for an update on recruitment. The Director of HR confirmed that an average of 10 posts were filled per recruitment event and this was a very encouraging performance.

Mr Miner, Non Executive Director, commented on overseas nurse recruitment and that he was surprised to note that local recruitment was more successful than overseas recruitment. Previously the Board had been advised that local recruitment success would be limited.

The Chief Executive commented that offering the opportunity for nurses to sign up to the Trust at the event itself had made a difference to securing the actual nurse numbers.

The Director of Finance and Information added that the information included in the report on the staffing numbers was in advance of the Nursing reviews undertaken.

Mrs Becke, Non Executive Director, asked about the effect of recruitment on current year spend. The Chief Executive confirmed that there will be gradual effect, with the expectation that there would be some reduction in Agency spend.

Mr Atkins, Non Executive Director, raised the importance of retention and asked what actions are taking place in relation to this. The Chief Nurse confirmed that the Trust is being more creative in retaining staff and recruiting to hard to fill roles. The Chairman added that it would be interesting to discuss in relation to this area at the Workforce Committee.

The Chairman and Board noted the report and recognised the work around recruitment and retention and also noted the hard work of all staff in contributing towards making Dudley a great place to work.

17/119.4 Safeguarding Report (Enclosure 7)
10.09am

The Chief Nurse presented the Safeguarding Report given as Enclosure 7.

The Board noted the following key issues:

- Changes had been made to the way the Safeguarding team work together. The Trust was recruiting a new Head of Safeguarding and interviews were taking place in November. The size of the team had previously not allowed for good cover arrangements and this had been an issue. The Trust has had a request to participate in 3 serious case reviews and this puts additional pressure on the team.

- Training compliance: Dudley had not been fully complying with the intercollegiate document. A local model had been devised to reduce the length of training time and this decision had been ratified by the Safeguarding Board. It has since been decided that staff must undertake the full training appropriate to their role to ensure full compliance. A Trust target of 90% had been set. Mental Health capacity and DOLS training is also being strengthened. For Prevent/WRAP training the national average is 90% and the Trust aims to reach 65% by December. The Chief Nurse asked the Board to note the non-compliant areas.

- Domestic Abuse: Experienced by 1 in 4 women in Dudley. Domestic abuse training will commence in key areas.

- FGM: Reporting needs to be strengthened.

The Chief Nurse confirmed that the Safeguarding Board had been kept fully updated on actions and the CCG Safeguarding Lead had been invited to sit on the interview panel for the Head of Safeguarding.

The Interim Medical Director commented on the importance of undertaking Safeguarding training. He added that in relation to domestic abuse we need to heighten awareness and recognition through our values and culture that this was a priority.

Mr Fellows, Non Executive Director, asked to see the detail around the figure of 1 in 4 women in Dudley suffering from domestic abuse. The Chief Nurse confirmed that she would provide this.

Mrs Becke, Non Executive Director, gave her support to the work being undertaken by the Chief Nurse and added that with competing priorities safeguarding has lost some focus and pace in respect to new regulations.

Mr Atkins, Non Executive Director, commented that safeguarding should be everyone's responsibility. The Chief Nurse agreed.

Dr Hopkins, Associated Non Executive Director, confirmed that Community staff are very well trained in this respect.

Dr Wulff, Non Executive Director, asked who the Head of Safeguarding will report to. The Chief Nurse confirmed that this would be to herself.

The Chairman and Board noted the report and the work being undertaken to become fully compliant for safeguarding training. The Board agreed to add this as a corporate risk and the Chairman confirmed that evidence on the incidence rate for domestic abuse would be shared with the Board. The report will continue to be reported to Board on a quarterly basis. The Chairman suggested that safeguarding training might be factored into doctor and nurse validation.

Safeguarding training to be added as a Corporate risk.
Evidence around the incidence rate for domestic abuse to be shared with the Board.
Safeguarding to be reported to Board on a quarterly basis and to be factored into doctor and nurse validation.

17/120 Responsive and Effective

17/120.1 Finance and Performance Committee Exception Report (Enclosure 8) 10.36am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 8.

The Board noted the following key issues:

- A detailed update was provided to the meeting on the MCP and the Committee noted the challenging deadline. The Chief Executive confirmed that there is a significant amount of discussion ongoing around organisational form and Miranda Carter is visiting Dudley on Monday to talk to the Partnership as a whole.

- STF funding had been secured for quarters 1 and 2. Securing further payments will be a challenge for the rest of the year.

- Nurse recruitment had been successful, the Trust now needs to see an impact by agency costs falling as a result, following the agreed period of supernumerary working for newly qualified nurses.

- Work was taking place on consolidating back office functions across the Black Country Trusts. Dudley is already working efficiently and will see less benefit from the work. One suggested area was recruitment and there was a perceived risk for Dudley in relation to this, especially as new processes recently introduced were working well.

The Chairman and Board noted the report and noted the proposed change to forecast outturn with further discussions on this in the private meeting.

17/120.2 Integrated Performance Report (Enclosure 9)
10.44am

The Interim Chief Operating Officer presented the Performance Report given as Enclosure 9.

The Board noted the following key issues:

This was the first version of the new Integrated Performance Report: Prior to Board, this had been discussed in relevant committees. It was noted that more analysis will be provided for future reports.

An overview of the report was then given by the Interim Chief Operating Officer Michael Woods. This highlighted the following,.

- ED: September performance was off track but had slightly improved for October and the Trust was looking to achieve 90% for the month. There had been an improved position for the last 7 days. Focus for the next 2 months will be on 5 key priority areas: community response team, implementation of the red to green solution, review of on-site management, a focussed effort around DTOCs and a review of Surgical Paediatric pathways. There would also be changes to front of house and urgent care interventions with a robust governance process in place.

Dr Hopkin, Associate Non Executive Director, raised the admission avoidance teams and the need for a more coordinated approach, as several teams already existed in the Community. The Chairman confirmed that there was a requirement to clarify this. The Chief Executive stated that a visit had taken place to Right Care in Barnsley around admissions avoidance and this would be progressed further with the CCG.

- The provisional cancer performance figure as at 26th October suggested delivery of the 2 week wait and 62 day cancer targets for September as being :

  - Cancer 62 Day Waits: The Trust was on track at 91.2%.
  - 2 Week Waits: 94.1%

  Quarter 2 performance to date for 62 day was 85.9% and for 2 week waits 92.5%. This means that the Trust will not meet the quarterly target. Improvements though had occurred from September.

- RTT: 94.01% in September. The Trust was well over target. The Board noted that there were 2 specialties that had delays - Urology and Ophthalmology. The Chairman asked about support to get Ophthalmology back on track. The Board noted that the Executive Team approved the approach suggested by the Division and Four Eyes are also doing a deep dive into Ophthalmology. More patients could be added to the appointment list and Sandwell could also assist.

  Dr Wulff, Non Executive Director, commented that it was helpful that Consultants were willing to make changes to accommodate more patients.

- DM01: This had improved in August, however the target was not achieved in September. The Trust was clear on the reasons why and this was due to specialistist Paediatrics, General Anaesthetics and musco-skeletal. It appears that the Trust will not deliver the target for October. The Division is producing a recovery plan.

  Dr Hopkin asked about ultrasound scanning and if there is any indication around inappropriate referrals, thus adding unwanted pressure. The Interim Chief Operating Officer confirmed that he will investigate to see if there is any evidence of this.

The Director of Finance and Information confirmed that there was still a reduction in the number of non-elective admissions and this was impacting adversely on the Trust's financial positon.

The Chief Executive confirmed that a number of actions were in place to bring costs down. This linked also to a planned reduction in beds.

The Board noted that the Workforce Dashboard was missing from the pack but recognised that this would have been discussed by the Workforce Committee.

Mr Atkins, Non Executive Director, raised the falls statistics as the target reported seemed appeared incorrect. It was agreed this was incorrect and should be a target per 1000 bed days and will be corrected for the next report.

The Chairman and Board noted the new report format and position relating to performance in particular for ED and other key targets.

The Interim Chief Operating Officer to check for evidence of inappropriate ultrasound scanning referrals.

17/120.3 Cost Improvement Programme and Transformation Overview Report (Enclosure 10)
11.00am

The Deputy Director of Strategy and Business Development presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 10.

The Board noted the following key issues:

- £12.5m CIP for the year had been identified. 4% of the CIP has currently been identified as non recurrent savings.

- The Year end forecast shows a deficit of £1.4m against the plan.

The Chairman and Board noted the report.

17/120.4 Black Country Pathology Report (Enclosure 11)
11.12am

The Chief Executive presented the Black Country Pathology Report given as Enclosure 11.

The Board noted the following key issues:

- In August the 4 Black Country organisations bought an outline business case to progress the delivery of a single Pathology service.

- This would consist of a single large hub supported by 3 ESLs.

- The new model was planned to be operational by the end of 2018.

- It was agreed that a more detailed due diligence should be undertaken to ensure that costs are accurate.

- The Board asked for a detailed analysis of staffing profiles and IT and logistic costs.

- The Board needed a more detailed analysis of capital investment and asked for an assessment of the implementation timeline.

- A FBC will be presented to the Board by the end of the calendar year, but it was noted that this may slip into 2018.

- Mr Fellows, Non Executive Director, added that the pace had been driven by trying to reduce the uncertainty for staff and because the new facility needed to fit with the Midland Met timescale. Toby Lewis had confirmed that there was a delay to Midland Metropolitan Hospital and the new service may not be operational until June 2019 giving a 6 month slippage.

  Trusts preferred to delay the opening but this cause a cost and IT pressure for Dudley in the interim. Further consideration of the issues arising from Shrewsbury and Telford inclusion in the network were also needed.

- The appointment of Clinical and Operational Directors has been helpful.

- Dr Wulff, Non Executive Director, asked about the delay and if there would be an impact on recruiting staff. The Chief Executive confirmed that this was the biggest area of concern for our staff but the Trust were working with staff to provide timely information on progress and would need to recruit as necessary.

The Chairman confirmed that joint investment between the Black Country Trusts had been previously agreed to develop the full business case and whether the delay would mean a request for further funds. Mr Fellows confirmed that this should not be the case.

The Chairman and Board noted the report.

17/121 Well Led

17/121.1 Digital Trust Programme Committee Summary Report (Enclosure 12) 11.24am

Mrs Becke, Committee Chair and the Chief Clinical Information Officer presented the Digital Trust Committee Exception Report, given as Enclosure 12.

The Board noted the following key highlights:

- Launch Event: The Board noted that staff will need pre and post implementation support. All staff feedback will be taken into account.

- Clinical Documentation: There had been a 3 week delay around clinical documentation but this was back on plan and had been resourced within budget.

- Work was underway around the admission and discharge transfer processes and this presents a key risk. Work had been split into 2, for hospital and community and work is ongoing. Three Divisional Chief Clinical Information Officers were being appointed.

The Board noted the need to change the Terms of Reference in relation to quoracy.

The Chairman and Board noted the report and **approved** the change to the Terms of Reference.

17/121.2 Board Assurance Framework (Enclosure 13)
11.28am

The Director of Governance/Board Secretary presented the Board Assurance Framework, given as Enclosure 13.

The Board discussed the following key highlights:

- Enhanced format, which gives greater clarity around assurances and key controls which will allow a more succinct report to be provided to the Audit Committee.

- Executive Directors continue to oversee the Framework through the Risk and Assurance Group.

- Risks arising from Paediatric Services, clinical capacity challenges and safeguarding will be added to the next report.

  The Chairman asked about staffing risks and the Board noted that these risks are included against other objectives. Given that workforce shortfalls presented a major risk it was accepted it would be preferable to highlight these within the appropriate strategic objective.

  The Chairman raised the risk score for the Major Incident Plan. The Board noted that this related to the previous report to Board and not being able to give full assurance against the standards. There is a plan in place to recover the position, with an expectation that full compliance will soon be achieved. The Trust will review the risk appetite levels identified on the framework at the end of the year.

The Chairman and Board noted the refined report

17/121.3 Trust Annual Plan 2017/18 Quarter Two Report (Enclosure 14)
11.07am

The Deputy Director of Strategy and Business Development presented the Trust Annual Plan 2017/18 Quarter Two Report, given as Enclosure 14.

The Board discussed the following key highlights:

- Clinical Strategy activity due in year has been included in the Plan as requested.

- Overall, the numbers of targets with red, amber or green rated risks had remained the same as last quarter. However, some reds have moved into green and amber, and some areas have slipped into red, including DTOCs, avoidable pressure ulcers, job planning for consultants and increased pharmacy time. A number of areas remain red from the previous quarter. The red areas are all on the risk register and have mitigations in place.

- The forecast position for Q3 showed an improvement but 3 indicators were anticipated to remain red: avoidable pressure ulcers, ED performance and job planning for Consultants.

The Chairman and Board agreed the report and the inclusion of Clinical Strategy elements. The Board noted the positive forward trajectory acknowledging that challenges remained.

17/122 Any Other Business
11.33am

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

17/123 Date of Next Meeting
11.20am

The next Board meeting will be held on Thursday, 7th December, 2017, at 8.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 2 November 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/097.3	Winter Plan Presentation	The Board to see the results of the September stress testing and alignment with the Health Economy Plan.	COO	12/10/17	In the Chief Executive's Report.
17/063.3	Research and Development Report	Research and Development Strategy to be produced and presented to Board. R&D newsletter to be made available to Community staff.	JN JN	7/12/17 7/12/17	On Agenda. Done
17/063.9	Organ Donation Report	Tissue and organ donation data to be included in future OD Annual Reports. The Chief Nurse to join the Organ Donation Committee. NHSBT to facilitate contacts with the Tissue Donation team.	JN/RE/RU SJ	7/12/17 November Organ Donation Committee Meeting	To January Board. Meeting cancelled.
17/109.1	Workforce and Staff Engagement Committee Exception Report	Workforce Committee consider demonstrable measures with links to strategy.	AM	30/11/17	Done
17/118	Chief Executive's Report	Chief Executive to provide regular updates on the Black Country Partnership to the Board.	DW	7/12/17	Pathology on the Agenda
17/119.4	Safeguarding Report	Safeguarding training to be added as a Corporate risk. Evidence around the incidence rate for domestic abuse to be shared with the Board. Safeguarding to be reported to Board on a quarterly basis and to be factored into doctor and nurse validation.	SJ	7/12/17 7/12/17 8/2/18	Done

17/120.2	Integrated Performance Report	The Interim Chief Operating Officer to check for evidence of inappropriate ultrasound scanning referrals.	MW	7/12/17	
17/098.4	Smoke Free Update Report	Smoke free update report to be presented to the Board in Quarter 4.	AM	11/1/18	
17/107.4	Monthly Nurse/Midwife Staffing Report	Outcome of Nurse Staffing Review to be presented to the January Board.	SJ	11/1/18	
17/117	Patient Story	Update on the work around theatre scheduling and pre-operative process to the January Clinical Quality, Safety and Patient Experience Committee. Follow up to the patient story to be presented to the Board.	DW LA	23/1/18 When care/ treatment completed	
17/109.2	EPRR Core Standard Submission Report	A further update on EPRR to be presented to the Board in Quarter 4.	KK	Quarter 4	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 7th December 2017

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Diane Wake, Chief Executive**	**PRESENTER**	**Diane Wake, Chief Executive**
CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6			

SUMMARY OF KEY ISSUES:

- Visits and Events
- Black Country Pathology
- Winter Plan
- Flu Update
- Staff Survey
- Charity Update
- End of Life Champions Event
- Children's Secret Garden
- Keeping Staff Informed
- National NHS News
- Regional NHS News

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	**Y**

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – December 2017

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and a highlight a number of items of interest.

Items below are not reported in any order of priority.

Visits and Events

2nd November	Long Service Awards
3rd November	MCP Collaborative Staff Briefing Session
	Chief Executive Monthly Staff Brief
	Black Country Chief Executives/Medical Directors Meeting
6th November	Chief Executive Community Staff Monthly Brief
7th November &	NHS Providers Conference
8th November	
9th November	Children's Secret Garden Opening
14th November	Dragon's Pen
15th November	A&E Delivery Board
16th November	Clinical Executive Fast Track Scheme Assessment Panel
20th November	Black Country Pathology Oversight Board
23rd November	Junior Doctors Forum
27th November	Trust/Summit Board to Board Meeting
1st December	MCP Staff Briefing Session
	Black Country STP Urgent Care Meeting
4th December	Visit to Guest Hospital
5th December	Santa Cycle Challenge
6th December	Burns Strategy Board

Black Country Pathology

A statement from the four Black Country Acute Trust organisations relating to Pathology services is attached at Appendix 1.

Winter Plan

Exercise "OLAF" took place on the 22nd September 2017, in collaboration with the Regional Capacity Management Team. This was a table top exercise to test the winter plans for the Dudley health economy and ensure lessons learned to be incorporated into the daily plans across the winter period. 30 points both positive and negative were identified and a 14 point action plan has been formulated. This action plan will be monitored through the weekly operations meeting.

Flu Update

To date 65% of staff have had their flu vaccine so we are close to our target of 70% so continue to push the message of the importance of having their vaccines. The latest breakdown of flu vaccine uptake figures by division is available on the Hub.
Vaccines are available at regular drop in clinics based at all three hospital sites and various locations in the community, as well as from more than 75 peer vaccinators across the Trust.

Staff Survey

We are currently at 32.5% *(1549 respondents from an eligible sample of 4761 staff)* for staff who have taken part in the National Staff Survey. For acute and community trusts, the worst performing is 29.8% response rate and the best performing trust is 44.9% (average 37.8%). Events have been taking place across the Trust to encourage staff to complete the survey which closed on Friday 1st December.

Charity Update

The Big Push Wheelchair Campaign
The campaign has so far raised more than, 19,006 which has purchased 31 Wheelchairs. The campaign is due to run until Christmas and I would like to say a huge thank you to local schools, businesses and individuals who have supported this appeal.

Santa Cycle Dash
Thanks to all our cycling Santa's who took part in a fundraising cycle dash of 26 miles in the main reception at RHH. The funds will go to help our End of Life campaign to raise money for ceiling sky lights to bring the outside in for those in their last days of life.

Carol Singing in RHH Main Reception.
On Friday 8th December four local primary schools and the hospital choir will be raising the roof with carols to raise funds for the neonatal unit.

Christmas Jumper Day.
Friday 15 December. Raising funds for the Children's Appeal.

End of Life Champions Event

We celebrated our End of Life Champions on Tuesday 28th November with an event to raise awareness of the importance of understanding what is on offer across Dudley.

We have 32 lead champions and a further 70 support champions across the Trust.

Children's Secret Garden

The Mayor of Dudley Dave Tyler has unveiled a secret garden that has been built for children with additional needs who attend Russells Hall Hospital for outpatient appointments. A bare piece of land next to the children's outpatients department has been transformed and features a slide, swings and sensory toys to provide children with a relaxing outdoor environment.

Cllr Tyler declared the garden open at an event attended by some parents and children who will benefit from the new garden. He said he was bowled over by the results of such hard work.

"It is fantastic to see the hard work and commitment from everyone involved and I am so pleased to see that such a team effort has resulted in such a wonderful transformation," said Cllr Tyler.

The secret garden was an idea suggested by parents at a listening event to improve the experience for children with additional needs. This idea also formed part of an award entry shortlisted for the Nursing Times Awards 2017.

Keeping Staff Informed

We have successfully launched two brand new weekly e-newsletters; Trust News, after people who completed our communications survey told us they wanted an email summary of the week's news, and our Patient Safety and Experience Bulletin, which focuses on a different topic each week, presented by a guest editor.

National NHS news

NHS Airbnb-style scheme 'not ruled out' by minister
The idea of NHS hospital patients recuperating in Airbnb-style accommodation has not been ruled out, health minister Philip Dunne has said.
Southend Hospital had been linked to a trial where hospital patients could be discharged to people's spare rooms.
BBC News (29.10.17)

IVF: Patients face postcode lottery for treatment
Nearly 90% of clinical commissioning groups (CCGs) fail to offer would-be-mothers the recommended three cycles of IVF treatment, new figures show.
Of the 208 CCGs in England, only 24 meet national guidelines and seven offer no treatment at all.
BBC News (30.10.17)

NHS trusts were warned about WannaCry cyber attack, NAO report finds
At least 34% of NHS trusts in England were disrupted by the WannaCry cyber attack in May 2017 despite critical alerts from NHS Digital two months earlier urging organisations to patch their systems to prevent such an attack, according to a report from the National Audit Office (NAO).
The Pharmaceutical journal (31.10.17)

The £97m bill for 'midwife shortage'
UK maternity units are turning to expensive temporary staffing arrangements such as overtime and agency staff to plug gaps in midwife rotas, union leaders say.
Royal College of Midwives data showed the bill hit nearly £100m in 2016, with services having to pay hourly fees twice as high as the normal rates.
The union said that was enough to cover the "national shortage" of 3,500 staff.
BBC News (31.10.17)

GPs told to appoint named cyber security lead as new standards take effect
Every GP practice in England is contractually required to have a named partner, board member or senior employee responsible for data and cyber security under new data security requirements published by the DH and NHS England.
GP Online (31.10.17)

Drug giants threaten NHS with legal action over cheaper drug that could save £84m a year
Two multinational drug companies are threatening legal action to prevent patients being offered a cheap version of an effective drug against blindness which could save the NHS millions of pounds.
The Guardian (31.10.17)

Five new medicines to be fast-tracked annually to NHS patients
From April 2018, around five drugs or devices will be selected by a panel of experts for fast-tracking each year.
This could mean they are available up to four years earlier than normal, ministers said.
The former head of drug company GlaxoSmithKline, Sir Andrew Witty, will lead the panel deciding on which products should be selected.
BBC News (02.11.17)

NHS staff 'working on edge of safety'
NHS staff in England are working on the "edge of safety" as rising demand is outstripping the increasing numbers being employed, health bosses say.
There are now 6% more staff than there were three years ago, but demand for services has risen by three times as much in some areas.
NHS Providers, which represents health chiefs, said staff shortages was now the number one concern in the NHS.
BBC News (06.11.17)

NHS offers smartphone GP appointments
A 24-hour service has been launched for NHS patients, offering GP consultations via videolink on smartphones.
The pilot scheme will initially cover 3.5 million patients in greater London.
Patients will be able to check their symptoms through the mobile app and then have video consultations within two hours of booking.
The Royal College of GPs has warned the service may not help patients with complex needs.
BBC News (06.11.17)

'Breakthrough' breast cancer drugs get NHS approval
Two new "breakthrough" drugs to treat breast cancer have been given the green light for use on the NHS.
The National Institute for Health and Care Excellence (NICE) approved palbociclib and ribociclib after negotiating prices for the treatments.
Research shows the drugs slow down advanced cancer for at least 10 months and can delay the need for chemotherapy.
Around 8,000 people in England will now have access to the medications.
BBC News (16.11.17)

Hospitals attack ‘barking mad’ NHS target to manage winter crisis
NHS England’s instructions, intended to avoid a repeat of hospitals’ descent into the sort of meltdown seen last year, also say that patients should not have to wait more than 15 minutes in the back of an ambulance outside an A&E unit as they wait to be handed over to hospital staff.
The Guardian (18.11.17)

Public services face real-terms spending cuts of up to 40% in decade to 2020
Further deep cuts in spending on some public services are already planned to go ahead, whatever the chancellor announces in the autumn budget, leaving departments such as justice and work and pensions facing a real-terms cut of as much as 40% over the decade to 2020.
The Guardian (22.11.17)

Budget's £1.6bn cash boost for NHS less than half of experts’ advice
A payment of £1.6bn for the NHS in England in 2018-19 will see its budget rise to £126bn, rather than the £124.4bn originally planned. Similarly, it will receive £900m more than planned in 2019-20 to help it withstand the pressures of coping with the increasing demand for care.
The Guardian (22.11.17)

Vaginal mesh operations set to be banned
Vaginal mesh implants should be banned in the NHS in England, the health watchdog has announced.
The recommendation comes after many women reported severe pain and disability after having the devices fitted.

In draft guidance, the National Institute for Health and Care Excellence (NICE) says they should only be used for research purposes.
Boots WebMD (27.11.17)

Regional NHS News

Sandwell hospital trust ordered to improve by CQC
The quality and levels of staff on wards at Sandwell and City Hospitals has also been identified as a concern.
Inspectors from the Care Quality Commission have now ordered Sandwell and West Birmingham NHS Trust to make improvements.
They highlighted a 'lack of mental health capacity assessments, poor care planning and inconsistent assessment of risk' within community inpatient care, which offers patients more personalised care.
Express and Star (30.10.17)

NHS' Health And Social Care Network Goes Live With First Customer Crescendo Systems
Crescendo Systems, a digital dictation and clinical records management firm, has become the first customer on the new networking framework
The first NHS organisations are expected to migrate from N3 to HSCN over the winter, including Moorfields Eye Hospital NHS Foundation Trust, West Midlands Ambulance Service and Devon Doctors.
Silicon (30.10.17)

NHS England Launch First Leadership Training For Pharmacists
The first course started in London on Monday (Oct 31), with further cohorts beginning across the country in Leeds, Manchester, Nottingham and the West Midlands from November, followed by 10 other regions. It will allow participants to study flexibly with the majority of learning taking place online in addition to three face-to-face workshops delivered locally.
The Voice Online (02.11.17)

Hospital cuts nursing numbers to make room for nursing associates
The Royal Wolverhampton Hospital NHS Trust's has decided to alter its nursing establishment following a skill mix report by its Chief Nurse Cheryl Etches. An NHS trust in the West Midlands will reduce its number of registered nurses and replace them with nursing associates.
Trust board meeting papers from the 30th of October 2017 reveal the board approved a reduction in the number of full-time equivalent band 5 registered nurses while simultaneously increasing their establishment of nursing associates by 600 percent.
Nursing Notes (02.11.17)

Revealed: West Midlands NHS crisis as GP numbers fall and patients soar
The West Midlands has lost more than 100 GPs in just over a year - as the number of patients soars.

NHS data reveals the region had just 1,586 full-time equivalent GPs at the end of June this year - the latest figures available - down from 1,476 in March 2016.
At the same time, the number of patients registered with a GP in the West Midlands went up by more than 50,000.
Birmingham Mail (16.11.17)

Support for tax rise to fund NHS has grown over past year, major poll finds
Support for a one-pence-in-every-pound tax increase specifically to fund the NHS is even higher now than a year ago, according to a new poll of 20,000 people.
While approval is above 50 per cent in all parts of the country, it is strongest in South-west London and among older and more well-off people, while the West Midlands had the lowest levels of support.
Independent (17.11.17)

Spitting, racial abuse and anti-social behaviour: NHS warning to louts at Shropshire's hospitals
Spitting and verbal abuse were among 109 intentional incidents of anti-social behaviour at the county's two main hospitals over the last year, figures have revealed.
There were 45 recorded incidents at the Royal Shrewsbury Hospital and 64 at Telford's Princess Royal Hospital in 2016/17.
Shropshire Star (23.11.17)

This is how much alcohol abuse cost the NHS in Birmingham and Sandwell
Alcohol abuse in Sandwell and Birmingham costs the NHS a staggering £72.1 million a year, new figures have revealed.
And around 300 patients are being seen every month at Sandwell and West Birmingham Hospitals NHS Trust (SWBH) suffering from some form of alcohol abuse.
The shocking statistics were released by the Trust during Alcohol Awareness Week earlier this month.
Birmingham Mail (27.11.17)

Appendix 1

BLACK COUNTRY PATHOLOGY SERVICE (BCPS)

Introduction

The development and delivery of pathology services within the NHS have long been subject to evaluation and discussion. In August 2006, in his review of NHS Pathology services in England, Lord Carter concluded that there was scope to achieve significant benefits from reform of pathology. The second phase of this review, carried out by Lord Carter in 2008, identified a strong case for consolidation of pathology to improve quality, patient safety and efficiency.

In February 2014, Lord Carter was asked to conduct a review of operational productivity and performance across NHS acute hospitals in England. This identified a number of areas where quality, efficiency and performance could be improved, including procurement, back office services, pharmacy and pathology. On pathology, Lord Carter found that the total cost of NHS pathology services was between £2.5 billion and £3 billion; that pathology costs as a proportion of trust operating expenditure ranged from under 1.5% to over 3.0% and that the mix and quantum of qualified employees was inconsistent with trust activity, ranging between 30 and 80 per 100,000 bed days. This review concluded there was an opportunity for the NHS to save around £200 million per annum in the provision of pathology.

Lord Carter developed a national set of pathology benchmarks and indicators as part of the Model Hospital, to allow trusts to compare services both in terms of quality and cost. He recommended that all trusts should either be achieving the benchmarks by April 2017, or have plans in place for consolidation, or outsourcing, of pathology services in order to achieve the benchmarks.

NHSI

In September 2017, after having worked with NHS trusts for nine months to validate pathology data and understand how pathology services could be delivered more efficiently, NHS Improvement, (NHSI), published a plan to improve pathology services and make them more efficient through bringing together clinical expertise, in order to deliver better value, high quality care for patients. The objectives of the NHSI plan are:

- that the 105 individual pathology services within NHS Hospitals in England will join-up, and form a series of 29 networks;
- that these new networks will bring together clinical expertise, ultimately making these services more efficient and capable of delivering better value, high quality care for patients
- to enhance career opportunities for staff, whilst being more efficient, delivering recurrent projected annual savings to the NHS of at least £200m

Providers were put in to 1 of the 29 proposed pathology networks and instructed to work with their local communities and clinical staff to implement this better way of delivering services for patients.

Under the NHSI plan the Midlands and East 1 pathology network comprised five trusts, Royal Wolverhampton NHS Trust (RWT) Sandwell and West Birmingham Hospitals NHS Trust (SWBH), Shrewsbury and Telford Hospital NHS Trust (SATH), The Dudley Group NHS Foundation Trust (DGFT) and Walsall Healthcare NHS Trust (WH). NHSI identified the potential to reduce the overall cost of pathology across this network by £5.1 million per annum.

Black Country and West Birmingham Sustainability & Transformation Partnership

Work had already commenced in early 2017 to look at pathology services within the Black Country and West Birmingham STP. An independent expert review of pathology services was carried out by Dr Mark Newbold and subsequently LTS, a specialist laboratory consulting firm was engaged to assist in the process of determining the baseline and developing the options for consideration.

Currently across the four Trusts the pathology services:

- have combined test volumes of 27.5 million per annum;
- operate from a combined area of 8,182 sq. m.;
- employ 671 staff, comprising 516 laboratory staff, 82 administrative, management and support staff, 18 clinical scientists, 47 consultants and 8 other medical staff;
- cost a total of £58.5 million per annum to operate;
- have productivity of 41,000 tests per person per annum with an average cost per test of £2.12.

Whilst there are agreed KPIs for pathology at each of the four Trusts, there is not consistency of KPIs. In addition, there are instances where some elements of the current services are unable to consistently deliver the agreed KPIs.

The sustainability of the current configuration of service is a concern. Recruitment to some consultant posts eg histopathology and microbiology is very problematic and in some cases this is affecting the provision of services

A Pathology Oversight Group, comprised of the four Trust Chief Executives and four Trust Medical Directors, was established to provide strategic direction and a Steering Group established to consider operational detail and evaluate the options identified for consideration. A Clinical Reference Group was also established to focus on the clinical and quality considerations for the service and on ensuring consistency of approach.

In July, an outline business case was presented to the four Trust boards. More detailed analysis followed, leading to the development of an agreed Target Operating Model (TOM).

In August, Dr Ye Lin Hock, a consultant histopathologist was appointed to the role of Clinical Director of the BCPS and Graham Danks appointed as Operational Manager of the BCPS. This provided clear focus to help

Target Operating Model (TOM)

The TOM has been developed with quality for patients and clinicians as its priority. The TOM is a pathology Hub site at RWT, together with essential services laboratories (ESLs) at each of the other three Trusts in order to undertake tests with urgent turnaround times. This TOM will provide economies of scale, improve the quality of the current service through sharing of resources and allow standardisation of the service across all sites, eliminating existing variations across services.

The TOM has been developed through an extensive engagement exercise with laboratory managers and leads, clinicians and other operational leads to determine the exact clinical requirements for each site and therefore the capability of the ESLs.

The TOM aims to ensure not only that all current standards are as a minimum maintained, but that as the service becomes fully operational other benefits are realised. These will include a 24/7 microbiology service, extended hours for other services and faster turnaround times.

All TOM risks identified by the clinical teams have been addressed in a risk register, with mitigation measures and impact assessed and monitored by the Clinical Reference Group and Clinical Director.

The creation of the Hub will require a 1,751 sq.m. extension to the existing facility at RWT to accommodate the additional testing volumes. This extension has been subject to detailed design. There will be a reduction of 3,637 sq.m in the space required across the other three Trusts.

The plan is for the TOM to be in place by June 2019. Please note, this is in line with the SWBH move to MMH. The final 'steady state' is for April 2020.

Financial Benefit

The TOM will deliver annualised savings of £6.7 million as follows:

	Current	Proposed	Change
	£m	£m	£m
Pay Costs	29.3	25.3	4.0
Non Pay Costs	20.8	18.7	2.1
IT Costs	0.8	1.5	(0.7)
Overhead Costs	7.5	5.8	1.7
Contingency		0.4	(0.4)
Total	**58.5***	**51.7***	**6.7***

*Please note that the difference on this line is the result of rounding.

Staffing: moving to the TOM will mean a reduction in staffing levels from 671 to 591 posts. The aim is to maintain security of employment and seek to effect this reduction through natural turnover.
Work on the process for staff to TUPE to the BCPS is underway by the HR teams. Details of this are expected in the New Year.

Non Pay costs: A new MES contract for equipment and reagents will be implemented over time in order to avoid incurring termination costs for current agreements. Detailed analysis has been conducted on logistics routes to ensure regular transport from sites to the Hub as required by clinical teams, together with an enhanced service for GPs. A service management contract will be put in place for the new LIMS system.

Overhead costs: the net reduction in space required to operate pathology services across the four Trusts will result in infrastructure cost savings.

The savings will be shared amongst the four Trusts based on the volumes of work undertaken.

The cost of the extension to the existing RWT facility has been verified with architects and quantity surveyors as £9 million. The intention is to prioritise an approach to the Lord Carter programme

and STP transformation funds to provide the funding for this, with the fallback of engagement with the Independent Trust Financing Facility (ITFF) to secure loan finance.

The identified savings of £6.7 million per annum exceed the £5.1 million target set by NHSI. There are however a number of organisations where the process of consolidating pathology services is more advanced, including:

- **North West London Pathology**, comprised of Chelsea and Westminster NHS Foundation Trust, Imperial College Healthcare NHS Trust, The Hillingdon Hospitals NHS Foundation Trust and West Middlesex University Hospital NHS Trust;

- **South West London Pathology** comprised of St George's University Hospitals NHS Foundation Trust, Kingston Hospital NHS Foundation Trust and Croydon Health Services NHS Trust;

- **The Pathology Centre at QE Gateshead**, providing most of the pathology services for the NHS across Gateshead, Sunderland and South Tyneside;

From evaluating the progress made by these more established consolidated pathology services, it is anticipated that annual savings for the BCPS may increase to approaching £10 million once the service is embedded, with potential both for greater efficiency, undertaking additional work and reducing the costs of equipment and reagents contracts.

Recommendation

As noted, the target date for the BCPS to be operational is June 2019. Whilst there remain some commercial issues to fully resolve, it is clear from the work carried out to date that the proposed pathology service will ensure the clinical sustainability of the service, improve the quality of service for patients and achieve as a minimum the efficiencies targeted by NHSI.

The service will also meet the ambition set out in the STP, which is:

"to offer a first class UKAS, MHRA and HT accredited pathology service across the Black Country and West Birmingham that ranks in the top quartile nationally on a range of quality, efficiency and outcome measures. This will include speed of access to results for inpatients to enable earlier decisions on treatment and so reduce length of stay, improved turnaround times for all pathology tests and appropriate out of hours coverage to reduce seven-day service gaps."

Accordingly, the board is recommended to approve the plan to establish the BCPS and to move to the implementation phase of the TOM. This approval is required now in order that:

- approaches can be made to secure the funding for the capital expenditure required and the necessary building work can commence;

- a new Laboratory Information Management System (LIMS) linking all the sites can be procured, implemented and fully tested;

- discussions can be progressed with SATH to integrate them into the BCPS, in line with the plan set out by NHSI;

- Heads of Finance and HR can be appointed to the BCPS management team and commence the detailed work on the integration of the service.

November 2017

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 7 December 2017

TITLE:	**28 November 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVES

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	**Approval**	**Discussion**	**Other**
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

The Committee requests the Board to note the assurances received at the meeting and the decisions made by the Committee.

The Committee requests the Board to approve the extended quality priorities for 2018/19

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	28 November 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The Committee received a verbal report on the Trust Red2Green initiative following a request at a previous meeting to understand the impact on patient flow, delayed discharges and thus patient experience. . The Committee were informed that members of the Trust Executive Team will be attended an NHS Improvement event on sustaining this initiative and will provide more detail on any changes the Trust will implement to secure more value from this initiative.
- The Committee reviewed the quality aspects of the Trust integrated performance report. The Committee discussed with both the Executive and the Divisions the actions being pursued to improve the infection prevention and control performance (this discussion was supported by the Director of Infection Prevention and Control); the action being taken to secure improved friends and family feedback; the ward quality dashboards now in use across the Trust and the pressure ulcer care performance, noting that the Trust had joined an NHS Improvement collaborative improvement initiative in this area.
- The Surgery, Women and Children's Division provided assurance on actions taken in respect of ophthalmology. Whilst the extra resources were continuing to have a positive impact on seeing patients and the delays had come down significantly, some internal resourcing challenges means that the clearance of the whole back log will take slightly longer than the end of November. The Division also provided an update on the work being undertaken in respect of paediatric outpatient waiting lists and whilst the Division is ahead of trajectory to clear these, there is on-going work to reduce the time those with a booked appointment are waiting beyond their ideal appointment time. The Committee was informed that whilst many patients were on the waiting list, a number of these had actually been seen within other pathways.
- The Committee received an update from the Chief Nurse on progress in respect of the delivery of the quality account priorities for this year recognising that for pressure ulcer care the Trust had had more than one grade four pressure ulcer and thus had failed the zero target for the year. The Committee also reviewed the e priorities proposed for 2018/19 which build on those set for 2017/18.
- The Committee recieved the Maternity Dashboard report which provided information on a wider spread of quality indicators for this service. The Committee was updated on the challenges to the delivery of a number of these measures, not least sustained mandatory training. The Committee, supported by the Chief Nurse, requested that this issue be rectified by the next meeting.
- An update was provided in respect of the Maternity Service Improvement Plan.

The report provided assurance of progress and the continued Executive oversight of the action tracking process which has and will continue to take place within the Division and the Directorate. The plan had been extended to include actions from an external assessment into infection prevention and control processes.

- The Committee received an update on the CQC insight report. The report sets out the data that the CQC holds on the Trust performance. The Committee requested that where the Trust has more recent data on performance this should be shared with the CQC. The Director of Governance agreed that this would be done and that the Trust has regular engagement meetings with the local inspection engagement lead which would allow this to happen.
- The Committee received a report on incident management. The report provided assurance on the Serious Incident process being applied and included information on the Trust position in respect of wider incidents. The report documented the continued focus on learning and improvement. The report provided assurance that the Trust has complied with Duty of Candour provision, where this had been possible. The Committee were updated on the actions being taken to close investigations in a timely manner and were asked to note that for five investigations actions remained in progress after the originally agreed implementation date
- The Committee was updated on the complaints activity over the second quarter of the year. The report provided information on the themes of the complaints and the progress being made on responding to them in a timely manner.
- The Committee received a report on the qualitative aspects of the estates contract management processes in respect of both estates and facilities. The report provided information on actions taken in respect of its remit for water safety, decontamination and the medical devices asset register. The Committee was informed that there is programme being undertaken to replace soft flooring with laminate flooring in patient waiting areas. The Committee requested that the replacement flooring be 'dementia friendly' and provide for visually impaired patients.
- The Committee received a report on the clinical audit activity being undertaken across the Trust. The report drew out the learning and changes made as a result of the clinical audit activity in the first part of the year. The Committee recognised that more work was required to secure more information on learning from the Divisions themselves. The report also provided confirmation that the Trust remains on track to deliver the expected national audits to be included within the Trust's annual quality account.
- The Committee received a report on the level of external reviews being undertaken across the Trust and that the Divisions. For the current quarter the reviews reported mainly related to Surgery and were driving improvements and learning.
- The Committee received assurance that the Trust process to assess compliance with National Patient Safety Alerts remains effective.

The Committee received reports from the Quality and Safety Group; the Health and Safety Group, the Internal Safeguarding Board; the Mortality Surveillance Group; the Infection Prevention and Control Forum; the Medicines Management Group, the End of Life Steering Group and the Clinical Approvals Group. These reports confirmed that the groups were quorate when meeting and were working in accordance with their terms of reference

Decisions Made / Items Approved
• The Committee supported the recommendation that the updated quality priorities for 2018/19 are placed before the Board and Council of Governors for approval. • The Committee supported the closure of 37 SI Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced. The Committee approved 3 policies, two of which had been the subject to a comprehensive rewrite with the other one having more minor changes to reflect process changes to reflect the Trust use NEWS (the national early warning score assessment).
Actions to come back to Committee (items Committee keeping an eye on)
That a report is brought back detailing the work done and improvement made to the discharge processes in the new year following the NHSI workshop attendance. That a further update is provided on the Trust infection prevention and control processes following the planned visit by NHSI in December. That the presentation of the maternity quality dashboard provides information on the expected improvement in mandatory training compliance. That following the national announcement regarding the increased scrutiny to be given to stillbirths, a report detailing the Trust processes for conducting such reviews and the learning extracted from the reviews of recent cases. That issues relating to the meetings of the Transfusion Group be monitored by the Quality and Safety Group and progress reported to the Committee
Items referred to the Board for decision or action
The Committee endorses the extended quality priorities for 2018/19, with the addition of a quality priority on discharge management and one on incident management and requests the Board to approve these.

Enclosure 5

The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board 7th December 2017

TITLE:	**Infection Prevention and Control Forum Report**		
AUTHOR:	**Dr Elizabeth Rees, Director of Infection Prevention and Control**	**PRESENTER**	**Ms S Jordan, Chief Nurse**

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- Statement of compliance with the Hygiene Code.
- For 2017/18 the Trust has had 17 cases of post 48 hr C. difficile of which 1 case was identified in October.
- No post 48 hr MRSA bacteraemia cases since 27th September 2015
- For 2017/18 there have been 7 post 48 hr MSSA bacteraemias identified in the Trust of which 2 cases were identified in October.
- For 2017/18 there have been 22 post 48 hr E. coli bacteraemias identified in the Trust of which 3 cases was identified in October.
- During October there has been 1 post 48 hr Klebsiella bacteraemia case.
- During October there were 0 post 48 hr Pseudomonas bacteraemia cases.
- Following an invited visit by the Infection Control Specialists at NHSi the Trust has developed an action plan to address issues identified within the report.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Y		**Risk Score:** No red risks
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe and effective care
	NHSI	**Y**	**Details:** MRSA and C. difficile targets
	Other	**Y**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE COMMITTEE: To receive the report and acknowledge the assurances.

The Dudley Group
NHS Foundation Trust

Introduction:
The summary information below provides assurance of compliance with the Code of Practice (The Health and Social Care Act 2008): Code of Practice on the Control of Infections and Related Guidance, July 2015). Therefore the Trust is declaring full compliance.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them.
Assurance: A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly.	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
Assurance: A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained.	
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.
Assurance: There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy.	
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.
Assurance: Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support.	
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
Assurance: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk.	
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Assurance: Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection.	
7	Provide or secure adequate isolation facilities.
Assurance: There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms.	
8	Secure adequate access to laboratory support as appropriate.
Assurance: The Trust has access to a CPA/UKAS accredited Microbiology and Virology laboratory.	
9	Have adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections.
Assurance: All policies, as recommended in the Hygiene Code, are in place. Audit data confirms compliance with policies and identifies areas for improvement.	
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
Assurance: There is in house provision of Staff Health and Wellbeing. There are regular reports to the Infection Prevention and Control Forum detailing any issues raised within this system.	

Summary of alert organism surveillance:

Clostridium Difficile – The target for 2017/18 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. The cases that count within this dataset are patients identified after 48 hrs admission with C. difficile in whom a lapse in care has been recognised using the national apportionment tool [1]. For 2017/18 there have been 17 post 48 hr cases to the end of October, of these 14 were associated with a lapse in care. For October 2017 1 post 48 hr case has been reported; it's apportionment has been completed and no lapse in care was identified.

The process to determine lapses in care is as follows: an RCA is completed for every post 48 hr case, there is a review undertaken internally using the national apportionment form to determine lapses in care. This information is then shared with the CCG who confirm the outcome decision. This results in the ability to describe individual C. difficile cases as 'avoidable/unavoidable'.

Themes identified for the lapses in care include: failure by areas to meet their mandatory IC training targets, environmental scores, cleaning score below the required standard and failure to complete a stool chart on admission of the patient.

Following this process themes identified are included in local and Trustwide action plans to address the above issues. The progress of these actions are reported in the Infection Prevention and Control Forum meeting.

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

MSSA bacteraemia (Post 48 hrs)

For 2017/18 there have been 7 post 48 hr cases identified of MSSA bacteraemia. Of which 2 cases were identified in October 2017. One patient has had recurrent bacteraemic episodes over several months associated with an irremovable intravascular device. No themes were identified with the other case.

MRSA screening – There is no external compliance target for MRSA screening. The internal target is to achieve 95% compliance with the policy. The Trust screens emergency admissions as well as appropriate elective day cases. The percentage of emergency admissions screened for October is 90.6%. Data is returned locally to the units to enable them to identify patients missing from the dataset to ascertain gaps in the system to ensure full compliance going forward.

The percentage of elective admissions screened for October is 88%. To ensure all day case patients are screened appropriately further work to identify these patients is ongoing. Each division feeds back progress at the Infection Prevention and Control Forum meeting.

E. coli bacteraemia – For the post 48 hr cases an enhanced surveillance module has been commenced in April 2017 in order to ascertain themes and trends within the acute Trust to see where lessons may be learnt. For 2017/18 there have been 22 cases of post 48 hr E. coli bacteraemias. There are 3 post 48 hr cases for October. In 2 of October's cases there was a history of urosepsis in each patient.

Work with the CCG, for whom a reduction of 10% cases is part of the quality premium, is commencing in the New Year with the recruitment of a member of staff by the CCG to facilitate this to optimise management of urinary catheter care.

Klebsiella* and Pseudomonas* bacteraemias – For October there was 1 post 48 hr Trust identified Klebsiella bacteraemia case and 0 post 48 hr Pseudomonas bacteraemia case. Work is ongoing to ensure a complete dataset is available from April 2017 onwards to identify areas for improved care.
Norovirus – The incident on B2 ward was closed at the end of October. No further cases have been identified.

Infection Control Mandatory Training – The current mandatory requirement is to update Infection Control training every 3 years. The percentage compliance as at 31.10.17 (target 90%)

Area	Total
Corporate/Management	90%
Medicine and Integrated Care	92%
Surgery	90.7%
Clinical Support	84%

The ward areas falling below 90% are A2 (88%), B5 (86%) and C2 (88%).

Following receipt of the NHSi report there is a programme to move the current 3 yearly mandatory infection control training to annual, with updating senior staff and Matrons as a priority with dates arranged in December.

Environment and Hand Hygiene – The revised Cleaning Policy has been approved by all groups. The implementation of the hand hygiene system is well underway but due to snagging and additional dispensers being required is expected to complete by end of first week in December.

A costing has been received by the Trust from the PFI partner to replace all the red and amber RAG rated carpeted areas. An implementation plan is being developed.

Infection Prevention and Control Forum – It has previously been agreed to increase the frequency of the meetings to 10 per annum and to introduce a cycle of reporting to ensure adequate time for discussion of agenda items. The membership was also reviewed and approved to reflect the revised divisional structures whilst maintaining membership of external agencies including the CCG, Office of Public Health and Public Health England. A number of sub-groups report into the meeting including the Water Safety Group and Antimicrobial Steering Group. The last meeting was held on 25th October; key issues identified were around increasing compliance with the MRSA screening policy, a dip in cleaning scores during October due to dust (initial investigations suggest this is related to decorating being performed in clinical areas), the antimicrobial stewardship agenda was progressing well and an update was received around the implementation of the new hand hygiene products.

NHSi Report – A report has been received which RAG rates the Trust for red for Infection Control. The visiting team reviewed policies and reports prior to the visit and on the day met with key individuals and visited clinical areas. The visit identified serious failings in compliance with basic infection prevention practices in the areas visited. In addition staff did not appear to be aware of their roles and responsibilities towards infection prevention. Based on the findings observed in the clinical areas focus of action should be amending of the mandatory training cycle from 3 yearly to annual to ensure all staff comply with Trust infection control policies. The other issues addressed have been incorporated into an action plan. The paper and the action plan have already been presented to the Clinical Quality, Safety and Patient Experience Committee on 28th November.

The paper will be presented at the next Infection Prevention Forum on 5th December and an update on the actions will be tabled at that meeting.

The Dudley Group
NHS Foundation Trust

GLOSSARY OF TERMS

MSSA

What is Meticillin Sensitive Staphylococcus aureus (MSSA)?

Staphylococcus aureus is a bacterium that is commonly found on human skin and mucosa (lining of mouth, nose etc). The bacterium lives completely harmlessly on the skin and in the nose of about one third of normal healthy people. This is called colonisation or carriage. *Staphylococcus aureus* can cause actual infection and disease, particularly if there is an opportunity for the bacteria to enter the body e.g. via a cut or an abrasion.

What illnesses are caused by Staphylococcus aureus?

Staphylococcus aureus causes abscesses, boils, and it can infect wounds - both accidental wounds such as grazes and deliberate wounds such as those made when inserting an intravenous drip or during surgery. These are called local infections. It may then spread further into the body and cause serious infections such as bacteraemia (blood poisoning). *Staphylococcus aureus* can also cause food poisoning.

MRSA

What is Meticillin Resistant Staphylococcus Aureus (MRSA)?

MRSA stands for meticillin-resistant *Staphylococcus aureus*. They are varieties of *Staphylococcus aureus* that are resistant to meticillin (a type of penicillin) and usually to some of the other antibiotics that are normally used to treat Staphylococcus aureus infections.

Who is at risk of MRSA infection?

MRSA infections usually occur in hospitals and in particular to vulnerable or debilitated patients, such as patients in intensive care units, and on surgical wards. Some nursing homes have experienced problems with MRSA. MRSA does not normally affect hospital staff or family members (unless they are suffering from a severe skin condition or debilitating disease). In general, healthy people are at a low risk of infection with MRSA.

E Coli

What is *Escherichia coli*?

Escherichia coli (commonly referred to as *E. coli*) is a species of bacteria commonly found in the intestines of humans and animals. There are many different types of *E. coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment.

What types of disease does *E. coli* cause?

The commonest infection caused by *E. coli* is infection of the urinary tract, the organism normally spreading from the gut to the urinary tract. *E. coli* is also the commonest cause of cystitis (infection of the bladder), and in a minority of patients the infection may spread up the urinary tract to the kidneys, causing pyelonephritis.

Otherwise healthy patients in the community may develop cystitis, and patients in hospital who have catheters, or tubes, placed in the urethra and bladder are also at risk. *E. coli* is also present in the bacteria that cause intra-abdominal infections following leakage from the gut into the abdomen, as for example with a ruptured appendix or following traumatic injury to the abdomen.

E. coli bacteria may also cause infections in the intestine. Diarrhoeal infections (intestinal) are caused by a group of *E. coli* known as 'enterovirulent' (harmful to the intestines).

Overspill from the primary infection sites to the bloodstream may cause blood poisoning (*E. coli* bacteraemia). In rare instances, *E. coli* may cause meningitis in very young children.

Klebsiella species

What is Klebsiella?

Klebsiella species includes a number of genre including *Klebsiella oxytoca and Klebsiella pneumoniae*. These organisms are colonisers of the human gastrointestinal tract and are capable of causing a wide variety of clinical syndromes including urinary tract infection, pneumonia and bacteraemia.

What types of disease does *Klebsiella species* cause?

These organisms are rarely associated with diseases in the normal host. They are a cause however of nosocomial and opportunistic infection.

Pseudomonas aeruginosa

What is *Pseudomonas aeruginosa?*

Pseudomonas aeruginosa is sometimes present as part of the normal microbial flora of humans. Hospitalisation may lead to increased rates of carriage, particularly on the skin in patients with serious burns, in the lower respiratory tract of patients undergoing mechanical ventilation, in the gastrointestinal tract of patients undergoing chemotherapy or in any site in persons treated with broad spectrum antimicrobial agents.

What types of disease does *Pseudomonas aeruginosa* cause?

Pseudomonas aeruginosa is an opportunist pathogen causing disease as a result of some alteration or circumvention of normal host defences eg, disruption or circumvention of skin or mucous membrane integrity in the case of intravenous lines, urinary catheters or endotracheal tubes.

C difficile

What is *Clostridium difficile*?

*Clostridium difficile (*also known as *"C. difficile" or "C. diff")* is a bacterium that can be found in people's intestines (their "digestive tract" or "gut"). However, it does not cause disease by its presence alone; it can be found in healthy people, about 3% of adults and two thirds of babies with no symptoms. It causes disease when the normal bacteria in the gut, with which *C. difficile* competes, are disadvantaged, usually by someone taking antibiotics, allowing the *C. difficile* to grow to unusually high levels. This allows the toxin they produce to reach levels where it attacks the intestine and causes symptoms of disease.

What are the symptoms of *C. difficile* infection?

Clostridium difficile causes diarrhoea (mild to severe) and, unusually, life threatening inflammation of the intestines. Other symptoms can include fever, loss of appetite, nausea and abdominal pain or tenderness.

How do you catch it?

Another person may acquire C.difficile disease by ingesting the bacteria through contact with the contaminated environment or patient. In most healthy people the C.difficile will not be able to multiply in the gut and they will not develop disease. In some more vulnerable people, particularly those whose normal gut bacteria have been disrupted by antibiotic treatment, the C.difficile may be able to multiply in the gut and go on to cause disease.

CPA/UKAS

What is CPA/UKAS?
CPA is Clinical Pathology Accreditation and UKAS is United Kingdom Accreditation Service. These are both organisations responsible for the inspection and accreditation of laboratories providing diagnostic pathology services.

RCA

What is RCA?
RCA is a root cause analysis which is an analytical method by which an investigation into a particular event seeks to identify the underlying cause.

PFI

What is PFI?
PFI is the abbreviation used for Private Finance Initiative and in this context is used to describe Summit Healthcare and Interserve Facilities Management.

CCG

What is CCG?
CCG is the Clinical Commissioning Group and in this context refers to Dudley Clinical Commissioning Group.

RAG

What is RAG?
RAG is Red, Amber, Green which is a term used to describe the risk rating associated with risks described within the report.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation, Public Health England.

*Klebsiella includes *Klebsiella oxytoca* and *Klebsiella pneumoniae* species and Pseudomonas includes only *Pseudomonas aeruginosa* species.

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th December 2017

TITLE:	**Monthly Nurse/Midwife Staffing Position – December 2017 report containing October 2017 data**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER**	Siobhan Jordan Chief Nurse

CLINICAL STRATEGIC AIMS

Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.

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

SUMMARY OF KEY ISSUES:

The attached paper contains the actual and planned hours for qualified and unqualified staff for both day and night shifts for each area of the hospital based on the present establishments and having a significant reliance on temporary staff (bank and agency). The fill rates and the Care Hours Per Patient Day (CHPPD) are also tabled. It can be seen that in general the fill rates are close to but less that 100 percent of the current establishment and there has been improvement in these figures from early in the year (January/February).

With regards to the CHPPD, from an in depth analysis of both the submitted data and the latest available figures in the Model Hospital (for August) it has come to light that since June the Trust has been using the incorrect monthly number of patients. This has now been corrected and the reasons are explained in the paper.

Under the guidance of the new Chief Nurse, the Trust has been undertaking a detailed, extensive staffing review of each of the wards and departments. To date all of the medical and surgical wards have been reviewed and the community and other specialised areas of the Trust e.g. out-patients are in the process of being reviewed.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Safe Staffing
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Led
	NHSI	**Y**	**Details: Safe Staffing**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note and consider the safe staffing data for October.

a) Monthly Nurse/Midwife Staffing Position

December 2017 Report containing October 2017 data

The attached Safer Staffing Summary (Appendix1) shows the actual and planned hours for four categories of staff, qualified and unqualified staff for both day and night shifts, for each area of the Trust for October 2017 (wards that have been fully or partially closed in the month are omitted). As well as showing the actual and planned hours the report shows the fill rate for each of the four categories. The totals for the Trust are also indicated. In addition, the last four columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in the National Model Hospital dataset.

The report shows that the overall fill rates for the Trust are nearly 100% but this has been achieved by using the present establishments and a significant reliance on temporary staff (bank and agency). A number of factors make it unlikely that a full fill rate will always be achieved although this is the aim. These factors include long term issues such as vacancies, short term issues such as sickness and maternity leave, the unavailability of temporary staff and unexpected numbers of patients requiring enhanced care.

It can be seen that for individual wards the fill rates vary although in the main they are close to 100%. On occasion, the fill rate is over 100%. C2, the paediatric ward, and NNU (neonatal unit) are exceptions with regards to this as the planned hours are derived from the dependency tools used for each shift. Each shift the planned hours are determined by the acuity of the children actually on the ward. Also, sometimes there are occasions when the fill rate of unqualified staff goes above 100%. This occurs when it is recognised that there will be a reduction in qualified staff (e.g. C5/C6 at night). The low fill rate during the days in CCU/PCCU reflects the problems in recruiting staff to this particular area. The new recruitment drive by the department mentioned in the last report resulted in four new staff starting but unfortunately four staff are also leaving (two promotions, one to the community and one for family reasons) so further recruitment is ongoing. The low fill rates for B3 are due to that ward now starting to use the new planned levels following the recent staffing review.

The chart below shows that the percentage fill rates have generally been improving over the year.

Table 1. Percentage fill rates January 2017 to the present

	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
Jan	94%	96%	94%	99%
Feb	93%	95%	96%	99%
Mar	95%	97%	97%	100%
Apr	97%	96%	98%	98%
May	97%	97%	99%	98%
June	96%	96%	98%	99%
July	96%	97%	98%	100%
August	96%	97%	97%	101%
September	96%	97%	98%	100%
October	96%	97%	97%	99%

With regards to the CHPPD, as has been explained in previous monthly reports this is a new indicator that can be used to benchmark the Trust.

Table 2. Care Hours Per Patient Day (CHPPD) – Overall Trust and Regional/National Comparators

2017 Month	TRUST Nurse & Midwife	Midlands & East Median	National Median	TRUST Care Support Workers	Midlands & East Median	National Median	TRUST Total number	Midlands & East Median	National Median
January	4.30	4.7	4.7	3.50	2.9	2.9	7.8	7.7	7.6
February	4.34	N/A	N/A	3.63	N/A	N/A	7.97	N/A	N/A
March	4.44	N/A	N/A	3.74	N/A	N/A	8.18	N/A	N/A
April	4.55	4.8	4.8	3.73	3.1	3.1	8.28	7.8	7.9
May	4.4	4.9	4.8	3.8	3.1	3.1	8.2	7.9	7.9
June*	4.7	N/A	N/A	3.8	N/A	N/A	8.5	N/A	N/A
July*	4.5	N/A	N/A	3.9	N/A	N/A	8.4	N/A	N/A
August*	4.6	4.7	4.7	3.9	3.1	3.1	8.4	7.9	7.9
Sept.*	4.5	N/A	N/A	3.7	N/A	N/A	8.2	N/A	N/A
October	4.6	N/A	N/A	3.8	N/A	N/A	8.4	N/A	N/A

N/A = Data not available. * Adjusted figures from previous reports (see explanation below).

This report contains the latest newly published regional and national average figures which are for August. Over time, it can be seen that the Trust's CHPPD for qualified staff has been increasing but still below the regional and national medians. The unqualified CHPPD remains above the comparators so that the overall CHPPD remains above the regional and national medians.

Two errors in some of the previously published data on safer staffing have been discovered this month as some of the recently available comparative information in the Model Hospital did not seem correct which led to a detailed review of the figures. The safer staffing figures originate from two sources: a) Lead nurses complete daily figures of planned and actual staff into individual ward/department spreadsheets. The total figures per ward/department flow into an overall spreadsheet (see Appendix 1) and b) the number of patient days per month or occupancy (column called Sum 24.00 Occ) is imported by the use of a software 'routine' into the spreadsheet from the OASIS system at the end of the month.

The first error discovered is because at the beginning of a month the summary spreadsheet rolls over the patient days of the previous month. At the end of the month when the Nursing Division confirms the staffing figures to the Finance Directorate, it is only after this confirmation that Finance Directorate staff update the patient day numbers from the previous month. The Nursing Directorate was unaware that that patient data is only updated after they confirm the staffing figures and so sometimes have immediately printed off the data for the Board at the same time as confirming the staffing figures to the Finance Directorate. Sometimes they have printed off the data later when preparing the report. This means that on some months the CHPPD data is based on the occupancy of the previous month. This error has now been corrected.

The second error discovered has come from the software routine that imports the data from OASIS into the occupancy figures used to calculate the CHPPD. It has been found that since June this routine has been importing incorrectly due to the closure of B6. The routine sometimes misses out the occupancy of one ward in particular and less often duplicates some of the data of that ward. This has either resulted more often in an increased or occasionally on a decreased CHPPD figure from the true value. This error has now been corrected. It is appreciated that the corrected figures need to be retrospectively imported

into the Model Hospital and communication has been sent to the national data centre asking if this is possible. An answer is awaited.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate using the present establishments and a significant reliance on temporary staff (bank and agency). Benchmarking the Trust workforce data using the CHPPD can be informative and will continue, although our own experience of the data inputted indicates that comparisons should be undertaken with caution.

The staffing review which commenced in May is using data from a wide variety of sources to inform and ensure the required outcome. As well as considering the above data, the review is structured discussions with Matrons and senior nurses from each area together with their managers using information on establishments, staffing ratios and vacancy, sickness and temporary staffing rates. It has considered the outcome of the most recent six monthly Safer Nursing Tool exercise and patient acuity.

Both the main medical and surgical ward areas, NNU and Critical Care reviews have been completed and decisions made following discussion and approval at Director level and the Finance and Performance Committee. Staff from a number of specialist areas have now been seen (e.g. Main Out Patients Department (OPD), Renal Unit) and requested information is awaited from those areas. Due to the number of smaller, specialist OPD areas, an initial questionnaire has been sent to these areas and the completed returns are awaited. A further meeting has been arranged for the emergency care/assessment areas due to the recent and imminent changes in configuration. All of the community localities and specialist teams (except one specialist team due to unavailability) have been seen and the report commenced.

The whole review will be concluded and presented to the Board by January 2018.

Safer Staffing Sun			Days in Month	31								Actual CHPPD		
Ward	Day CSW Day MSW Plan	Day CSW Day MSW Actual	Night RN Night RM Plan	Night RN Night RM Actual	Night CSW Night MSW Plan	Night CSW Night MSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Registered	Care staff	Total
Evergreen														
A2	217	224	155	153	187	212	97%	103%	99%	113%	1,160	4.07	4.51	8.58
A3														
A4														
B1	68	64	66	67	67	64	95%	94%	102%	96%	561	3.62	2.75	6.37
B2(H)	253	230	93	91	221	211	94%	91%	98%	95%	874	2.79	5.92	8.71
B2(T)	126	124	62	61	94	91	96%	98%	98%	96%	595	2.90	4.32	7.22
B3	185	157	203	179	159	148	80%	85%	88%	93%	1,058	4.32	3.38	7.70
B4	240	219	156	141	183	175	94%	91%	90%	96%	1,372	2.70	3.45	6.15
B5	126	122	158	159	113	121	97%	97%	101%	107%	972	4.10	3.00	7.10
B6														
C1	313	283	155	140	191	176	96%	90%	90%	92%	1,450	2.64	3.80	6.43
C2	69	65	146	163	40	38	147%	94%	112%	95%	626	7.26	1.77	9.03
C3	389	387	156	155	391	386	99%	100%	99%	99%	1,584	2.57	5.86	8.42
C4	65	63	94	94	96	90	92%	97%	100%	94%	670	4.03	2.74	6.77
C5	241	251	155	132	166	183	93%	104%	85%	110%	1,446	2.51	3.60	6.11
C6	70	67	62	61	72	75	99%	96%	98%	104%	513	3.49	3.32	6.81
C7	145	147	124	118	155	156	91%	101%	95%	101%	1,117	3.02	3.26	6.27
C8	247	249	186	180	264	263	95%	101%	97%	100%	1,288	3.33	4.77	8.10
CCU_PCCU	31	40	155	154	-	-	80%	129%	99%		700	5.50	0.69	6.18
Critical Care	62	59	305	305	12	12	100%	95%	100%	100%	305	23.58	2.03	25.61
EAU	155	148	155	155	155	153	97%	95%	100%	99%	734	5.35	4.92	10.28
Maternity	217	211	527	486	155	138	95%	97%	92%	89%	568	17.59	7.19	24.78
MHDU	35	31	123	116	3	3	90%	89%	94%	100%	231	11.58	1.76	13.34
NNU	-	-	152	165	-	-	112%		108%		417	9.56	0.00	9.56
TOTAL	**3,254**	**3,140**	**3,388**	**3,274**	**2,724**	**2,695**	**96%**	**97%**	**97%**	**99%**	**18,241**	**4.6**	**3.8**	**8.4**

Enclosure 7

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
on 7th December 2017

TITLE:	**Quality Priorities for 2018/19** **Quality Metrics for 2017/18 Annual Quality Report** **Update on Action Plan from External Auditors Review of Quality Account 2016/17**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER:**	Siobhan Jordan Chief Nurse
CLINICAL STRATEGIC AIMS			
Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.			
CORPORATE OBJECTIVE: Deliver a great patient experience, Safe and Caring Services, Be the place people choose to work, Make the best use of what we have			

SUMMARY OF KEY ISSUES:

Quality Priorities for 2018/19
At this time last year, the Trust was required by NHSI to submit an operational plan for two years (2017/19). At that time, the Trust decided to have the following topics as quality priorities for the two year period and these have been monitored through this year:

Patient Experience (FFT/Pain Control) **Pressure Ulcers** **Infection Control**
Nutrition/Hydration **Medication**

After reflection on the current situation at the Trust, this paper is proposing that there are changes to these topics for 2018/19. The proposed topics are:

Patient Experience (FFT/Pain Control) **Pressure Ulcers** **Nutrition/Hydration**
Discharge Management **Medication** **Incident Reporting**
Infection Control

The additions above are suggested based on the following reasons:
Comparatively speaking the Trust has a low incident reporting rate (latest comparative figures for October 2016 to March 2017, published in September 2017, show the Trust reporting rate was 79th of 136 organisations). The Trust also needs to improve its discharge processes to ensure both patient safety and patients do not remain in hospital longer than necessary.

The five existing topics remain important and improvements still need to be made.

The CQSPE committee on the 28th November endorsed the above proposal and the Board is asked to approve this.

(*Next year's specific targets for each topic can be agreed, as usual, nearer the time in March 2018 when the Trust is aware of any nationally imposed targets and when the end of year results are easily predictable).*

(The Trust awaits national planning guidance which will outline the process when changes are made to the present two year plan which only lists the five existing topics).

Quality Metrics for 2016/17 Report

As well as the requirement to have at least three quality priorities in the Quality Account, NHSI mandates that in Part Three of the report, Trusts should include three quality metrics for each of the three domains of quality. The regulations also state that the Board has to agree these each year. The following are the ones agreed for last year's report. It is proposed that these are retained for this year's report on our 2017/18 performance:

Patient Experience Domain

These metrics are the results from three questions posed in the national adult inpatient survey as these allow comparison with other Trusts. The three topics/questions are:

1 Patients who agreed that the hospital room or ward was clean
2 Rating of overall patient experience
3 Patients who felt they were treated with dignity and respect

Patient Safety Domain

The three metrics are:

1 Patients with MRSA infection/1,000 bed days
2 No. of venous thromboembolism (VTE) cases presenting within 3 months of admission
3 Never Events – events that should not happen whilst in hospital

The CQSPE committee on the 28th November endorsed the above proposal and the Board is asked to approve this.

Update on Action Plan from External Auditors Review of Quality Account 2016/17

The external auditors produced a report on their review of both the contents of the Quality Report and the data quality of the two mandatory and one local indicator in the 2016/17 report. A number of recommendations were made and an action plan was presented to CQSPE in July 2017. The Committee asked for an update later in the year. This was presented to the CQSPE in November and the committee noted the progress made.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** Safe Staffing
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Led
	NHSI	**Y**	**Details:** Safe Staffing
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:			
Decision	**Approval**	**Discussion**	**Other**
	✓	✓	

RECOMMENDATIONS FOR THE BOARD: To agree to the proposals regarding the Quality Priority topics for 2018/19 and the metrics for the 2017/18 report. To note the progress with the action plan from the external audit of the Quality Report 2016/17

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 7th December 2017

TITLE:	**Speak Up (FTSU) Guardian Update**		
AUTHOR:	Derek Eaves, Professional Lead for Quality/FTSU Guardian Carol Love-Mecrow Deputy Chief Nurse/FTSU Guardian	**PRESENTER**	Derek Eaves, Professional Lead for Quality/FTSU Guardian

CLINICAL STRATEGIC AIMS

Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.

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

SUMMARY OF KEY ISSUES:

This paper gives an update on:

- Numbers of concerns raised in the last quarter and an outline of outcomes from some of those concerns.
- The results of a national survey of Guardians and the Trust's response/position with regards to the recommendations from the survey
- Initiatives and developments to increase the profile of the role.
- National/Regional Guardian activity
- Reflections and future plans

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To receive and note the latest developments with Freedom to Speak Up Guardian issues.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak Up (FTSU) Guardian December 2017 update

Introduction

The appointment of the new Guardian, Derek Eaves, Professional Lead for Quality and the continued support in the role by Carol Love-Mecrow, Deputy Chief Nurse has provided an opportunity to review the current processes and reporting in line with recent developments related to the Freedom to Speak Up agenda.

Numbers of concerns raised at the Trust

The table below indicates the numbers and types of concerns raised with the Guardians each full quarter this year and from October 1st to date (November 27th). It can be seen that the numbers are increasing each period. This could be due to increased publicity about the service. The National Guardian Office (NGO) has discussed the difficulties in categorising types of concerns being raised and the categories below are locally based. It can be seen that the majority of concerns being raised are regarding behaviour unrelated to patient care. We have divided the national category on this topic into two; into a) perceived bullying and harassment and b) perceived unfair behaviour, the latter including concerns raised about unfair recruitment, unfair rotas and concerns about redeployment of staff. All of these two types of concerns have been concerns regarding line and senior managers.

2017/18	Number	Anonymously	Patient Safety	Behaviour: Bullying/ Harassment	Behaviour: Unfair	Other
Apr-Jun	2	0	0	2	0	0
Jul-Sep	14	3	4	8	2	0
Oct-date	10	1	1	3	5	1

The table below breaks down the types of staff who are raising the concerns and it can be seen that these come from a cross section of staff except medical staff.

2017/18	Number	Nursing	Midwife	Medical	AHP	Clinical Scientist	Administration	Unknown
Apr-Jun	2	0	0	0	0	0	0	0
Jul-Sep	14	7	2	0	1	0	3	1
Oct-date	10	5	0	0	0	1	4	1

Actions/Outcomes

The concerns being raised vary considerably in complexity and as a consequence the time and resources required to come to a conclusion do differ markedly. Some issues can be resolved quickly by the Guardian, sometimes with the assistance of the Chief Executive, in liaison with local management while others are handed over, with the agreement of the person raising the concern, to such departments as Human Resources and Complaints.

The following are examples of actions/outcomes as a result of concerns raised on the following topics:

- Recruitment process: resulted in meetings with all staff and changes to the person specification of the post
- Lack of communication on redeployment: resulted in meetings with relevant manager and clarification of process
- Inappropriate discussion about patient details: resulted in discussion with person about how to behave in future

- Inappropriate access to a department: resulted in tightening up of procedures in place
- Management behaviour: resulted in a wide review which is ongoing
- Unclear management decision on hours worked of a staff member: resolved to the satisfaction of the person raising the concern
- Being opted into the NHS person scheme when this was not wanted: resulting in an explanation of the national rules that the Trust has to operate within
- Inadequate staffing levels: resulted in a meeting between the person raising the concern and the Matron

Numbers of concerns raised at the Trust compared with other Trusts.

With regards to the Q2 figures there were 14 concerns raised at the Trust. At the end of November the National Guardian Office (NGO) released the final data of the submissions from Trusts for Q2. The headlines were:

- 1,611 cases were raised to Freedom to Speak Up Guardians.
- 551 of these cases included an element of patient safety / quality of care.
- 733 included elements of bullying and harassment.
- 365 anonymous cases were received.
- 23 trusts did not receive any cases through their Freedom to Speak Up Guardian.
- 210 of the 233 NHS trusts sent returns.
- Highest Trust had 61 cases (Local Trusts: 8, 1, No data returned x2)

Freedom to Speak Up Guardian Survey 2017 - Findings and recommendations and Trust Response September 2017

In September 2017, the NGO published the results of a survey of Guardians across the country. A number of recommendations were made. These are listed below with the Trust's response.

Topic	Recommendation	Trust Response/Proposed Actions
Appointment	We recommend that appointment of guardians is made in a fair and open way, and that senior leaders assure themselves that workers throughout their organisation have confidence in the integrity and independence of the appointee.	COMPLIANT. Trust Directors discussed in detail the appropriateness of the individuals appointed and based their decision on the relevant qualities of the individuals
Potential conflicts of interest	We recommend that all guardians / ambassadors / champions reflect on the potential conflicts that holding an additional role could bring and that they devise mechanisms to ensure that there are alternative routes for Freedom to Speak Up matters to be progressed should a conflict become apparent when supporting someone who is speaking up. We see particular potential for conflicts to arise where a guardian also has a role as a human resources professional and recommend that guardians do not have a role in any aspect of staff performance or human resources investigations.	COMPLIANT. The two Guardians have discussed this and have agreed that they will not take on cases where there is or could be perceived to be a conflict of interest. They will pass these on to their colleague. A contingency is in place also if they both have or there could be perceived to be a conflict of interest for both them. An appropriate person can be called on to take these cases.
Local networks	We recommend that all trusts consider developing a local network of ambassadors / champions, depending on local need, to help provide assurance that all workers have appropriate support and	NON COMPLIANT This recommendation has been discussed with the Executive Lead for Speak Up and, at present due to the number of cases and other priorities we have agreed not to take

	opportunities to speak up, and to give guardians alternative routes to pursue speaking up matters should they be faced with a real or perceived conflict. Members of a local network could also cover the guardian role when the guardian is absent, on leave etc.	this forward until 2018, when we will review the situation further. It is hoped to gain a better view of the usefulness of champions across both the local and national networks before any plans are put into place. **Action:** Further consideration of this prior to March 2018 and look at the potential of champions who could have a role across Speak Up, Diversity, Equality and Staff Engagement.
Diversity	We recommend that all trusts take action to ensure that all workers, irrespective of their ethnicity, age, sexuality or other diversity characteristics, have someone they feel able to go to for support in speaking up. Guardians should consult with relevant representative groups in developing their approach on this matter. Guardians should also take action to assure themselves that any potential barriers to speaking up that particular groups face are understood and tackled.	PARTIAL COMPLIANT With both Guardians having experience of protected characteristics they realise that there is work to do on this issue. **Actions:** Agreed to take an active part in the soon to be formed Diversity Group, be involved in the formation of the Diversity Strategy, liaise closely with the newly appointed Equalities Co-ordinator and co-ordinate with future Staff Engagement activities.
Communication and training	We recommend that all guardians use all appropriate communication channels to ensure that all staff know of their role, and work with colleagues to ensure that Freedom to Speak Up is incorporated in all relevant staff training and development programmes, and particularly in staff inductions. In conjunction with the relevant parts of their organisation, guardians should monitor the effectiveness of their communication and training activities. Guardians should ensure that the language and message of communications and training are consistent with national guidance.	PARTIALLY COMPLIANT • Intranet page updated • Press release included in Express and Star • Staff Leaflet • Managers Guide • Leaflet for PFI staff • Updated policy agreed • Further intranet publicity • Attend graduate nurse and new doctors induction • Introduction to general induction now emphasises 'Speak Up' rather than Whistleblowing • New posters produced and distributed. **Action:** To continue to publicise across the service across the Trust. Nov/Dec 17: Further reminder on front page of Hub/
Partnership	We recommend that all guardians continue to develop working partnerships with all relevant parts of their organisation.	PARTIALLY COMPLIANT. Working relationships occur with HR, union Reps, PFI/Interserve and senior/junior managers and clinical staff, **Action:** Continue to strengthen the above relationships and build closer working with medical staff
Access to senior leadership	We recommend that all guardians have direct and regular access to their chief executive and non-executive director with responsibility for speaking up.	COMPLIANT. Regular monthly meetings are scheduled and there is an agreement in place for the Guardians to speak with the CE any time and this is working satisfactorily
Board reporting	We recommend that guardians or a representative from a local network of champions / ambassadors personally presents regular reports to their board. Board reports should include measures of activity and impact and, where possible, include 'case studies' describing real examples of speaking up that guardians are handling.	COMPLIANT. Quarterly reports and attendance at the Board of Directors is established. The reports needed to include more details on impact. This has been commenced in Q2 report.

Feedback	We recommend that guardians always gather feedback on their performance, from their line managers, the partners they work with, and from those they are supporting.	COMPLIANT. Feedback is always requested from those raising concerns and both line manager and CE provide this. A questionnaire has been designed for those raising concerns.
Time	We strongly recommend that all trusts provide ring-fenced time for anyone appointed as a guardian / ambassador / champion to carry out their role and attend training, regional and national network meetings, and other events.	COMPLIANT. There are no time constraints with regards to the present workload and ability to attend outside events.

National/Regional Guardian activity

On the 19th October the NGO held its annual conference. One of the Trust's Guardians attended. Discussions with a variety of Guardians at other Trusts was useful in assessing where we at with the concept here at the Trust. While some Trusts seemed to be more advanced in the sense of having networks of champions in place these tended to be Trust's with diverse multiple sites while others had little infrastructure in place. The conference was useful in that Helene Donnelly OBE was attending (the nurse who raised concerns about Mid Stafford Hospital) and after contact agreed to speak at the Trust's nursing conference in November. The NGO has also published its Annual Report in October 2017. This has been place on the Raising Concerns Webpage. The front page has photographs of the two Guardians on it and photographs of Trust staff inside. Regional network meetings continue.

Reflections and future plans

Regular monthly meetings with the Chief Executive continue and a number of ad hoc meetings have taken place regarding the more complex cases to enable both Guardians to discuss concerns being raised and to provide support for the Guardians. With regards to PFI staff, specific leaflets have now been printed for distribution to all staff and as inductions are undertaken on an individual basis a meeting with all the managers is arranged for early December so that they understand the concept and can inform all new staff about the role.

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 7th December 2017

TITLE:	Report on Learning from Deaths		
AUTHOR:	J Hobbs Medical Director	**PRESENTER:**	Mr R Callender Deputy Medical Director
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		
CORPORATE OBJECTIVE: SO2: Safe and Caring Service SO3: Drive service improvements, innovation and transformation			
SUMMARY OF KEY ISSUES: Learning is the key issue when considering mortality in our Trust. As a caring organisation we must demonstrate how we review mortality, assure that we demonstrate how we learn by reviewing our care. We must be honest and open if we could have done better, and demonstrate that we learn by changing what we do when necessary.. This report demonstrates our commitment.			

IMPLICATIONS OF PAPER:			
RISK	**~~Y~~/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/~~N~~**	**Details:** Safe, Effective, Caring, Responsive, Well-led
	NHSI	**Y/N**	**Details:**
	Other	**Y/~~N~~**	**Details:** National Quality Board – National Guidance on Learning from Deaths (March 2017)

ACTION REQUIRED OF COMMITTEE :

Decision	**Approval**	**Discussion**	**Other**
	✓	✓	

RECOMMENDATIONS FOR THE COMMITTEE:
.Detail further assurance required

Mortality report

1. Purpose of the paper

To provide the information and assurance necessary to the board that mortality rates at Dudley hospital are within the acceptable range and that the hospital has implemented the recommendations contained in the learning from death document.

2. Background

The Trust has a well-established mortality review process and a sophisticated electronic tracker for handling reviews. This has been in place for 5½ years.

3. Current process

Currently the process is split into two phases with an initial directorate based review, and the positive output being reviewed by the Trust mortality assurance group with reporting to board.

The trust mortality group meets once or twice monthly to assess quality of care and avoidability of cases alerted by the tier one review process. In addition they consider SI's, coroners inquests and litigation. To provide additional assurance they now consider all elective deaths and a random sample of 10% of all deaths within the Trust. Currently this process takes place outside programmed SPA time. Moving forward from the 1st November the target time for reviews is 100% within 30 days within directorates and 14 days for second review. This target will remain difficult to achieve until the implementation of an integrated electronic patient record in April 2018.

Ten reviewers will be trained in structured judgement methodology, accepting the limitations of this, and using multiple reviewers to ensure reproducibility. Action plans based on themes will be developed and reported annually. They will be included in the long-term forward audit plan.

All avoidable mortality will be investigated as an SI and the duty of Candour policy followed. Timely review is essential to be a compassionate organization.

4. Data set

	Parameter	*Period*	*Numbers*
Mortality	Crude mortality	Nov 2016 to Oct 2017	1735 – 2.83% *
	SHIMI	Aug 2016 to Jul 2017	0.97
	HSMR	Sep 2016 to Aug 2017	100.4
Condition specific alerts at December	Secondary Malignancy	See 6 below	
Rule 28 notices	Neurosurgical care VTE	N/A	N/A
National audits	COPD	2014	HSMR 154. No. of deaths = 133
Highest 6 condition groups	Sepsis Secondary malignacy Cerebrovascular disease GI haemorrhage COPD Non-Hodgkin's Lymphoma	See 6 below	N/A
MPR level 1	Completion	Jul 2016 to Jun 2017[!]	98% (1700/1742)
MPR level 2	Completion	Jul 2016 to Jun 2017[!]	34% (20/59)

NOTE: *Deaths as % of all inpatient admissions (excl. Well babies, Obstetrics, Midwifery)
[!] Date range = date of death of patient, not audit or review.

5. Trust mortality is measured using the three standard and complimentary indices, crude mortality, HSMR (Hospital Standardized Mortality Rate), SHIMI (Standardized Hospital Mortality Index).

At the present time crude mortality sits at 1735 (2.83%) and this is against a backdrop of a rise nationally. It is influenced by many factors including the provision of social care, palliative care, primary care provision and the quality of secondary and tertiary care. As such it is a useful measure as to the need for palliative care, cardiac arrest and as a baseline against which avoidability can be measured. Using PRISM 2 methodology between 0.3 and 4% of mortality in hospital care is felt to meet the 50% threshold for avoidability.

SHIMI is a measure of overall care measured at 30 days and includes those discharged from hospital. There is some adjustment for comorbidities and risk stratification. Whilst coding may be a confounder, interpretation of SHMI should focus on trends and condition specific mortality alerts to provide assurance as to the effectiveness and safety of the service. Our current SHMI remains within the expected range and is below 100.

HSMR is another measure of the safety and effectiveness of hospital care but patients who have been discharged alive are not included. Potentially the provision of regional services and palliative and hospice care can significantly influence this measure.

Given the limitations of any one measure outcomes should be assessed on an appreciation of all three measures. Currently mortality is within the expected range.

6. Condition specific Alerts from HED: **(Last 2 months)**

Alert	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score
CUSUM	42-Secondary malignancies	1.51	3	37	3.17

- CUSUM Alert Month **July 2017**
- SHMI Alert Period **July 2016-June 2017**
- HSMR Alert Period **August 2016-July 2017**

Alert	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score
CUSUM	42-Secondary malignancies	1.51	3	45	3.65
HSMR	42-Secondary malignancies	25.87	46	677	177.84

- HSMR Alert Period **September 2016-August 2017**
- SHMI Alert Period **August 2016-July 2017**
- CUSUM Alert Month **August 2017**

You have **No alerts** in **SHMI** for the period mentioned above.

Note :*The HED CUSUM alert provides an indication of adverse changes in mortality rate.*

The recent CUSUM alert for Sepsis has dropped out because of a reduction, but remains in the table of highest causes of death. Secondary malignancies has alerts in different parameters (CUSUM, SHMI, HSMR). They are of note as they are a significant driver to our overall mortality position and are top in our “Highest Condition Groups” below.

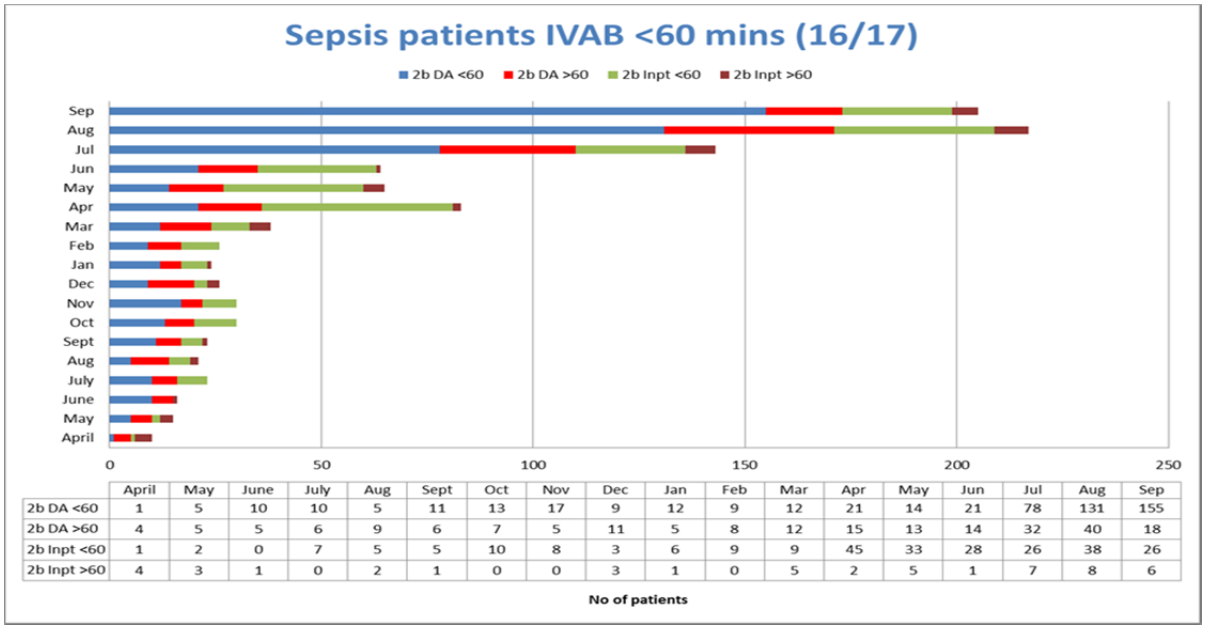
7. Six Highest condition groups. (Source HED)

Diagnostic Group (CCS)	No. of discharges	Expected	Observed	HSMR	Crude mortality rate	Obs. - Exp.
Septicemia (except in labor)	693	123.88	158	127.54	22.80%	34
Secondary malignancies	677	25.87	46	177.84	6.79%	20
Acute cerebrovascular disease	657	112.56	127	112.83	19.33%	14
Gastrointestinal hemorrhage	790	27.67	37	133.74	4.68%	9
Chronic obstructive pulmonary disease and bronchiectasis	1354	56.6	65	114.84	4.80%	8
Non-Hodgkin`s lymphoma	178	7.82	14	179	7.87%	6

8. Learning and actions:

8.1 Sepsis:

Work has continued since the first sepsis alert in 2015 and the formation then of a Sepsis Group. We now have a sepsis team led by the Trust Sepsis Nurse Practitioner, part of the deteriorating patient group. Detailed audits are reported monthly via Quality and Safety. An illustration of the continuous improvement in treatment is below (IVAB = Intravenous antibiotics):



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2b DA <60	1	5	10	10	5	11	13	17	9	12	9	12	21	14	21	78	131	155
2b DA >60	4	5	5	6	9	6	7	5	11	5	8	12	15	13	14	32	40	18
2b Inpt <60	1	2	0	7	5	5	10	8	3	6	9	9	45	33	28	26	38	26
2b Inpt >60	4	3	1	0	2	1	0	0	3	1	0	5	2	5	1	7	8	6

8.2 COPD review:

The National secondary care audit from 2014 indicated that Russells Hall Hospital had increased inpatient mortality and readmissions.

The respiratory department has considered the results and reviewed practice though it must be noted that both SHMI and HSMR were both lower for that year (HSMR 92.12(58/62.96) (observed/expected) and SHMI 0.8(54/67.13)). We have concluded that the results represent case mix variation rather than any worrying trend.

Furthermore the respiratory department has actively engaged in a more detailed national COPD audit for 2017 onwards with the submission of over 250 cases to date. This will provide further evidence of current practice but will also provide more detailed information on care provided for respiratory patients.

8.3 Secondary malignancies:

The numbers here are small and a re-look at the case notes is planned.

9. OtherThematic Learning:

9.1 Concerns had arisen about the care pathway of patients with **fractured neck of femur**. The department's action plan was agreed at the Mortality Surveillance Group and the following report was received at the CQSPE this month:

Following the National Hip Fracture Database 2015 report where the Trust's case mix adjusted mortality was identified at 10.4%, this has now significantly dropped to 5.4% (in line with the national average) for 2017.

This reduction is credited to extensive work undertaken within the department including: an anaesthetic review of all mortalities, the introduction of 15min spinal rule and 20min surgical rule and a re-focus on admission to theatre time.

9.2 Concerns had arisen about **possible delays** in reviewing surgical admissions as the emergency surgical SpR is often in operating theatre for prolonged periods.

Action: Having reviewed the situation, the department now rosters another SpR to deal with emergency assessments.

9.3 Though the matter of **patient's ward location** had been flagged as a matter of concern by the level 1 review team on several occasions, there was hardly ever evidence of poor care at the level 2 review. However, there is clearly a concern in general terms that the outlying policy may not always work smoothly.

Action: The Chief of Medicine is aware and engaged with making sure that medical staff are up to date with patient location. The introduction of the "Nervecentre" call system for junior doctors out of hours has also mitigated any potential problem arising from patients location.

9.4 There were general concerns about defining quality of end-of-life care. This is more about decisions around level of interventional care rather than the quality of care.

Action: This has been discussed at the Mortality Surveillance Group and the palliative care team has contributed to modification of the level 1 audit questionnaire. From Q3 this year the questions about care are more detailed and reports will be available to direct training and support. The palliative care team will also discuss results of their ward audits at the MSG with the aim of enabling directed feedback.

10. Rule 28 notices.

10.1 Neurosurgical care

This is provided by UHB. There are a number of delays in transfers identified via Datix. The chief of medicine has written formally to the medical director at UHB. Audit data confirms significant delays at the tertiary centre regarding actioning referrals.

Actions

1. Daily update on patients awaiting transfer
2. Explore alternative referral streams
3. Clarify SLA with UHB.

10.2 Venous Thromboembolism

The Trust need to implement the NICE guidance around VTE and meet the targets around this. Not all cases of hospital associated thromboembolism are preventable. Nationally those sites which are compliant have a forced choice implemented via an electronic solution.

Actions

1. EPR algorithm to be implemented: 2018 April.
2. Reconfigure thrombosis groups.

11. Mortality Peer review

The trust has adopted the NHSI dashboard for reporting Peer review and will adopted a structured review methodology in line with the RCP process. (appendix 1)

Avoidable mortality whilst important to understand process failure possibly does not represent the main area of gain from quality improvement. To understand this the areas of highest where interventional bundles and process to rescue deteriorating patients have potentially the biggest impact.

To this end we are reviewing the sepsis and COPD pathway and the Executive has approved a business case to manage NIV on Medical HDU.

12. Deaths of patients with learning difficulties:

The Patient Administration System now flags patients who are known to have LD. As well as the standard process for review, the LD nurse is notified and will review the case under the Learning Disabilities Death Review Programme (LeDeR). Going forward, these cases will all be subject to the Trust level 2 review as well.

13. Avoidable deaths assessments from Q1

7 (1.6%) assessed RCP 5 (slight evidence of avoidability)

1 (0.24%) assessed RCP 4 (possibly avoidable but not very likely) – RCA attached to tracker

1 (0.24%) assessed RCP 3 (probably avoidable more than 50:50) – following RCA action has been taken to appoint an extra surgical registrar for the emergency rota

14. Summary

The trust process is compliant with the “Learning from deaths” guidance.

New targets around completion, timeliness of and scope of review will make the output more useful and allow the compassionate exercise of our duty of Candour.

Subsequent reports will include the action plan to support quality improvement work and improved outcomes.

NHS Anytown Foundation Trust: Learning from Deaths Dashboard - September 2017-18

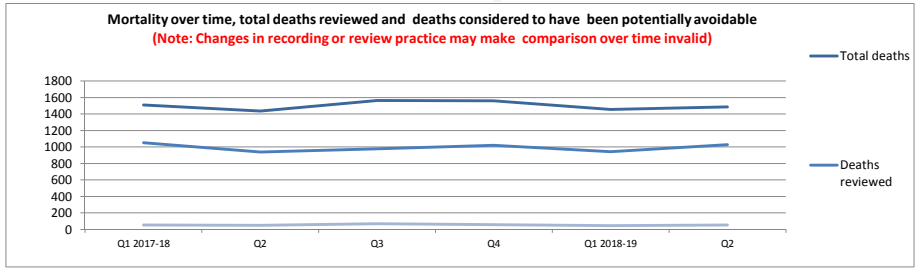
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
454	523	339	298	14	20
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1436	1509	939	1053	50	54
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
6069	0	3991	0	227	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

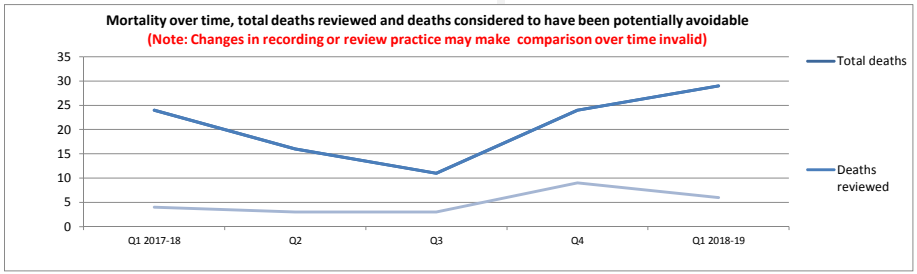
Score 1			Score 2			Score 3			Score 4			Score 5			Score 6		
Definitely avoidable			Strong evidence of avoidability			Probably avoidable (more than 50:50)			Probably avoidable but not very likely			Slight evidence of avoidability			Definitely not avoidable		
This Month	0	0.0%	This Month	4	1.2%	This Month	10	2.9%	This Month	33	9.7%	This Month	65	19.2%	This Month	227	67.0%
This Quarter (QTD)	5	0.5%	This Quarter (QTD)	14	1.5%	This Quarter (QTD)	31	3.3%	This Quarter (QTD)	90	9.6%	This Quarter (QTD)	178	19.0%	This Quarter (QTD)	621	66.1%
This Year (YTD)	30	0.8%	This Year (YTD)	65	1.6%	This Year (YTD)	132	3.3%	This Year (YTD)	378	9.5%	This Year (YTD)	754	18.9%	This Year (YTD)	2632	65.9%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
10	2	10	2	2	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
16	24	16	24	3	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
75	0	75	0	19	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



The Dudley Group NHS Foundation Trust: Learning from Deaths Dashboard - September 2017-18

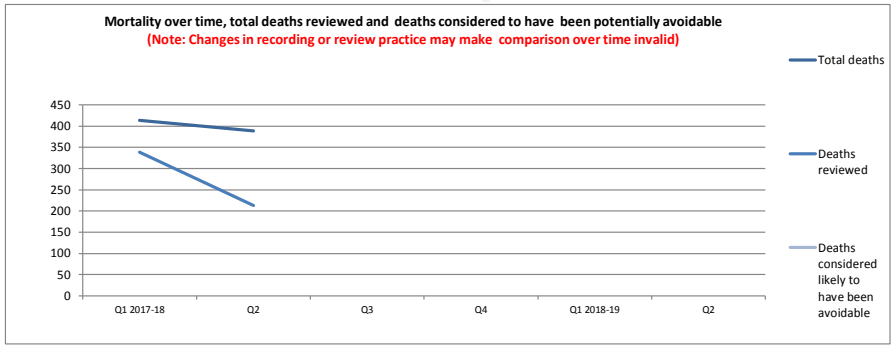
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
139	134	59	76	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
389	413	213	338	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
802	0	551	0	1	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



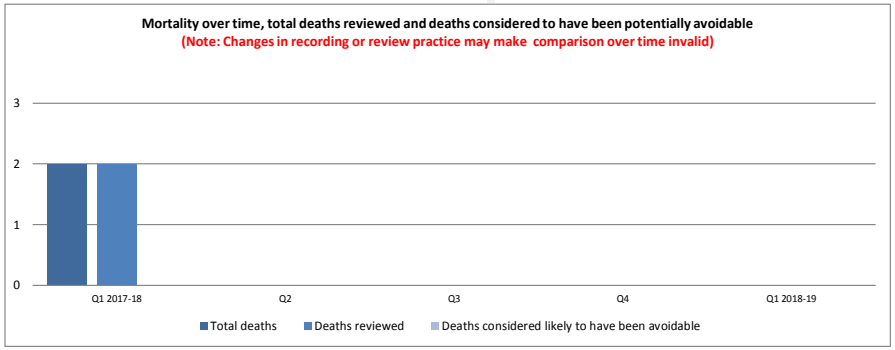
Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	1.7%	This Month	58	98.3%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	0.9%	This Quarter (QTD)	211	99.1%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.2%	This Year (YTD)	1	0.2%	This Year (YTD)	4	0.7%	This Year (YTD)	545	98.9%

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	2	0	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	0	2	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



The Dudley Group NHS Foundation Trust: Learning from Deaths Dashboard - September 2017-18

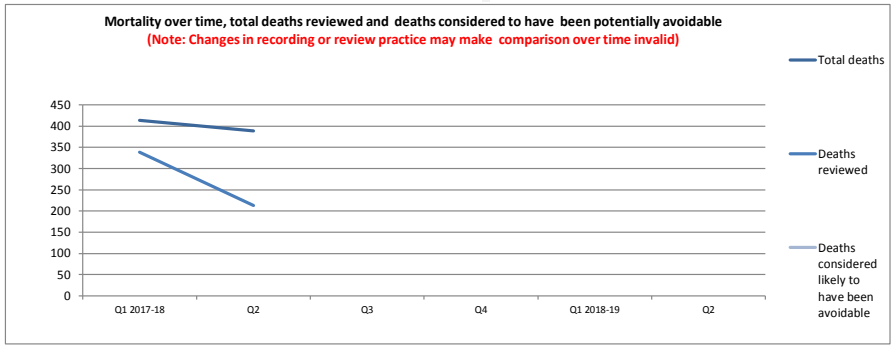
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
139	134	59	76	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
389	413	213	338	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
802	0	551	0	1	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q2



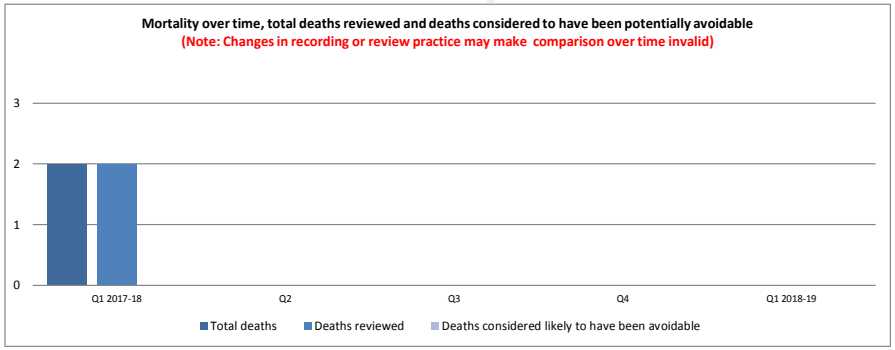
Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	1.7%	This Month	58	98.3%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	0.9%	This Quarter (QTD)	211	99.1%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.2%	This Year (YTD)	1	0.2%	This Year (YTD)	4	0.7%	This Year (YTD)	545	98.9%

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	2	0	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
2	0	2	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 7 December 2017

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	J Fellows Non-Executive Director
CLINICAL STRATEGIC AIMS: Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way			
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 30 November 2017.			

RISKS	**Risk Register**	**Risk Score Y**	**Details:** Risk to achievement of the overall financial target for the year
COMPLIANCE	**CQC**	**Y**	**Details:** CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.
	NHSLA	**N**	
	NHSI	**Y**	**Details:** Achievement of all Terms of Authorisation
	Other	**Y**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**30 November 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- The current status of the Black Country Back Office proposal was discussed and it was agreed that further work be undertaken on the start point position for each Trust; to ensure there was no loss of local control arising from the arrangements;
- The current arrangements for nurse staffing recruitment were explained and the proposed impact on agency costs for the rest of the year. A detailed discussion was undertaken on nurse establishment levels, vacancies, the revised establishments and the consequent use of agency
- Proposals to reduce medical agency costs were discussed and it was agreed that target reductions would be monitored in 2017-18
- The current financial position of the Trust as at October 2017 was discussed in detail and the steps being taken to take remedial action to ensure it doesn't get worse than originally forecast at Month 6. The underlying reasons for the financial issues were discussed in detail and the timing of the impending discussions with NHS Improvement
- The current performance against NHS Constitution standards was discussed and remedial steps being taken for performance against the A&E 4 hour standard; Cancer 62 day standard (although the position here is recovering);and Diagnostics
- The current position of deficiency points on the PFI contract was discussed together with recent meetings with members of the Summitt board about performance on the estate management

- That the back office proposal could proceed to the next stage of designing a collaborative arrangement between Trusts before any formal combined arrangement is created, and to report back on progress
- Directors to find a way to make a financially viable financial position in 2018-19 by looking differently at how services are provided within the income available to the Trust, which should involve improved discharge arrangements and fewer beds

Actions to come back to Committee

- An further outline budget plan for 2018-19
- Next steps for shared back office functions

Performance Issues to be referred into Executive Performance Management Process

- None

Areas of Risk to be escalated onto the Corporate or Divisional Risk Register

- The position on the Cancer 62 day target to be raised from the Divisional to the Corporate Risk Register

Items referred to the Board for decision or action

- The current forecast financial position for 2017-18 and the risks to it being

contained to within a £5m deficit

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th December 2017

TITLE:	Integrated Performance Report for Month 7 (October) 2017/18		
AUTHOR:	Andy Troth Head of Informatics	**PRESENTER:**	Michael Woods Interim Chief Operating Officer

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

A&E target

October performance was 90.06% which has improved from that in September (87.73%).
Activity for October is up on September with 9156 attendances (8563 September) of which 3419 were conveyed by Ambulance (3094 September). Ambulance handover delays over 60 minutes reduced to 15 (29 September)
For context: 15 out of 137 Trusts exceeded 95%. Our performance was 63rd out of 137 Trusts.

The 5 key priorities for focus continue, however additional operational changes have been effected. They include:

- Quadrupled size of Ambulance triage area
- Moved EAU area and working on single model of Acute medicine
- Red2Green process
- Appointment of project manager dedicated to ED redesign project

Despite some of the changes above it is clear that there is still significant work to be undertaken regarding grip, control and culture.

Cancer (provisional)

The provisional performance figure as at 30th November suggests delivery of the 2ww & 62 day targets for October:

- Cancer 62 day wait is 91%
- 2WW is 94.8%

The Weekly Cancer Performance meeting continues to meet and a Cancer Sustainability Plan has been formulated that reviews our processes and delivery systems against the best practice guidance. A comparison of performance by tumour site is included in the backing pages of the report.

Referral to Treatment (18 week)

The incomplete pathway was achieved in month with a performance of 93.76% against a target of 92%, although performance in two specialities fell below the expected.

Urology(91.57%) – slightly up from last month
Ophthalmology (82.41%) – down from last month

The non-admitted measure of 95% was not achieved based on a provisional figure of 93.07%. The admitted measure was below its target of 90% at a provisional figure of 88.53%.

DM01 Diagnostic Performance
Despite improving on the September position, the performance for October was not achieved with a performance of 98.56% against a national target of 99%.

The internal improvement trajectory has not been achieved in month (original trajectory was 98.4%). Two main areas of breach relate to specialist capacity in:

- Paediatric GA MRI
- Muscular-skeletal USS

The division has produced a recovery plan and anticipate meeting the target in November

Clostridium Difficile & MRSA
Total No. of C. Diff cases identified after 48hrs for the month was 1. (17ytd.)
There were 0 post 48 hour MRSA cases reported in month.

Mixed sex accommodation
There were 4 MSA breaches in month relating to MHDU and capacity to move patients out.

Never Events
There were 0 never events recorded in month.

VTE Assessment On Admission: Indicator
The indicator achieved the target in month with provisional performance at 95.35% against a target of 95%. This is an increase on the previous month's performance of 94.37%.

Finance
The month 07 financial position was below the original plan by £2.278m due to shortfalls on income (largely resulting from impact of month 1-6 re-phasing), pay (highest spend/WTE to date) and non-pay. Agency costs have now exceeded the annual cap of £5.772m. The cumulative adverse variance equates to £2.246m.
Consolidation of Dudley Clinical Services Ltd and technical changes relating to donated assets amend the adverse variance to £2.256m. The October performance was £0.515m worse than forecast. This, coupled with the greater risk on CQUIN, has fully negated the impact of the recovery plan schemes.
As such the mitigated forecast is now estimated to be a deficit of £5m (£7.5m in excess of the control total). The likely loss of STF linked to this financial forecast and the quarter two A&E performance shortfall equates to £6.088m.

Workforce
Appraisals:
The month has seen the position improve in the percentage of appraisals undertaken, from 84.07% to 87.2%. Clinical Support Division is red at 76.26% (below 80%), but up from previous month of 67.86%. Corporate/Management, Surgery and Medicine and Integrated Care are amber at 88.89%, 89.98% and 87.17% respectively (>80% <90%).
Performance meetings have been undertaken with the divisions and expectations are that 90% will be achieved by all for October 2017.
Mandatory Training:
Mandatory Training has fallen slightly from 86.04% to 85.9% in month. The Director of HR is working with respective Divisions based on the feedback from a series of forums that were held to identify issues within the mandatory training system. The Chief Executive has signalled that for the year of 2017/18 that the Trust's targets need to be met. Performance meetings have been undertaken with the divisions and expectations are that 90% will be achieved by all for October 2017.
Sickness:
Sickness rate overall has worsened slightly from 4.26% in the previous month to 4.16% in month. Medicine & Integrated Care are red with 4.91%, Surgery Division red at 4.31%. Clinical Support amber at 3.96% and Corporate / Mgt. green at 2.65%.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** High levels of activity could impact on the delivery of KPIs – particularly the emergency access target and RTT. The latter would be impacted by increased levels of outliers resulting in cancelled operations**.**
	Risk Register: Y		**Risk Score:** 20 (COR079)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:** A sustained reduction in performance could result in the Trust being found in breach of licence.
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
		X	

RECOMMENDATIONS FOR THE BOARD:

To note the performance against the national mandated performance targets and where there has been non achievement to seek assurance on the plans to recover the expected position.

Performance - Key Performance Indicators

	Target	Oct-17	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)					
All Cancer 2 week waits	93%	94.7%	94.6%	↑	
2 week wait - Breast Symptomatic	93%	99.3%	98.3%	↑	
31 day diagnostic to 1st treatment	96%	99.3%	98.6%	↓	
31 day subsequent treatment - Surgery	94%	100.0%	98.8%	↔	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	90.7%	84.1%	↓	
62 day screening programme	90%	100.0%	97.4%	↔	
62 day consultant upgrades	85%	98.9%	93.8%	↑	
Referral to Treatment					
RTT Incomplete Pathways - % still waiting	92%	93.8%	94.3%	↓	
RTT Admitted - % treatment within 18 weeks	90%	88.5%	88.8%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	93.1%	93.2%	↑	
Wait from referral to 1st OPD	26	28	203	↓	
Wait from Add to Waiting List to Removal	39	42	293	↑	
ASI List		2475	0	↑	
% Missing Outcomes RTT		0.0%	0.2%	↓	
% Missing Outcomes Non-RTT		5.6%	3.6%	↓	
DM01					
No. of diagnostic tests waiting over 6 weeks	0	87	1455	↓	
% of diagnostic tests waiting less than 6 weeks	99%	98.6%	97.0%	↑	
ED - TRUST					
Patients treated < 4 hours Type 1 (Trust ED)	95%	84.9%	84.5%	↑	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	90.1%	90.3%	↑	
Emergency Department Attendances	N/A	9156	61416	↑	
12 Hours Trolley Waits	0	0	0	↔	
Ambulance to ED Handover Time - TRUST					
30-59 minute breaches		228	1753	↓	
60+ minute breaches		11	236	↓	
Cancelled Operations - TRUST					
% Cancelled Operations	1.0%	1.8%	1.2%	↑	
Cancelled operations - breaches of 28 day rule	0	1	7	↔	
Urgent operations - cancelled twice	0	0	0	↔	

Performance - Key Performance Indicators cont.

	Target	Oct-17	Actual YTD	Trend	Month Status
GP Discharge Letters					
GP Discharge Letters	90%	82.0%	78.1%	↑	
Theatre Utilisation - TRUST					
Theatre Utilisation - Day Case (RHH & Corbett)		76.0%	76.7%	↓	
Theatre Utilisation - Main		86.2%	86.3%	↑	
Theatre Utilisation - Trauma		86.4%	90.8%	↓	
GP Referrals (1 month in arrears)					
GP Written Referrals - made		6109	39152	↓	
GP Written Referrals - seen		5318	32304	↓	
Other Referrals - Made		2537	16082	↓	
Throughput					
Patients Discharged with a LoS >= 7 Days		6%	6%		
Patients Discharged with a LoS >= 14 Days		3%	3%		
7 Day Readmissions		3%	3%		
30 Day Readmissions - PbR		7%	7%		
Bed Occupancy - %		91%	90%		
Bed Occupancy - % Medicine & IC		96%	94%		
Bed Occupancy - % Surgery, W&C		89%	88%		
Bed Occupancy - Paediatric %		53%	56%		
Bed Occupancy - Orthopaedic Elective %		79%	80%		
Bed Occupancy - Trauma and Hip # %		91%	94%		
Number of Patient Moves between 8pm and 8am		87	648		
Discharged by Midday		16%	16%		
DNA Rates					
New outpatient appointment DNA rate	8%	6.8%	7.5%	↓	
Follow-up outpatient appointment DNA rate	8%	7.9%	8.0%	↓	
Total outpatient appointment DNA rate	8%	7.5%	8.5%	↓	
Average Length of stay (Quality Strategy Goal 3)					
Average Length of Stay - Elective	0.0	2.3	2.6	↓	
Average Length of Stay - Non-Elective	3.4	3.0	3.3	↓	

Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	581	522	-10.2%	-59	3,883	3,468	-10.7%	-415
Day Cases	4,186	4,535	8.3%	349	27,971	29,160	4.3%	1,189
Non-elective inpatients	5,238	5,087	-2.9%	-151	36,153	35,180	-2.7%	-973
Outpatients	39,903	41,474	3.9%	1,571	266,623	257,361	-3.5%	-9,262
A&E	8,610	9,156	6.3%	546	59,683	61,416	2.9%	1,733
Total activity	**58,518**	**60,774**	**3.9%**	**2,256**	**394,313**	**386,585**	**-2.0%**	**-7,728**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	131	96	-26.9%	-35	700	632	-9.7%	-68
Pay	770	-34	-104.4%	-804	3,201	2,870	-10.3%	-331
Non-Pay	294	280	-4.7%	-14	1,913	2,472	29.2%	559
Total CIP	**1,195**	**342**	**-71.4%**	**-853**	**5,815**	**5,975**	**2.8%**	**160**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	28,152	27,791	-1.3%	-361	191,447	189,415	-1.1%	-2,033
Other Clinical	130	92	-29.4%	-38	909	712	-21.7%	-197
STF Funding	857	857	0.0%	0	3,858	3,858	0.0%	0
Other	1,857	1,281	-31.0%	-576	12,949	15,813	22.1%	2,864
Total income	**30,997**	**30,021**	**-3.1%**	**-976**	**209,164**	**209,798**	**0.3%**	**635**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-17,178	-18,080	5.3%	-903	-120,410	-123,221	2.3%	-2,811
Drugs	-633	-713	12.6%	-80	-4,195	-4,597	9.6%	-402
Non-Pay	-6,257	-7,102	13.5%	-845	-47,077	-47,799	1.5%	-722
Pass-through	**-2,640**	**-2,667**	**1.0%**	**-27**	**-17,646**	**-17,455**	**-1.1%**	**191**
Total Costs	**-26,708**	**-28,562**	**6.9%**	**-1,854**	**-189,328**	**-193,072**	**2.0%**	**-3,744**

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
EBITDA	**3,882**	**959**	**-75.3%**	**-2,923**	**19,385**	**16333**	**-15.7%**	**-3,052**
Depreciation	-784	-743	-5.2%	41	-5,445	-5208	-4.4%	237
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,123	-1,014	-9.7%	109	-7,856	-7762	-1.2%	94
SURPLUS/(DEFICIT)	**1,975**	**-798**	**-140.4%**	**-2,773**	**6,084**	**3363**	**-44.7%**	**-2,721**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	1,491	800	-46.3%	0	10,671	7703	-27.8%	-2,968
Inventory					2,840	2984	5.1%	144
Receivables & Prepayments					20,870	24934	19.5%	4,064
Payables					-16,193	-19672	21.5%	-3,479
Accruals							n/a	0
Deferred Income					-4,656	-3467	-25.5%	1,189
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					15,343	18,192	18.6%	0
Loan Funding							n/a	0
KPIs								
EBITDA %	12.50%	3.10%	-9.4%		9.30%	7.80%	-1.5%	
Deficit %	6.40%	-2.60%	-9%		2.90%	1.60%	-1.3%	
Receivable Days					0.0	0.0	n/a	
Payable (excluding accruals) Days					0.0	0.0	n/a	
Payable (including accruals) Days					0.0	0.0	n/a	
Use of Resource metric					1	3		

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Oct-17	Actual YTD	Trend	Month Status
Friends & Family Test - Footfall						
Friends & Family Test - ED	14.5%	21.3%	28.6%	18.0%	↑	
Friends & Family Test - Inpatients	26.0%	35.1%	34.0%	31.6%	↑	
Friends & Family Test - Maternity	21.7%	34.4%	34.8%	43.1%	↓	
Friends & Family Test - Outpatients	4.7%	14.5%	10.9%	3.9%	↑	
Friends & Family Test - Community	3.5%	9.1%	4.9%	2.6%	↑	
Friends & Family Test - Recommended						
Friends & Family Test - ED	89.9%	93.4%	83.7%	77.8%	↑	
Friends & Family Test - Inpatients	96.3%	97.4%	95.2%	96.1%	↓	
Friends & Family Test - Maternity	96.0%	98.1%	98.6%	97.7%	↑	
Friends & Family Test - Outpatients	94.6%	97.2%	90.8%	92.5%	↓	
Friends & Family Test - Community	96.4%	97.7%	95.2%	96.8%	↓	
Complaints						
Total no. of complaints		N/A	37	218	↑	
Complaints closed within target	90%	90%	100.0%	94.5%	↔	
Complaints re-opened			0	1	↔	
PALs Numbers			269	0	↑	
Ombudsman						
Dementia (1 month in arrears)						
Find/Assess		90%	97.3%	97.4%	↑	
Investigate		90%	100.0%	100.0%	↔	
Refer		90%	94.4%	97.0%	↓	
Falls						
No. of Falls		0	77	579	↑	
No. of Multiple Falls		N/A	6	65	↓	
Falls resulting in moderate harm or above	0	0.19	1	9	↔	
Falls per 1000 bed days	3	6.63	4.53	4.75	↑	
Pressure Ulcers (Grades 3 & 4)						
Hospital Avoidable		0	0	12	↓	
Hospital Non-avoidable		0	1	7	↓	
Community Avoidable		0	0	32	↓	
Community Non-avoidable		0	8	43	↓	
Mixed Sex Accommodation Breaches						
Single Sex Breaches		0	4	20	↓	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Oct-17	Actual YTD	Trend	Month Status
Mortality (Quality Strategy Goal 3)						
HSMR Rolling 12 months (**Latest data August 17**)	110	105	100.41	N/A		
SHMI Rolling 12 months (**Latest data June 17**)	1.10	1.05	0.99	N/A		
HSMR Year to date (**Latest data August 17**)			101	N/A		
Infections						
Cumulative C-Diff due to lapses in care		15	14	N/A		
MRSA Bacteraemia		0	0	0	↔	
MSSA Bacteraemia		0	0	5	↔	
E. Coli - Total hospital		0	1	24	↔	
Stroke Admissions - PROVISIONAL						
Stroke Admissions: Swallowing Screen		75%	86.8%	80.2%	↓	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	100.0%	94.7%	↑	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	90.9%	93.5%	↓	
VTE - PROVISIONAL						
VTE On Admission		95%	95.4%	93.8%	↑	
Incidents						
Total Incidents			1407	4486	↓	
Recorded Medication Incidents			499	2275	↑	
Never Events			0	1	↔	
Serious Incidents			7	94	↓	
of which, pressure ulcers			2	65	↓	
Incident Grading by Degree of Harm						
Death			1	3	↔	
Severe			0	9	↓	
Moderate			10	59	↑	
Low			280	1381	↑	
No Harm			988	8214	↓	
Percentage of incidents causing harm		28%	22.8%	15.0%	↑	
NQA Think Glucose						
NQA Think Glucose - EAU/SAU	85%	95%	80%	71%		
NQA Think Glucose - General Wards	85%	95%	97%	92%		

People

	Target 17/18	Target YTD	Oct-17	Actual YTD	Trend	Month Status
Workforce						
Sickness Absence Rate	3.75%	3.75%	4.25%	3.96%	↑	
Staff Turnover (1 month in arrears)	0%	0%	9.2%	9.1%	↔	
Mandatory Training	90.0%	90.0%	85.9%	85.2%	↑	
Appraisal Rates - Total	90.0%	90.0%	87.2%	83.9%	↑	

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board
on 7th December 2017

TITLE:	Transformation and Cost Improvement Programme (CIP) Summary Report		
AUTHOR:	Lisa Peaty, Deputy Director: Strategy & Performance	**PRESENTER**	Lisa Peaty, Deputy Director: Strategy & Performance

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

SUMMARY OF KEY ISSUES:

The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18.

To support this, the Trust has identified 58 schemes currently on the work programme which contribute to the £12.5m identified. 3% of the CIP has currently been identified as non recurrent savings.

Based on the Month 7 position, the Trust has achieved *c.* £6m against the year to date (YTD) plan of £5.8m. However, the full year effect variance is forecast by to under-deliver by £2.3m (i.e. delivery of £10.3m). .

Transformation Executive Committee (TEC) met on 16th November to discuss:

- Review overall CIP delivery status and progress for 2017/18 to date.
- Review risks to delivery and agree mitigation plans.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: (*Please select from the list on the reverse of sheet)***
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

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

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR TRUST BOARD:
Note delivery of CIP to date and the end of year forecast.

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

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation	
SO4: Be the place people choose to work	
SO5: Make the best use of what we have	
SO6: Deliver a viable future	
CARE QUALITY COMMISSION CQC) : *(Please select for inclusion on front sheet)*	
Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and treat people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

The Dudley Group NHS
NHS Foundation Trust

TRUST BOARD

Cost Improvement Programme

Summary Report: Month Seven (October 2017)

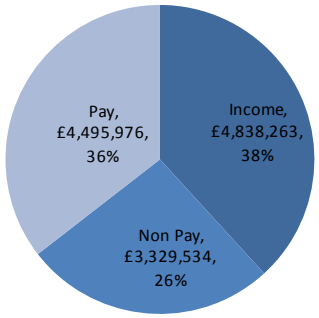
Date of Trust Board: 5th December 2017

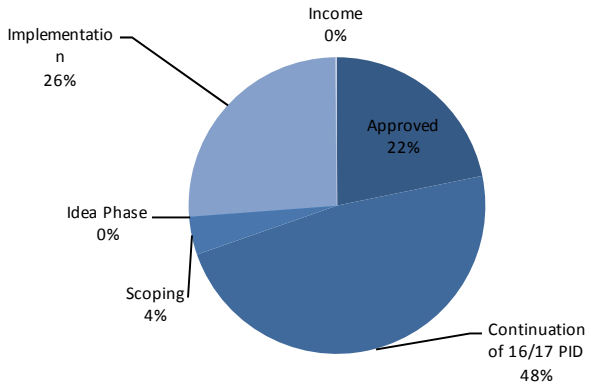
Executive Summary – 2017/18

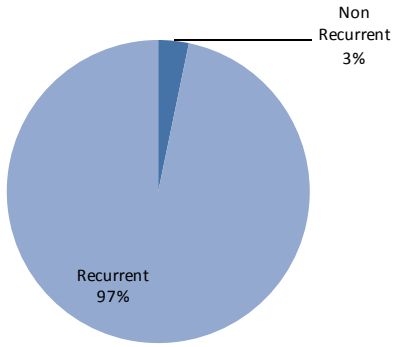
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this, there are 58 schemes on the work programme which contribute to the £12.5m identified, and 3% of of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 7 is provided below (with supporting detail overleaf):

CIP Project Plans	Full Year (FY)			YTD Performance Against Identified Plans			Y/E Forecast of Identified Plans	
	FY Target	FY Identified	Variance Against FY Target	YTD Pan	YTD Actual	YTD Variance	FYE Forecast	FYE Variance
Total	£12,500,000	£12,633,758	£ 133,758	£ 5,801,167	£ 5,946,551	£ 145,384	£10,342,020	-£ 2,291,738







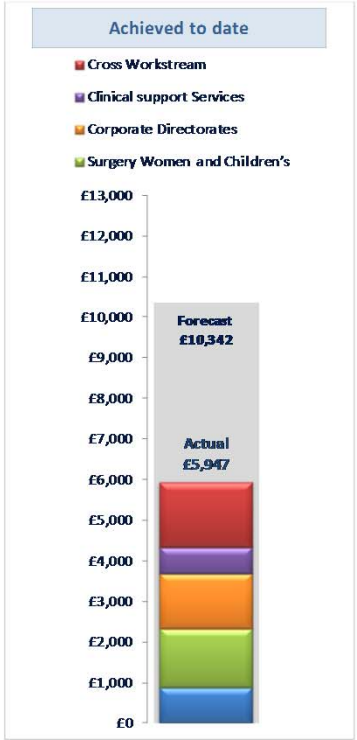
Based on the Month 7 position, the Trust has identified schemes totalling £12.6m against a Full Year (FY) target of £12.5m. As at Month 7 the Trust is forecasting to deliver £10.3m.

For the 17/18 programme of work, 33 Quality Impact Assessments (QIAs) have now been approved by the panel, and 39 QIAs have been deemed not applicable. QIAs for pipeline schemes continue to be worked up.

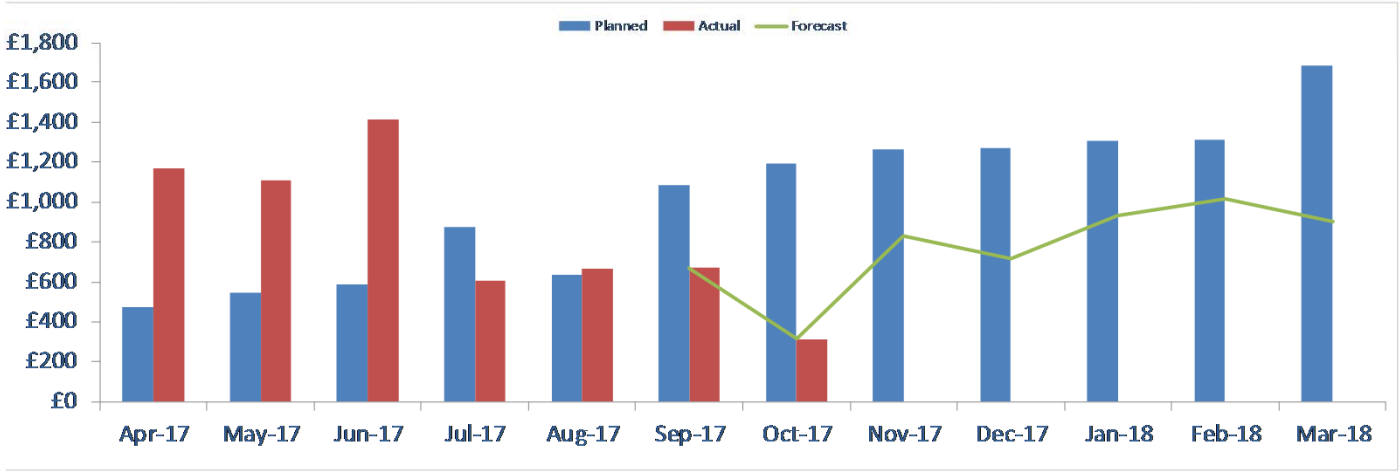
Executive Summary – 2017/18

	YTD	FYE			Submitted Plan
Planned	£5,801,167			Identified	£12,633,758
Actual	£5,946,551			Target	£12,500,000
Forecast		£10,342,020			
Variance	£145,384	-£2,291,738			£133,758

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£1,885,697	£1,455,241	-£430,456	£3,232,624	£2,765,683	-£466,941
Medicine and Integrated Care	£756,245	£881,227	£124,982	£1,457,627	£1,477,514	£19,887
Clinical support Services	£549,783	£659,414	£109,631	£998,746	£1,231,193	£232,447
Corporate Directorates	£1,092,787	£1,356,155	£263,368	£2,023,556	£2,207,441	£183,886
Cross Workstream	£1,516,655	£1,594,514	£77,859	£4,921,205	£2,660,188	-£2,261,017
View all Projects	£5,801,167	£5,946,551	£145,384	£12,633,758	£10,342,020	-£2,291,738



2017/18 Forecast Non Recurrent	£410,041
% of Total CIP Forecast as Non Recurrent	3%



Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board on 7 Dec 2017

TITLE:	**Research & Development 6- monthly Report**		
AUTHOR:	**Claire Phillips, R&D Manager;**	**PRESENTER**	**Jeff Neilson, Director of R&D**

CLINICAL STRATEGIC AIMS

Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE: SO1 through to SO6 (research seeks to improve all aspects of patient care)

SUMMARY OF KEY ISSUES:

- Research Nurse coverage of studies
- NIHR study portfolio balance
- Support Department Capacity Issues
- Research Data Archiving

IMPLICATIONS OF PAPER:

RISK	**Y**		• **Risk Description:** • Identification of suitable archiving space • Finding funding for research data archiving when income is diminishing
	Risk Register: Y		**Risk Score:** 16
	Risk Register: N		**Risk Descriptions**: • Lack of clinical support department capacity is affecting our ability to take on new research.
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, effective, caring, responsive, well led
	NHSI	**Y**	**Details:** R&D activity included in the Annual Report
	Other	**Y**	**Details:** Recruitment activity is monitored by CRN:WM, NIHR, DH

ACTION REQUIRED OF BOARD :

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD

The Board is requested to note the key issues arising and identify any further actions required.

Research & Development Report

Strategic Direction
Please refer to draft R&D Strategy 2017-2020 – presented by Dr Jeff Neilson.

Accolades for the Research & Development Department
The Department continues to add to the collection of awards. The Clinical Research Network West Midlands awards held October 2017 resulted in the Biomedical Scientist team, headed by Jackie Smith, collecting 'Support Services Winner' award for the second year running. We were also 'Highly Commended' for the Business Intelligence Leader' award, for up to date and complete data to support the monitoring of the CRN HLO performance, innovative solutions in EDGE database and sharing of best practice.

National developments and performance management

High level objectives
Performance targets relating to patient recruitment (currently 99% pro rata target) and activity based funding (currently 76% pro rata target) have been steadily increasing from around May/June 2017 time. We are currently around 65-70% performance for HLO 'recruitment to time and target' and 'time taken to confirm site' (70 days of receiving an initial Health Research Authority assessment letter and full set of documents from the Sponsor). Capacity issues and financial constraints affecting study initiation and ability to recruit to time and target. New processes are being implemented to try and improve on this figure

Capacity for research support departments
Capacity within Radiology is still an ongoing issue, however we have managed to negotiate with radiology to agree to take on 1-2 studies that require CT or MRI scans that are additional to the DGH clinical pathway within Orthopaedics. Continue to monitor. Procurement approvals can delay some studies opening due to approval of research equipment. To be monitored.

Finance and Staffing
The Trust has been successful with four short-term strategic funding bids (until end March 2018. One bid is for a WTE ITU nurse/s to work on DGH's expanding Anaesthetics portfolio studies, to assist with patient recruitment. The second to support Pharmacy Technician to cover maternity leave, and 0.7 WTE admin posts split between teams to assist with general study/finance administration duties.
We have assessed research nurse and data manager capacity, and now all staff are working across specialties to maintain patient recruitment and data collection. Research nurse is currently further exacerbated by 2 x long term sickness and retirement (end March 2018) by experienced team members who cover a number of specialties.

Electronic Patient Record/IT/Archiving
R&D is represented at the EPR meetings to highlight any R&D issues and to address ways of how EPR can enable research.
Acquiring external secure space for long term clinical data storage is now a priority task and is being addressed by R&D Manager, Claire Phillips.

Education/Professional Development/Promotion
R&D now have a module allocated on the Wolverhampton University Student Nurse Mentor Programme, whereby a placement within R&D can be selected. A presentation was delivered 5th Dec 2017 at Student Nurse Induction.
Dudley-based half-day refresher courses in Good Clinical Practice for research purposes continue to be led by Margaret Marriott. GCP Fundamentals and PI Master Class are also available.
A regular R&D newsletter is now available every quarter and available on the Hub (third edition due Dec 2017). This is also now circulated to Community Staff. Regular fundraising events have now been arranged (second one in January 2018).

The Hub and The Trust external website is currently being updated to promote R&D more widely.

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 7th December 2017

TITLE:	**Research Development Strategy**		
AUTHOR:	**Dr Jeffrey Neilson R&D Director**	**PRESENTER**	**Dr Jeffrey Neilson R&D Director**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		
CORPORATE OBJECTIVE: SO1, SO2, SO4, SO3, SO6			

SUMMARY OF KEY ISSUES:

We seek approval and support of the board for this aspirational strategy whose success relies on a shift in culture and attitude towards research across the whole organisation and involving all staff groups. Progress has been slow on this front in the past, and we request proactive support of senior leaders to realise this strategy through engagement with a Research Plan, which will follow.

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details: Safe, Effective, Caring, Responsive, Well Led**
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF BOARD OF DIRECTORS:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

The Board is asked to consider the Strategy and approve this.

The Dudley Group NHS Foundation Trust

Research Strategy 2018-2021

Dr Jeffrey Neilson

Director of Research and Development

DGNHSFT

Introduction

The Dudley Group NHS Foundation Trust Research Strategy will form the basis of a three year plan that builds on the foundation of success in research within the Trust built over nearly two decades. This success has been based around a number of core specialities and our vision is to make research business as usual across most, if not all, specialities by fostering a high quality research culture.

A research-active culture can contribute to improved Trust overall performance[1] and better patient outcomes,[2,3] as well as creating opportunity for staff development. This in turn will benefit staff recruitment and retention.

Background

National context

In its Mandate commitment within the NHS England research plan, published in April 2017, NHS England states that 'The Department of Health requires us to promote and support participation by NHS organisations, patients and carers in research funded both by commercial and non-commercial organisations, so that the NHS supports and harnesses the best research and innovations and becomes the research partner of choice.' This aligns with the NHS Constitution's description of an 'NHS committed to the promotion and conduct of research,' requiring the NHS to do all it can to ensure that patients from every part of England are made aware of research that is of particular relevance to them.

Clinical research networks have been established in each of the four UK nations funded by the UK Health Departments. Together these national networks form the UK Clinical Research Network (UKCRN). The networks' structures vary between countries, but all share the common goal of providing the infrastructure to support high quality clinical research studies for the benefit of patients. Clinical research infrastructure in England is provided through the NIHR Clinical Research Network. The Network supports the delivery of a portfolio of clinical research studies, including life-sciences industry studies, across all parts of the NHS in England. It does this by providing funds to hospitals and surgeries to invest in research nurses and other allied health professionals. This highly-trained workforce matches patients with appropriate study participation opportunities, and carries out the clinical duties required by the studies, enabling research teams to answer the research question to time and target. Network funding also covers costs related to study delivery such as x-rays and scans.

The NIHR Clinical Research Network also works to ensure that clinical research occupies the place it deserves in the day-to-day work of the NHS by encouraging clinical professionals to engage actively in research activities for the benefit of patients and the NHS as a whole. The Network comprises 15 geographical areas that cover the whole of England; our own is the Clinical Research Network: West Midlands, hosted by the Royal Wolverhampton NHS Trust.

Regional Context

CRN: West Midlands is the largest of the 15 local English networks and serves an economically and ethnically diverse population of around 5.67m. The network monitors and manages individual Trust performance against nationally agreed high level objectives (HLOs). The HLOs are designed to improve research performance, such as increasing overall recruitment numbers, improving recruitment to time and target, and reducing the time it takes to set up research studies. Monthly reports are generated to track performance against these agreed objectives. CRN: West Midlands has adopted an activity based funding (ABF) model which takes into account the complexity of studies when judging overall recruitment, with more complex studies accruing more activity points per patient recruited. It is recruitment against ABF targets that determines the proportion of funding individual Trusts receive from the regional allocation. The regional allocation varies from year to year; in 2016/17 it was £29m. Significant changes in ABF activity, if translated into swings to funding allocations, could destabilise trusts, so capping is used to moderate this. A small percentage is top-sliced from the fund to enable Trusts to bid for funds annually: so-called 'strategic funding'.

Local Context

Research delivery at DGNHSFT over the last two decades has been dominated by a small number of key specialties: Rheumatology, Cardiology, Haematology, Oncology and Metabolic Medicine. In recent years these have been joined by Dermatology, Diabetes, Orthopaedics and Anaesthesia/Critical Care. Most of the research carried out at DGNHSFT is multi-centre collaborative research sponsored by other organisations and is CRN approved. We have a significant commercial research portfolio based in Cardiology, Diabetes, Dermatology and Rheumatology. The commercial portfolio income is roughly equivalent to the funding DGNHSFT receives from the CRN.

Home grown research, where DGNHSFT is the sponsor and/or the chief investigator is employed here, is a small but important part of our portfolio which has been traditionally dominated by Rheumatology and Pain Management. More recently Anaesthesia and Gastroenterology are producing studies. With Professors in Rheumatology, Pain Management, Gastroenterology, Orthopaedics and Neurology working at the trust, home grown research is an area marked for growth.

Vision

Together, we will develop, across the trust, a high quality research culture where research will be integrated into the routine clinical care of our patients and seen as everybody's business.

To realise our vision we will:

1. Foster a research culture across the whole organisation and in all staff groups.
2. Become a fully research active organisation
3. Optimise research capability and capacity
4. Further enhance partnerships between industry, academia and DGNHSFT to improve the delivery of our research portfolio
5. Improve patient experience by providing the opportunity and choice to participate in research across all possible specialities in our organisation.

6. Deliver high quality research through excellence in research governance.
7. Ensure outputs of research are rapidly integrated into clinical care for our patients.

Goals to facilitate achieving our vision

Goal 1: Fostering a research culture across the organisation and in all staff groups.

Our **aim** is to foster a vibrant culture of research in all areas of DGNHSFT, not just the current areas of activity. Leading this will be enthusiastic, locally trained principal investigators (PIs) from nursing, pharmacy and allied health professions as well as the more traditional medical backgrounds. The research will be delivered in routine clinical settings, facilitated by both R&D staff and the local clinical staff who will appreciate how research activity contributes to better patient outcomes. Operational leaders will be aware of and value research undertaken in their units and by their staff since research activity will be a key marker of quality of care.

Our **success** will be measured by

1. An increase in the number of PIs from non-medical disciplines.
2. An increase in PIs from medical backgrounds.
3. Formal recognition of research in the consultant job planning process.
4. Increased profile of R&D across the trust through a R&D portal on the trust hub that will provide resource, governance and training information.
5. Wider celebration of the successes of local researchers
6. Engagement of all corporate directorates so that research is included in all DGNHSFT strategies.
7. Considering research input in the recruitment of all senior staff, clinical and non-clinical.
8. Creating an operational research reporting mechanism that demonstrates the benefits of research, financial or otherwise, to each section of the organisation.

Goal 2: To become a fully research active organisation.

Our **aim** is to increase the number of specialties and areas of the trust that are engaged in research, so that it is the rule and not the exception that clinical units are research active. Senior leaders will ask why units are not research active, so that encouragement to undertake research comes from several directions, not just from R&D. The profile and visibility of research will be greater so that patients will actively enquire about research opportunities, as well as being approached by our own staff. Support services, such as radiology and pathology, will be aware of the crucial role that they play in ensuring the success of the research agenda and will be adequately supported to facilitate this.

Our **success** will be measured by

1. An increase in the number of specialities that are involved in CRN portfolio research.
2. Greater visibility of research activity in clinical areas.
3. The community disciplines becoming involved in research activity.
4. Senior leaders' increased awareness of research in their areas, benchmarked against the rest of the trust.

5. The existence of a transparent support mechanism for support services to enable their engagement with research activities.

Goal 3: To optimise research capacity and capability.

Our **aim** is to increase as far as possible the research capability and capacity across DGNHSFT . We will increase the number of individuals who receive generic research training (Good Clinical Practice (GCP) training) and invest in staff who are capable of becoming chief investigators, thus enabling us to grow our own research. This will necessarily be supported by an effective and efficient research administration function capable of supporting individuals within the trust. We will optimise study set up and report our activity externally in a timely, effective fashion. This will enable us to recruit more patients into CRN adopted studies and, by careful selection of studies run locally, increase our ABF activity.

Our **success** will be measured by

1. An increase in the number of individuals who have GCP training across the trust
2. An increase the number of chief investigators.
3. An increase in home grown studies
4. The existence of a research ready team of generic research nurses to assist the running of studies in any specialty.
5. An increase in the number of participants in CRN adopted studies.
6. An increase in ABF activity.
7. A balanced portfolio of studies to enable us to meet our CRN targets for recruitment and ABF.
8. Being a beacon in the use of EDGE – the electronic system that is used to report research activity externally and that can generate internal reports about research activity.
9. Evidence that research requirements are integrated into the new EPR

Goal 4: To further enhance partnership between industry, academia and DGNHSFT to improve delivery of our research portfolio.

Our **aim** is to further enhance our links to the pharma, device industries and other emerging technologies, in order to increase the number of commercial studies we can offer our patients. This will involve strengthening involvement in specialties that currently offer commercial studies and increasing, where possible, the number of specialties that are involved in commercial research. We also aim to optimise our links with academic institutions to further our research activity, by using existing links and forging new ones as opportunities arise.

Our **success** will be measured by

1. An increase in the number of patients recruited into commercial studies
2. An increase in the number of commercial studies offered at DHNHSFT
3. An increase in commercial income
4. Evidence of collaboration with local universities resulting in increased research activity
5. Maintenance of a fully accredited research laboratory on site at DGNHSFT and the marketing of this regional exemplar to other trusts.

Goal 5: To improve patient experience by providing opportunity and choice to participate in research across all possible specialties in our organisation.

Our **aim** is to improve our patients' experience by offering the opportunity to contribute to research. We will also elicit their feedback on their experiences of both being approached to become involved and the involvement itself. While there is evidence of better outcomes from participation in research,[2,3] patients' research experience is an under-researched area, and it is not known if involvement in research results in a better experience compared to patients who are not involved. We will strive to capture our patient's experience of research in order to improve it and conduct further research on this topic.

Our **success** will be measured by

1. An increase in the number of specialties offering research at DGNHSFT
2. An increase in patient involvement in R&D decisions/study proposals' (where they can contribute to the design and delivery of studies).
3. Evidence of surveys of patient experience of research and actions resulting from these.
4. Evidence of participation in research into patients' experience of research.

Goal 6: To deliver high quality research through excellence in research governance.

Our **aim** is to be a beacon of excellence in research governance. Our innovative use of the EDGE system has already been recognised through a CRN West Midlands award. EDGE is the electronic system that is used across the regions to report research activity externally and that can generate internal reports about research activity. Meticulous research governance helps imbed a culture of thoroughness that is essential for the delivery of high quality research. We will offer local good clinical practice (GCP) training and training for new principal investigators.

Our **success** will be measured by

1. Improved performance against HLO5
2. Up to date and relevant policies and SOPs
3. Improved quality through an audit programme of Trust sponsored studies
4. Delivery of GCP and principal investigator training courses locally
5. Evidence of R&D engagement in the EPR project to optimise it's functionality for furthering research

Goal 7: Ensure outputs of research are rapidly integrated into clinical care for our patients.

Our **aim** is that patients benefit as soon as possible from research-evidenced interventions that improve their care and/or their outcomes. This is not something R&D has traditionally been involved in; in the past this has been dealt with through mechanisms concerned with 'Clinical Effectiveness'. We will explore how R&D can provide assistance to deliver this.

Our **success** will be measured by

1. Evidence of review of the trust mechanism for ensuring the adoption of interventions proven to improve care/outcomes.

Risks

This strategy is deliberately aspirational and is based on growing our research output. This will be challenging in the current NHS environment and its success relies on our ability to deliver on the main thrust of our vision: to develop a high quality research culture across the trust as a whole, not just within R&D. The external factors that will negate this strategy are:

1. Fewer academic studies for us to engage with, which will in turn reduce our research activity and, over time, reduce our CRN funding.
2. Fewer commercial studies available to us, which BREXIT could potentially catalyse. This will result in less commercial income.
3. If income is reduced, this will result in fewer research nurses, less capacity to conduct research under the current model of delivery, and a downward spiral.

Should one or more these materialise, then success may consist of maintaining our current performance. If research can be seen as everyone's business - regardless of whether we have fewer research staff, or fewer trials - then our ability to deliver will improve regardless of the funding R&D receives. This would require a shift in attitude from clinical and support staff regarding research and a different model of research delivery which relies less on research nurses and more on clinical staff.

Conclusion

We invite comments from the Trust Board on the contents of this strategy and request active support for our vision: Together we will develop, across the trust, a high quality research culture where research will be integrated into our patients' routine clinical care and where research is seen as everybody's business.

Once approved, a Research Plan will be drawn up to enable delivery of this strategy, incorporating appropriate milestones to measure progress against our goals.

References

1. Hanney S, Boaz A, Jones T, Soper B. Engagement in research: an innovative three-stage review of the benefits for health-care performance. Health Serv and Deliv Res. 2013;1(8).

2. Ozdemir BA, Karthikesalingam A, Sinha S, Poloniecki JD, Hinchliffe RJ, et al. (2015) Research Activity and the Association with Mortality. PLOS ONE 10(2): e0118253. https://doi.org/10.1371/journal.pone.0118253

3. Downing A, et al. High hospital research participation and improved colorectal cancer survival outcomes: a population-based study. Gut 2016;0:1–8. doi:10.1136/gutjnl-2015-311308

First draft shared with the individuals below for comment, and adjusted.

Margaret Marriott

Claire Phillips

George Kitas

Mark Dolphin

Wara Mudunge

Angie Watts

Jackie Smith

Margaret Jackson

Saima Aziz

Victoria Quinn

Gail Parsons

Julian Hobbs

Julian Sonksen

Rainer Klocke

Stephen Jenkins

Terence Pang

Craig Barr

Karen Douglas

Adrian Hall

Effie Ladoyanni

Ed Davis

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7 December 2017

TITLE:	**28 November 2017 Audit Committee Summary Report to the Board**		
AUTHOR:	Richard Miner – Committee Chair	**PRESENTER**	Richard Miner – Committee Chair

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee, the decisions taken in accordance with the Committee's terms of reference and action any items referred to the Board.

Committee / Group highlights report to Board / Committee

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**28/11/2017**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

None

Assurances Received

- That R&D research studies continue and there were no serious adverse events on drug trials to report.
- That action has been followed up in the areas of appraisals and mandatory training – which has also been reported to the Workforce Committee – following weaknesses highlighted to the August Audit Committee.
- That delivery against the Trust's Cyber Security strategy continues to be made and is an ongoing process.
- That progress is being made against the 2017/18 Internal Audit plan. This included receiving a "Reasonable Assurance" report in respect of "Do not attempt cardiopulmonary resuscitation" and a "Substantial Assurance" in respect of "Data Quality – Six Weeks Diagnostics". A further "advisory report" was received in respect of Payroll – Data Analytics.
- That counter-fraud (mainly pro-active fraud awareness sessions) initiatives continue with a view to prevention and that "lessons learned" continues to be an important part of this.
- The continuing work of the Caldicott and Information Governance Group which had noted the continued attainment of ISO 27001 (cyber security).
- The declining and relatively low level of losses and special payments made up to 30 September 2017.

Decisions Made / Items Approved

The Committee:

- Approved the external audit plan, including PwC's fees, and agreed to write to PwC (as in previous years) affirming its views on the risks of fraud in the Trust.
- Approved changes to the internal audit plan – mainly delays – where further input was required.
- Approved the addition of 11 clinical audits to and the removal of 1 from the 2017/18 Annual Clinical Audit Plan.
- Confirmed that the assurances received from the Risk and Assurance Group and that met on 11 October, supported the risk assessments made by the Executive Team and reported to the Board in November.
- Approved the amended Terms of Reference of the Audit Committee subject to the specific requirement that the Chair should have relevant experience and hold an accountancy qualification (which is consistent with the relevant guidance).
- Approved the procedural document in respect of the revised Risk Management Strategy.

Committee / Group highlights report to Board / Committee

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

- There remain a significant number of management actions (39) outstanding, some of which have target dates which have been substantially exceeded. This has been impacted by new executive leads although we expect to reductions in the next quarter.
- The scoping of the IT Projects/IT Infrastructure Internal Audit work due start in January.

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

- To note there were some breaches in policy identified in the “Do Not Attempt Resuscitation” Internal Audit report and these should be referred to CQSPE.
- To recommend the Board’ Assurance Framework which includes the “direction of travel” for the next quarter, when it comes to the Board, be approved.
- To recommend ratification of the amended terms of reference for the Audit Committee.
- The outstanding management actions noted above, clearance of which the Board is asked to support.

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board on 7 December 2017

TITLE:	Complaints report		
AUTHOR:	Jill Faulkner Head of Patient Experience	**PRESENTER:**	Siobhan Jordan Chief Nurse

CORPORATE OBJECTIVE:
SO1: Deliver a great patient experience
SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

Complaints received: During Quarter 2 (Q2), the trust received 115 complaints (July, August and September) compared to 81 in Q1 and 73 in Q2 in 2016/17. This is an increase of 42% compared to the previous quarter and a 60% increase for the same period in the previous year.

The divisional performance during Q2 is as follows:

- Surgery Division – 49 complaints
- Clinical Support Division – 4 complaints
- Medicine & Integrated Care Division – 61 complaints
- Other – 1 complaint (facilities)

All 115 complaints were acknowledged within 3 working days.

The Trust had 286,785 clinical patient contacts in Q2 which equates to 0.0400 of patients/family's making a complaint.

Complaint responses: The trust is below achieving the response target of 90% in accordance with NHS Complaints Regulations. 30 responses were provided to complainants from complaints received in previous quarters. Of those closed 5 (17%) were closed within 40 working days. In relation to those closed outside of the 40 working days, 100% were closed within the agreed timeframe as extension requests were made in line with 'The Local Authority Social Services and NHS Complaints (England) Regulations 2009.

- Medical & Integrated Services Division provided written responses to 14 formal complaints, of those closed, 2 were closed within 40 working days. On average it took an average of 63 working days to respond to complaints.
- Surgery Division provided written responses to 14 formal complaints, of those 3 were closed within 40 working days. On average it took an average of 54 working days to respond to complaints.
- Clinical Support Division provided written responses to 2 formal complaints, of those 0 were closed within 40 working days. On average it took an average of 59 working days to respond to complaints.

Seven Local Resolution Meetings (LRMs) took place which impacts on the 40 working day timescale in which to respond to complaints due to staff and patients/complainants availability to attend the meeting.

- Medical Division held 3 Local Resolution meetings.
- Surgery Division held 4 Local Resolution meetings.

The outcome of the 30 complaints responded to during Q2 is as follows:

- 0 upheld
- 18 partially upheld
- 12 not upheld

The overall top 5 themes across the 3 areas over the preceding 2 quarters are summarised as follows:

Q2, 2017/18	Q1, 2017/18
Clinical treatment	Communication/attitude
Communications	Clinical treatment
Clinical treatment	Patient care including nutrition/hydration
Admissions/discharges & transfers	Admissions/discharges & transfers
Appointments including delays and cancellations	Delays/ordering tests/scans

Reopened complaints: One reopened complaint; a subsequent letter was received from the complainant who was dissatisfied with the initial response

Parliamentary Health Service Ombudsman (PHSO): The trust received no applications from the PHSO during Q2 and none have been resolved during this quarter.

Local Government Ombudsman (LGO): The Trust received one application from the LGO during Q2.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** Timeframes are not being achieved due to capacity within the Patient Experience Department and within the Divisions.
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details**: Safe and responsive
	Monitor	Y	**Details:**
	Other	Y	**Details:**

ACTION REQUIRED OF BOARD			
Decision	**Approval**	**Discussion**	**Other**
		Y	

RECOMMENDATIONS FOR THE COMMITTEE: To note complaints received within the organisation.

The Dudley Group
NHS Foundation Trust

Complaints Report – Quarter 2, 2017/18

1. Introduction

During Quarter 2 (Q2), the trust received 115 complaints (July, August and September) compared to 81 in Q1 and 73 in Q2 in 2016/17. This is an increase of 42% compared to the previous quarter and a 60% increase for the same period in the previous year.

All 115 complaints were acknowledged within 3 working days. The trust currently works to a 40 working day timeframe to respond to complaints.

As at 30 September 2017 there were 135 open complaints, 6 complaints hosted by Dudley Clinical Commissioning Group (CCG) and 1 complaint hosted by Wolverhampton Hospital.

The trust had 286,785 clinical patient contacts in Q2 which equates to 0.0400 of patients/family's making a complaint.

. The divisional performance during Q2 is as follows:

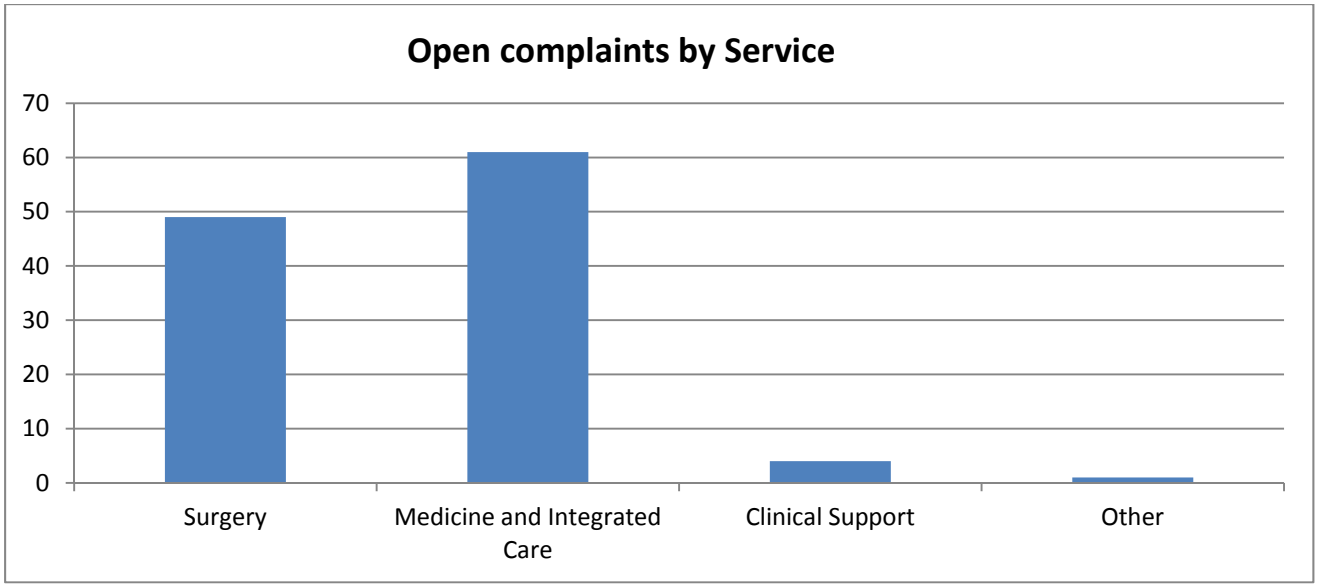
- Surgery Division – 49 complaints
- Clinical Support Division – 4 complaints
- Medicine & Integrated Care Division – 61 complaints
- Other – 1 complaint

The 'other' complaint related to a patient falling outside of the Urgent Care Centre causing injuries to hand, face and knee. This was investigated by Facility Services.

2. Complaints open

Table 1 represents complaints open as at 30 September 2017 (115).

Table 1



A comparison of complaints received by division and service for Q2, 2017/18 and Q1, 2017/18 can be seen in *tables 2, 3 and 4* below:

Table 2

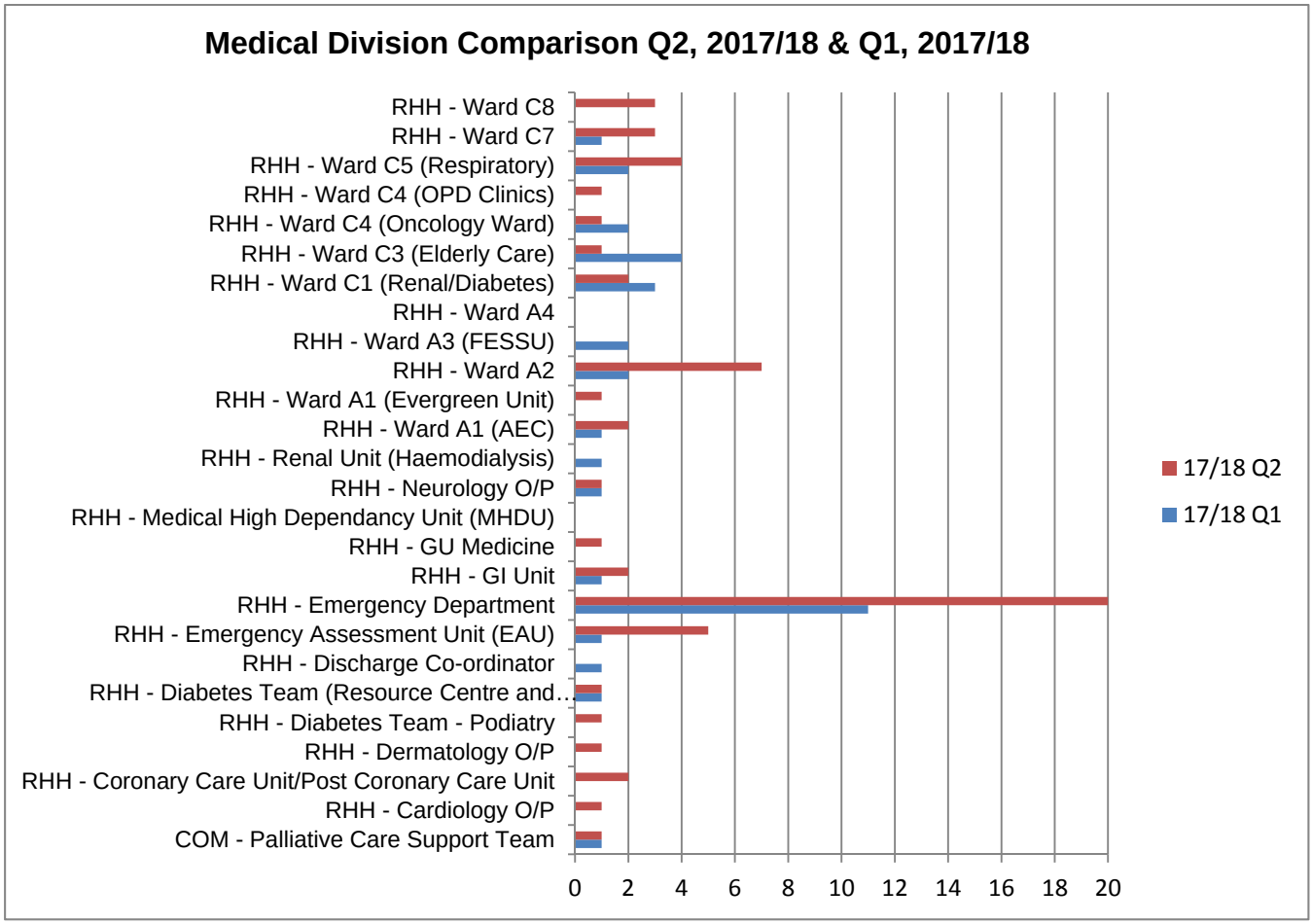


Table 3

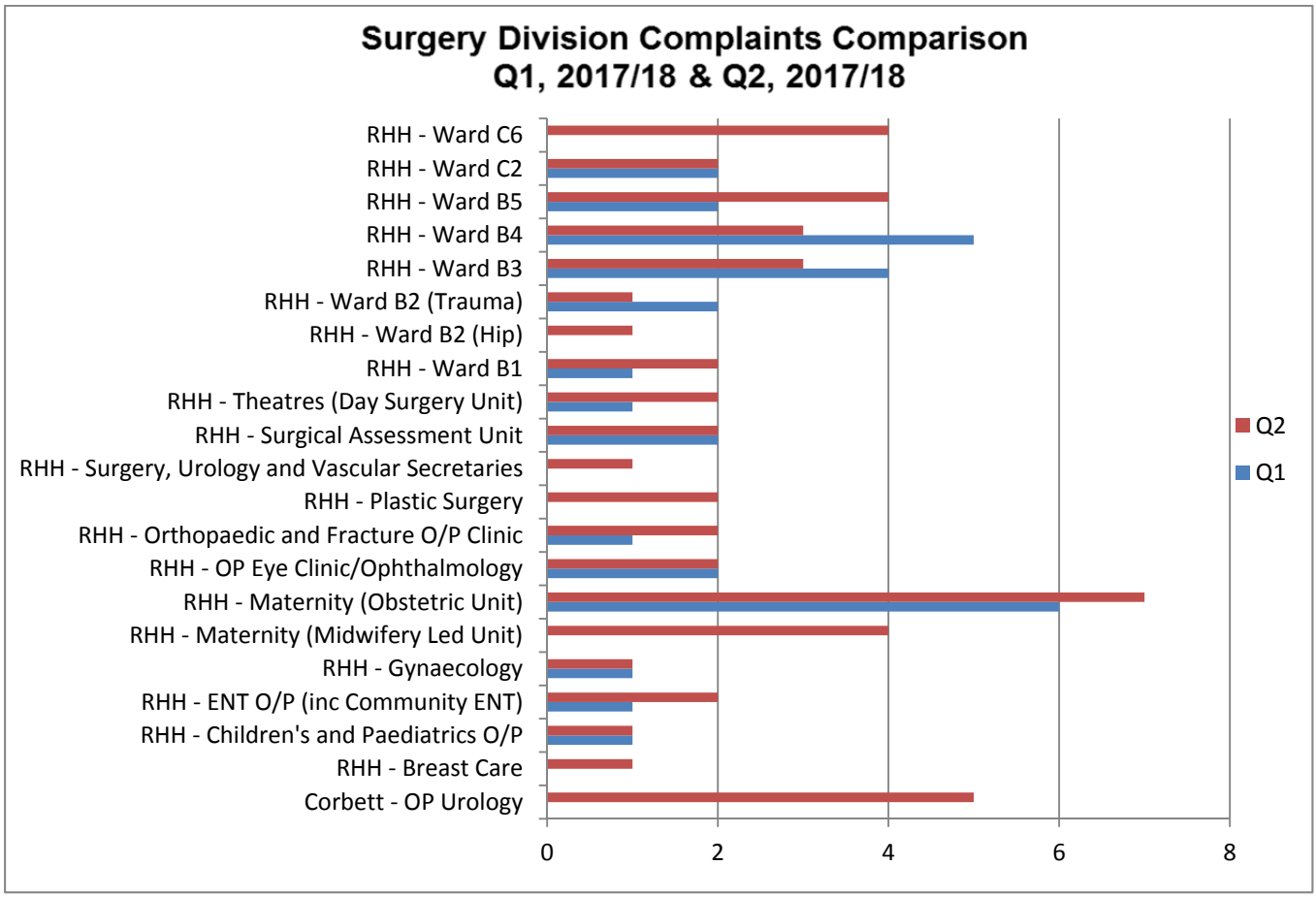
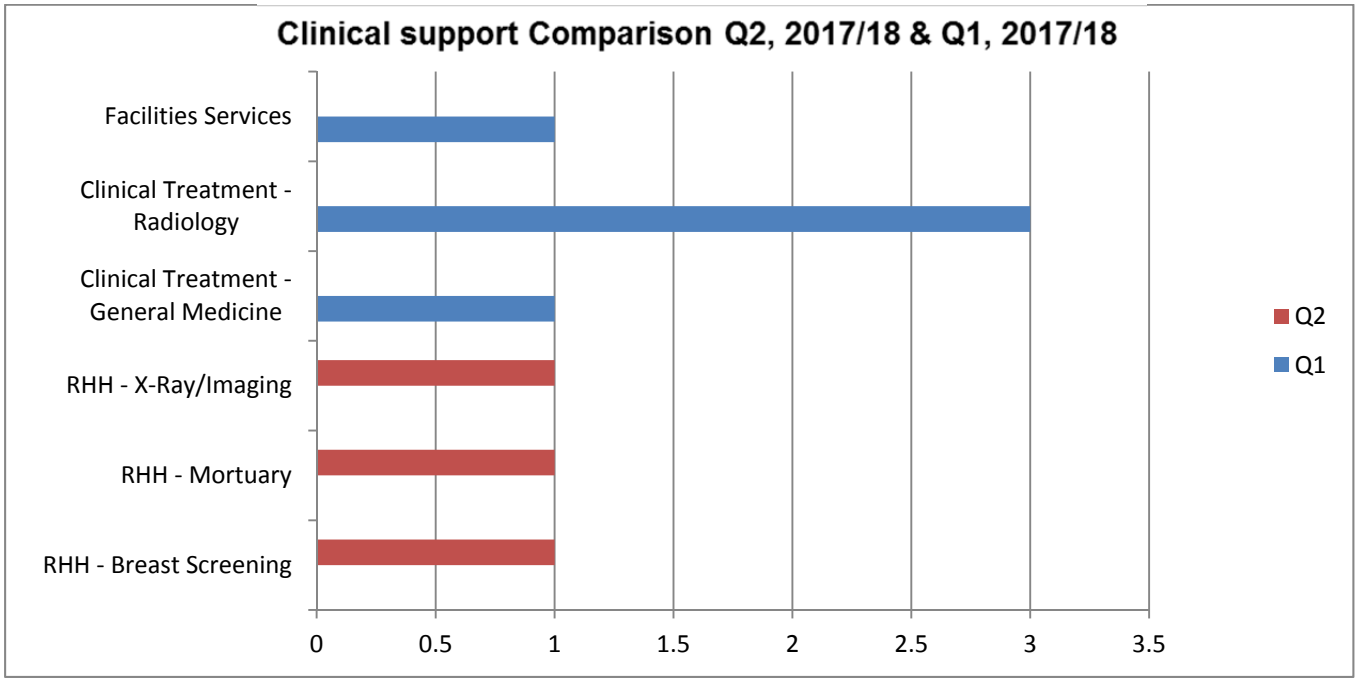


Table 4



The majority of complaints continue to relate to Medicine & Integrated Care and Surgery Divisions in both Q2, 2017/18 and Q1, 2017/18.

Dudley CCG has requested an investigation by the trust into 6 complaints they are hosting. All 6 of these complaints relate to Medicine and Integrated Care Division. These will be reported on the KO41 by the CCG in their Q2 return.

One further complaint received was from Wolverhampton Hospital where comments were requested on a complaint they are hosting. This complaint will be reported on Wolverhampton Hospitals KO41.

Previous to July 2017 ‘out of time’ complaints were investigated (NHS complaints regulations state that complaints should be made within 12 months of the event or when the complainant becomes aware of the event). These were not given a timeframe and were investigated intermittently. During Q2 there was 1 out of time complaint open for investigation which has been given a 40 day timeframe.

The out of time complaint was opened due to a lack of communication regarding end of life care which became apparent sometime after the event when the patient sadly passed away in 2015. The complainants have requested a Local Resolution Meeting (LRM) instead of a formal response letter.

2.1 Complaints Received

Of the 115 complaints received all were risk rated as follows:

- 0 major
- 57 moderate
- 58 minor

2.2 Medicine & Integrated Care Division

During Q2, a total of 61 complaints were received by the Medical & Integrated Care Division which indicates an increase of 65% from Q1, 2017/18 (37).

Table 5 details complaints received by service:

Table 5

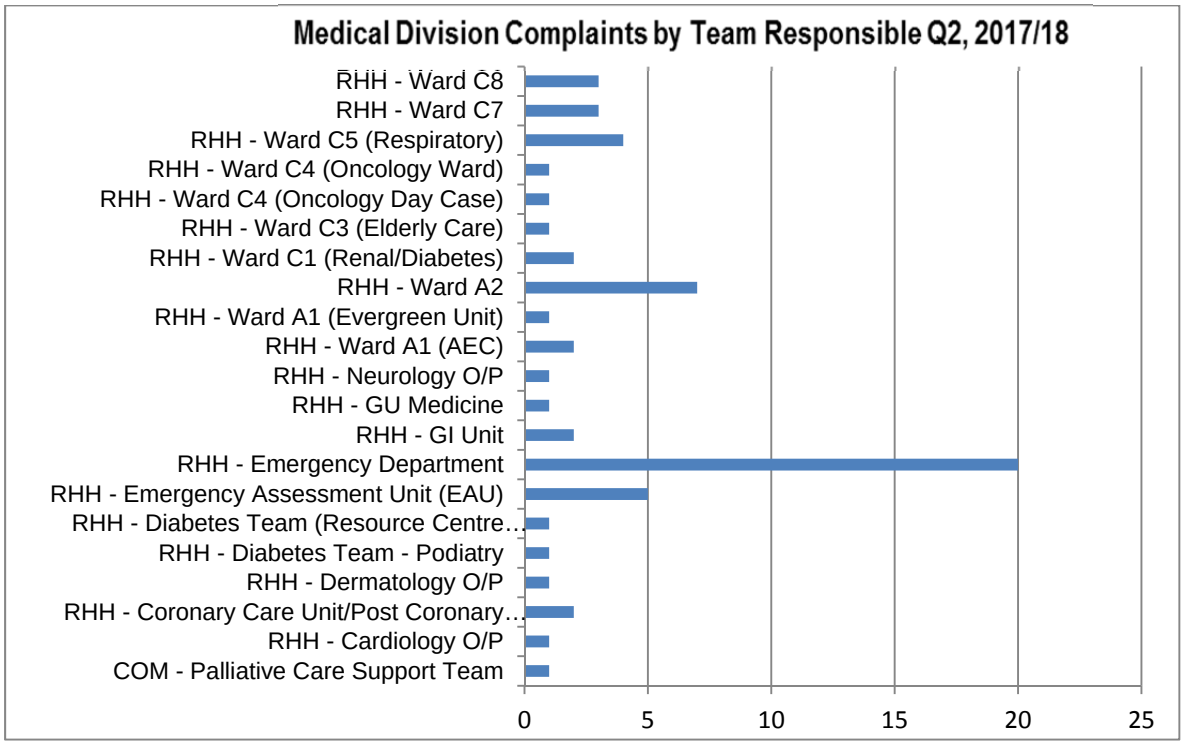
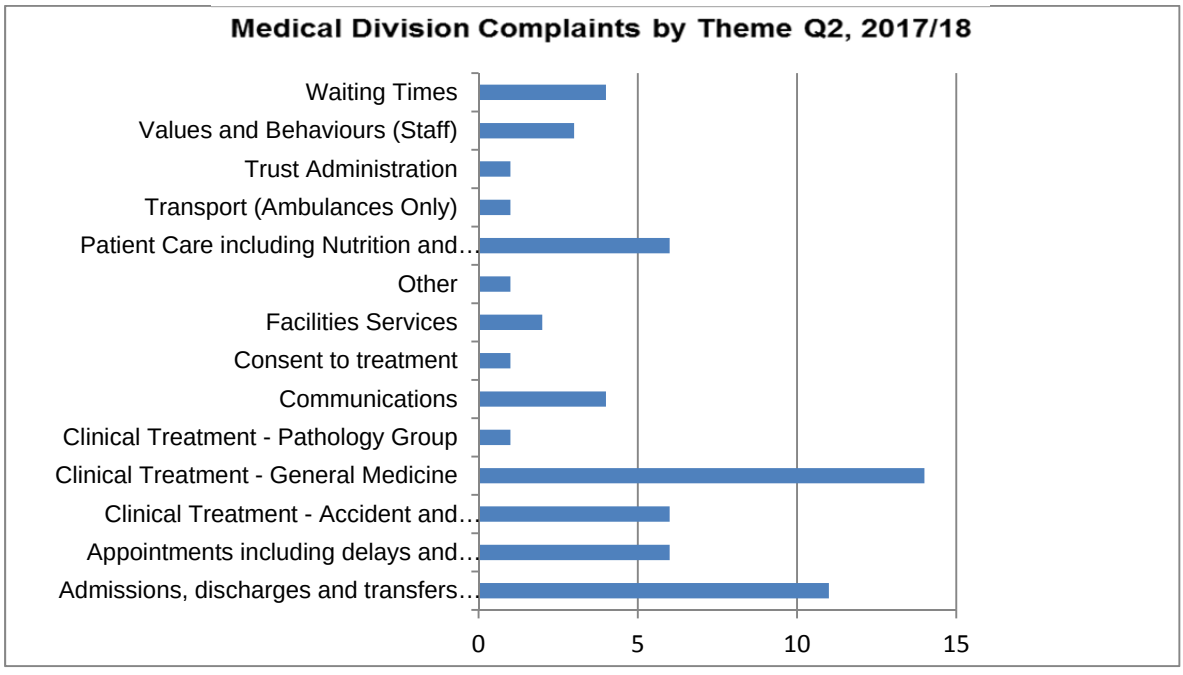


Table 6 details complaints received by subject.

Table 6



The significant themes identified relate to:

- Clinical treatment in the Emergency Department (ED)
- Appointments including delays and cancellations
- Admissions, discharges and transfers

- Clinical treatment – general medicine

Complaint themes within Q2 are as follows:

- Poor communication is a recurring theme with many complainants. Patients and relatives feeling that staff are generally unsupportive and do not listen to their concerns or questions raised. There appears to be a lot of miscommunication when discussing a patient's condition. Staff are not checking that the family/patient understand what they are being told.

- Patients are concerned they are not being discharged appropriately with many feeling it is too soon or adequate provisions and follow up are not in place.

- Staff behaviour and attitude including staff appearing disinterested or having no time to assist patients is raised frequently. This makes patients feel they are a burden or will be 'told off' for requesting help. Patients have also reported that they have heard staff 'moaning' or discussing their colleagues in an unprofessional manner.

- Basic care needs/hygiene is a concern for many families. This includes the competence of care and compassion patients receive from staff. In addition, concerns relate to lack of assistance with personal care and catheter care.

- Patients feel that they have to contact the hospital after discharge to chase up appointments, scans and results. This concern has also been raised under the Surgical Division.
-

2.3 Surgery Division

During Q2, a total of 49 complaints were received by the Surgical Division which indicates a 53% increase from Q1, 2017/18 (32). Further analysis has identified that maternity, general surgery and paediatrics/neonatal is a recurring area of complaints.

Table 7

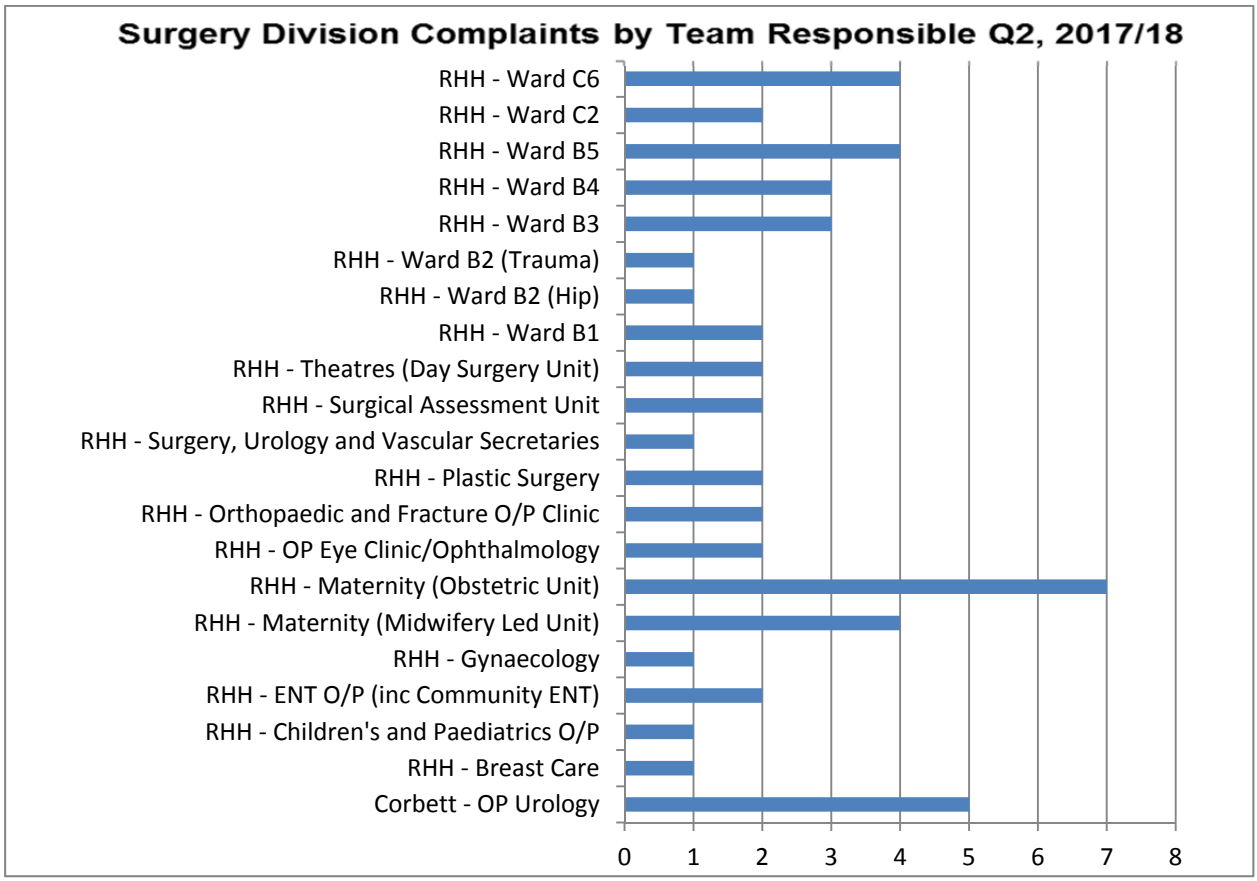
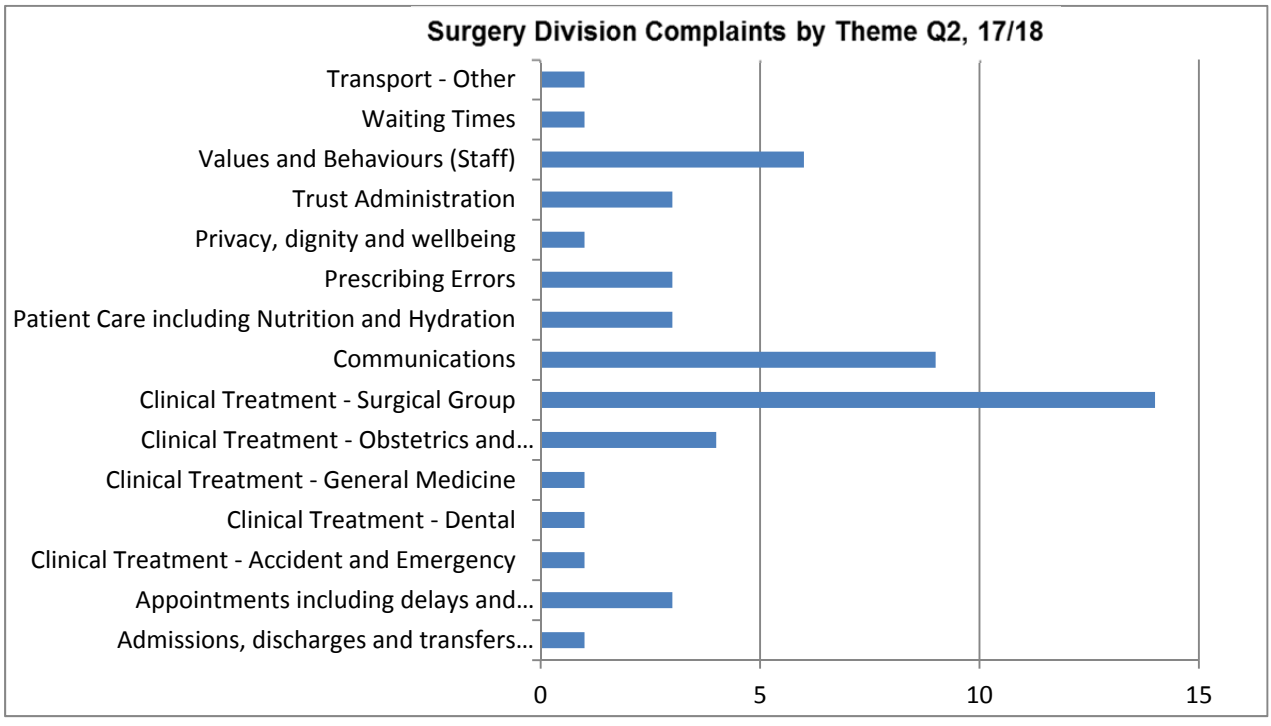


Table 8 details complaints received by subject.

Table 8



The significant themes identified relate to:

- Clinical treatment
- Poor Communication and attitude of staff
- Staff behaviour and values
- Prescribing errors

Complaint themes within Q2 are as follows:

- Clinical treatment including failure to diagnose appropriately and lack of care and treatment were the most common themes. Patients feel that symptoms are not managed appropriately and that there is a delay in diagnosis or misdiagnosis of the conditions presented. In addition, there is no clear treatment plan in place or clinical assistance.

- Poor communication and information about treatment/care has been raised throughout the trust. Patients feel they are not being given enough time to recover from their procedures or are not receiving the appropriate post-operative care.

- Referrals for appointments and tests as an inpatient and upon discharge are taking longer than expected to organise. Patients feel appointments are not being requested properly or discussed between the various specialities. When the surgical team transfer a patient to the medical team (or vice versa) the receiving team will sometimes decline the transfer resulting in no one taking ownership of the patient. This causes confusion for the patient/family as well as missed or delayed tests/referrals.

- Patients feel that they have to contact the hospital after discharge to chase up appointments, scans and results. This concern has also been raised under the Medical & Integrated Care Division.

2.4 Clinical Support Division

During Q2, a total of 3 complaints were received by the Clinical Support Division which indicates a 40% decrease from Q1, 2017/18 (5).

These complaints were in relation to delay in treatment, delay in obtaining a death certificate, staff attitude and patient assistance with clinical and catheter care.

Table 9 details complaints received by service:

Table 9

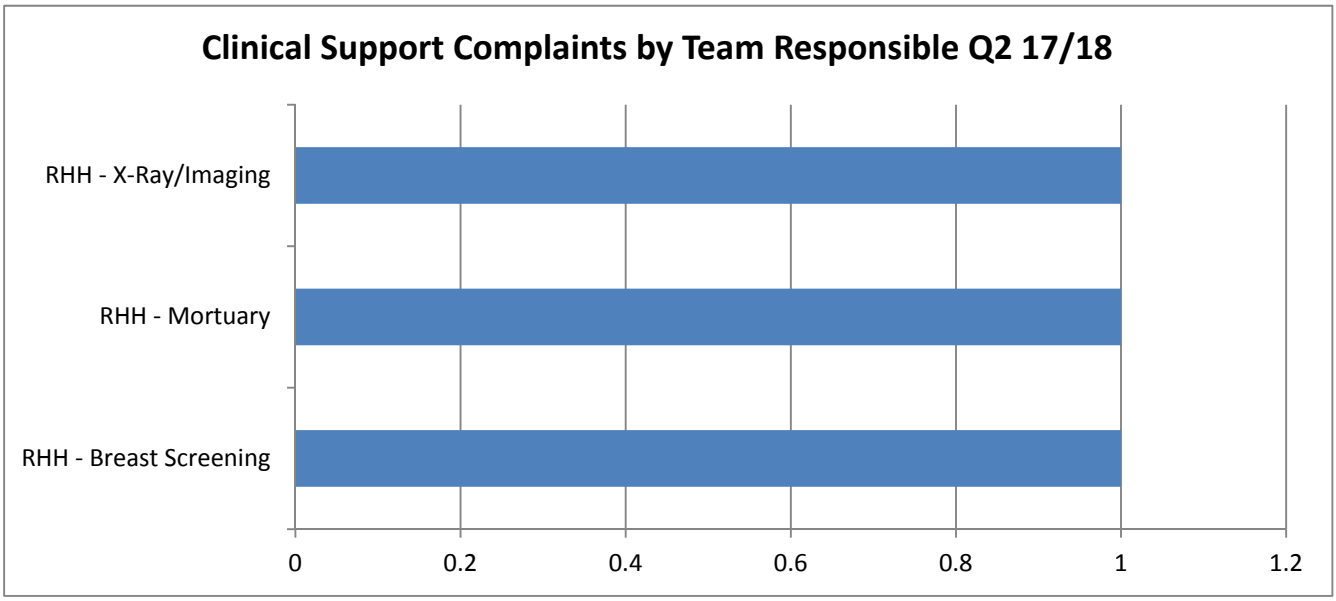
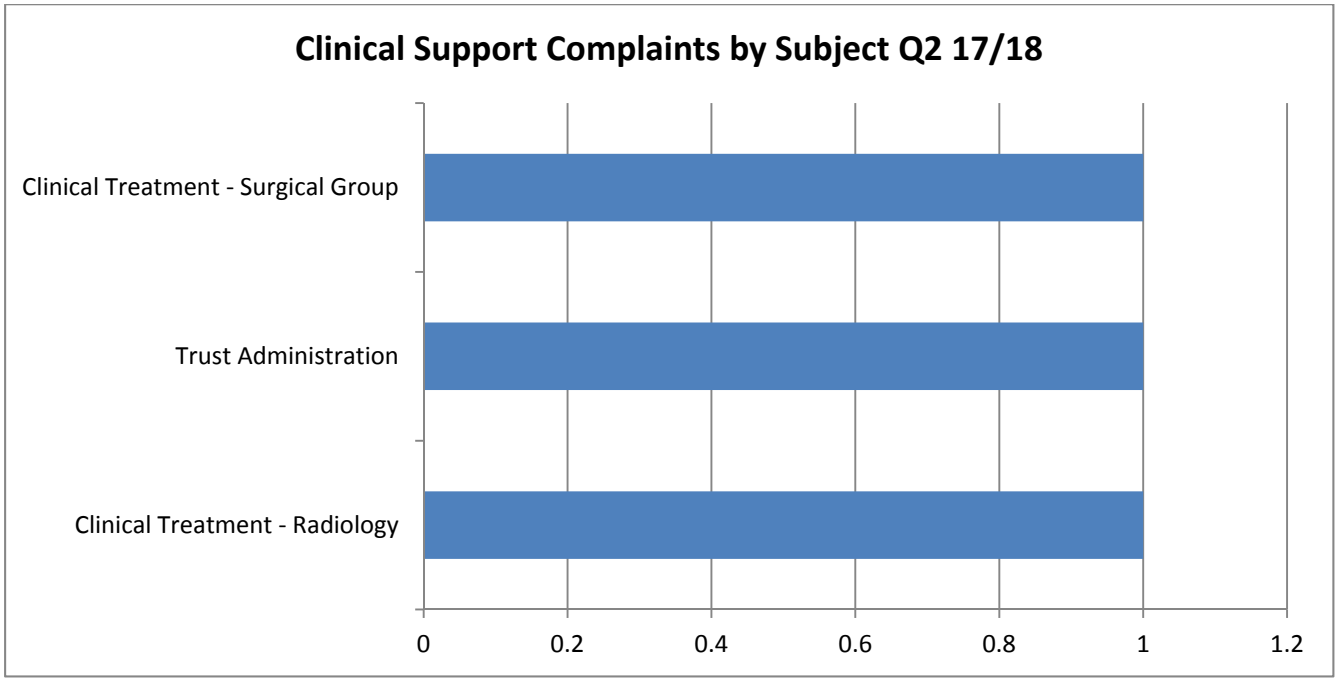


Table 10 details complaints received by subject.

Table 10



The themes identified related to:

- Lack of communication
- Unprofessional/unhelpful staff

Concerns raised through Q2 are as follows:

Communication with patients and family's has been raised including staff appearing to be disinterested and not providing basic care.

2.5 Complaint Themes

The overall top 5 themes across the 3 areas over the preceding 2 quarters are summarised as follows:

Quarter 2, 2017/18	Quarter 1, 2017/18
Clinical Treatment – Surgical	Communication/staff attitude
Communications	Clinical treatment
Clinical Treatment – General Medicine	Patient care including nutrition/hydration
Admissions/discharges & transfers	Admissions/discharges & transfers
Appointment including delays and cancellations	Delays/ordering tests/scans

2.6 Reopened Complaints

During Q2 the trust received 1 reopened complaint; a subsequent letter was received from the complainant who was dissatisfied with the initial response. This included clinical and chronological discrepancies within the initial response letter. The complaint was initially closed in Q1 and reopened in Q2.

2.7 Complaint responses

In Q2, the trust was below achieving the response target of 90% in accordance with NHS Complaints Regulations. Thirty responses were provided to complainants from complaints received in previous quarters. Of those closed 5 (17%) were closed within 40 working days. In relation to those closed outside of the 40 working days, 100% were closed within the agreed timeframe as extensions were requested in line with 'The Local Authority Social Services and NHS Complaints (England) Regulations 2009.

In addition, 7 LRMs took place which impacts on the 40 working day timescale in which to respond to complaints due to staff and patients/complainants availability to attend the meeting.

The following provides an overview of local resolution meetings that took place during the quarter:

- Medical Division held 3 Local Resolution meetings.
- Surgery Division held 4 Local Resolution meetings.

All local resolution meetings convened include a divisional representative and a member of the complaints team (and others if required). A CD recording of the meeting is provided to the complainant and a follow up letter is generated to confirm discussions held, findings and subsequent action plans if appropriate.

The following provides an overview of Divisional responses during Q2:

- Medical & Integrated Services Division provided written responses to 14 formal complaints, of those closed, 2 were closed within 40 working days. On average it took an average of 63 working days to respond to complaints.

- Surgery Division provided written responses to 14 formal complaints, of those 3 were closed within 40 working days. On average it took an average of 54 working days to respond to complaints.

- Clinical Support Division provided written responses to 2 formal complaints, of those 0 were closed within 40 working days. On average it took an average of 59 working days to respond to complaints.

3. Complaint Outcomes

During Q2, the trust responded to 30 formal complaints. The outcomes of these were as follows:

- 0 upheld
- 18 partially upheld
- 12 not upheld

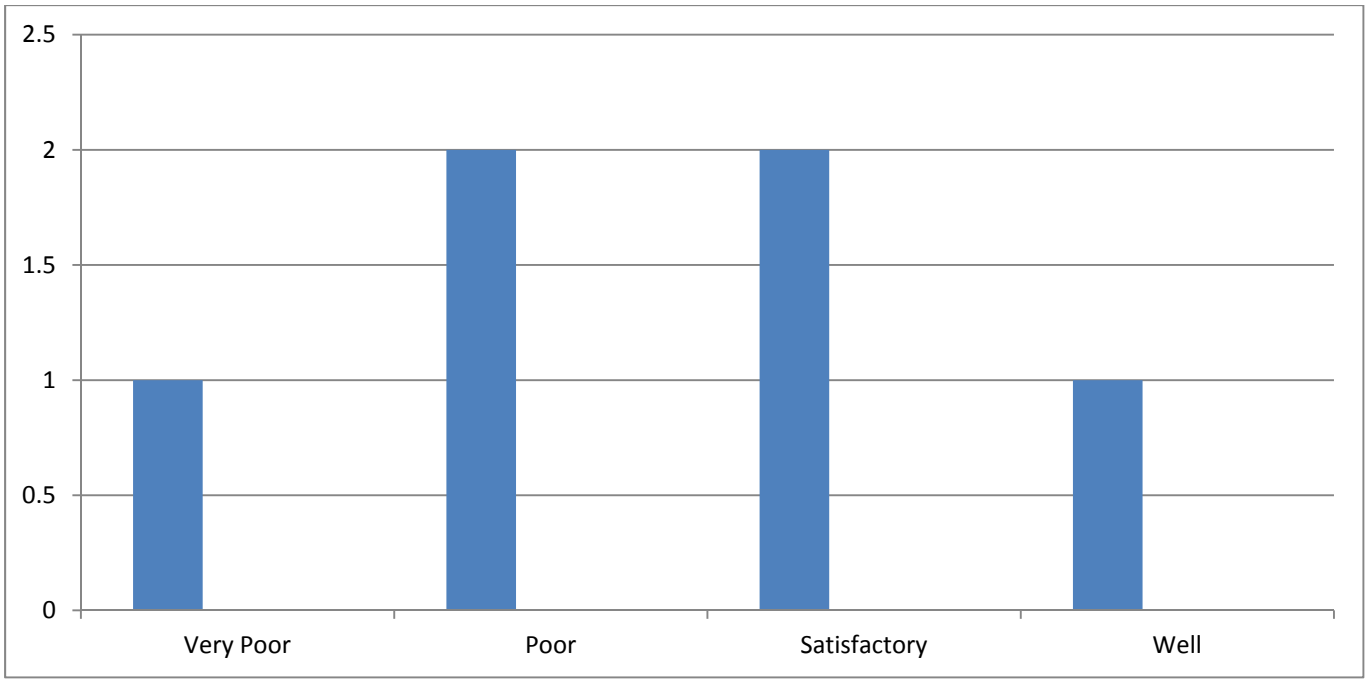
3.1 Complaints satisfaction surveys

During Q2, 39 complaint satisfaction surveys were sent out (6 weeks after closure). Of the 39 surveys sent out the trust has received 6 completed surveys back.

The survey is about the process and management of the complaint and not about the outcome. However those complainants that are unhappy with the outcome of their complaint base the survey on their dissatisfaction. All survey responses are anonymous.

Table 11 below details the findings of the surveys that have been returned.

Table 11



3.2 Actions and Learning

The trust is committed to learning from complaints to ensure service improvements are embedded into every day practice. The following section provides an overview of trust wide service improvements during Q2:

Medical Division:

- How easily a negative impression can be formed by appearances and words used. Reflection and discussion has taken place.
- To ensure all staff reduce the risk of lost patient's property by implemented the approved policy in completing the relevant trust documentation regarding valuables.
- To ensure effective communication with patients to allay anxiety and provide a quality patient experience.
- To ensure complaints processes are monitored to reduce any poor patient experience and ensure efficiency.
- To promote high nursing standards and monitor any patient negative nursing experiences and take action.

Surgery Division:

- To follow protocols i.e. sepsis 6.
- To be mindful of patient's requests such as to continue with breastfeeding.
- To provide fluid and antibiotics as soon as they are prescribed.
- To record all dealing accurately on medical records.
- Clearer communication with patients.
- To document all conversations and discussions fully with family/patients.
- To be mindful of manner when dealing with patients/families particularly on sensitive and emotional issues.
- To ensure clear communication with patients/families again on sensitive and emotional issues.

Clinical Support Division:

During Quarter 2, Clinical Support Division closed 1 complaint and this was not upheld, therefore there were no actions or lessons to be learnt.

4. Parliamentary Health Service Ombudsman (PHSO)

The trust received no applications from the PHSO during Q2 and none have been resolved during this quarter.

4.1 Local Government Ombudsman (LGO)

The trust received one application from the LGO during Q2.

LGO will look at the following:

- Failure to provide/arrange oxygen on patient's discharge in 2016.

The health records, complaints file and other documentation requested has been sent and we await their decision/findings.

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board
December 2017

TITLE:	**Digital Trust Programme Committee update**		
AUTHOR:	**Mark Stanton CIO**	**PRESENTER**	**Ann Becke**

CORPORATE OBJECTIVE:

SO3: **Drive service improvements, innovation and transformation**
SO5: **Make the best use of what we have**

SUMMARY OF KEY ISSUES: ***(please identify key issues arising from report or minutes)***

A summary of the Digital Trust Programme Committee (DTPC) November 2017

- A project exception assessment has been issued for stage 3 of the project which risks the planned deliverables for 23/4/17. The planned high level deliverables in the original project plan are: -

  a) Electronic Prescribing and Medicines Management (ePMA)
  b) Emergency Department
  c) Order Communications (The electronic order of services across the Trust such as Diagnostics and Pathology)
  d) Inpatient documents (the 112 forms that are used in patient care at a ward level)

  Stage 3 of the project encompassing the four main deliverables (a-d above) is running eight weeks behind schedule, this is mainly due to late starting of this activity (unavailability of Subject Matter Experts) and the group trying to design high functionality documents with many of iterations impacting upon volume.

- A draft recovery plan has been developed reducing the scope . The reduced scope initial deployment will still be delivered as per the schedule (go-live 23/4/17) with the addition of a new rollout in June 2017 allowing time to gain trust-wide cultural adoption of digital processes such as electronic orders and results management. A full plan is being prepared for the December DTPC (EPR Programme Directors from a number of trusts have been consulted on this plan). The plan has no cost impact and does not impact the overall delivery dates.

- Assurance through the internal auditors (RSM) will be sought on the recovery plan

- The CCIO has stepped down from the role with immediate effect. As an interim measure, two of our long-standing consultants with great knowledge and experience of our Trust are stepping in to ensure the system continues to be designed by clinicians and to maintain a focus on clinical safety. Whilst

discussions are taking place about long-term clinical leadership, we will recruit into new, project-funded Divisional CCIO positions (DCCIO) in order to secure protected clinical time (2 PAs per week per division).

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

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:** ***(Please select from the list on the reverse of sheet)***
	Monitor	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

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

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE COMMITTEE

Demonstrate to the Board that the DTPC is providing governance for this project.

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

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

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

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Digital Trust Programme Committee	22nd November 2017	Ann Becke	yes	no
			X	

Declarations of Interest Made

None

Assurances received

Project status

Stage 3 of the project (Configuration) is now in exception, meaning that there is no further contingency time within the stage and that the project critical path through to go live is impacted.

The three main causes for the delay in configuration are:

- SME time; the delay of 4-8 weeks in getting clinical SMEs freed up from clinical work in order to design and own the forms.
- Design process; there has been a focus on building high functionality patient record forms that have been through many iterations of clinical design. This has been to the detriment of delivering clinically approved content; out of the 112 clinical forms none so far have been completed and signed off, although over 50% are in design or configuration.
- Governance; application of the governance framework has resulted in excessive red-tape for approval of design and configuration work competed by clinicians.

This exception means that it will not be possible to deliver the full scope of the project for the go-live date of 23/4/18.

Recovery Activity

Initial project re-assessment in conjunction with external advice from three other NHS Programme Managers indicates that significant components can still be achieved for go-live on 23rd April as long as the new proposed approach to designing and producing clinical documents is embraced without delay.

It is now necessary to take a radically different approach to form design. The proposal is that forms will be configured via a more agile approach with validation of clinical safety by a clinical-Subject Matter Expert (SME) in the testing phase.

Sunrise forms will be configured from the following sources:

- existing paper forms in use at DGFT

- copies of existing forms in Soarian (ED and Radiology Orders)
- imports of forms in existing use at other Sunrise sites

This approach has been taken by other Trusts that have experienced the same delays. All above sources are already in production use without clinically safety concerns.
The scope of Rollout 1 (April 2018) and Rollout 2 (September 2018) is also being reviewed.

It was agreed that all Sunrise configuration required for use in ED would be prioritised with immediate effect and further analysis will take place to establish when the remainder of inpatient forms could be complete, there is a preference to delivering these within 3 months of the initial go-live date.

The CCIO has stepped down. In the interim consultants from the Trust with extensive experience in digitally mature clinical environments will assume some level of clinical responsibility for the programme. The DTPC has requested an audit takes place to ensure that project will deliver against its recovery plan and take into account clinical safety factors.

The DTPC was clear that this audit was specifically to give assurance of clinical effectiveness for the revised plan and was not an audit on the agreed strategy or overall deliverables of the project. The Chair of the audit committee is to discuss this with our external auditors (RSM) who have been involved prior to project inception.

A number of Strategic Gaps have been identified in the following areas with remedial plans being developed: -

1. Electronic Storage of Legacy documents
2. Clinical information – Analytics
3. Real time Admissions, Discharges and Transfers (ADT)
4. Pathology orders
5. Medicine Discharge letters
6. ICU adoption of Sunrise

Decisions Made / Items Approved

- High-level recovery proposals were accepted in principle with a full recovery plan requested for December DTPC. This is to include the detailed scope of each deployment throughout 2018, delivering a revised project plan.

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

• Revised Project plan.
Items referred to the Board for decision or action
None
Comments relating to the DTPC from the CCIO
N/A
Comments relating to the DTPC from the CNIO
N/A

Enclosure 17

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th December 2017

TITLE:	**Workforce & Staff Engagement Committee Meeting Summary**		
AUTHOR:	Andrew McMenemy, Director of Human Resources	**PRESENTER**	Julian Atkins, Committee Chair

CORPORATE OBJECTIVES

The assurance and actions from the Workforce & Staff Engagement Committee were consistent with the following Corporate Objectives:

- Be the place people choose to work;
- Drive service improvement, innovation and transformation; and
- Plan and deliver a viable future.

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: COR105, COR109, COR 083, COR102, COR110 & COR 119.**
	Risk Register: Y		**Risk Score: 20, 20, 16, 16, 15 & 12.**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y	Y		Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	30th November 2017	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

No declarations registered.

Assurances received

Presentation to Committee

1. The Committee received a presentation from Victoria Passant, Leonard Cheshire Disability Charity. The charity were invited to attend to present their Change 100 initiative that supports paid summer work placements for disabled students and recent graduates. The Committee recommends that further work is undertaken to support this initiative.

Matters Arising

2. The Committee received confirmation of the Trust's commitment to participate in the 'Stepping-Up' Programme alongside our NHS partners in the Black Country. The programme supports the development of BME staff within band 5, 6 and 7 posts. It is facilitated by the Leadership Academy and for the first time will be held regionally in this area. The request for nominations will be communicated to Divisional and Corporate teams in December 2017.

Workforce Governance

3. The standard report highlighting risks associated with the workforce was presented. It was agreed that the risk associated gap in Medical Rota needed to change to reflect the accuracy and timeliness of rotas rather than if they are filled.
4. The Committee received a policy update with confirmation on policies being developed but at this time no policies were reported as being out of date.
5. The practical arrangements for transferring to the new appraisal window were developed further and presented to the Committee. It was agreed that further communication as well as the collation of appraisal dates prior to April 2018 would help assist in ensuring a smooth transfer as well as the continuation of high levels of compliance.
6. The Committee were also provided with assurance that spans of control across the Trust are being reviewed to ensure that all appraisers have an appropriate and achievable number of staff to review and agree objectives with.

Workforce Education

7. The first data of the new Trust training needs analysis was presented with further work to be undertaken prior to the Committee meeting in February 2018. The Committee specifically requested an overview of staff development priorities by staff group, Division as well as overall Trust priorities.

8. An update report received regarding our use of apprentices. In order to make us more competitive in this market the Committee received a proposal to align terms and conditions for apprentices with Agenda for Change and other local NHS organisations. The Committee supported this change.

Workforce Performance

9. The Workforce Key Performance Indicators were presented to the Committee. Further concerns were raised regarding mandatory training and the commonly raised issue of Resus training being cancelled and this having an impact on compliance. The concerns regarding performance around the recruitment indicators and in particular the management responsibility to shortlist and interview within 16 days continues to cause concern. It was requested that the new mediation service to support informal resolution of staff disputes would be recorded as part of the next KPI report to determine if this mechanism is being used and if it is successful.

10. The CQUIN areas associated to workforce are currently green in terms of progress. In particular the Committee recognised the work undertaken to achieve 65% flu vaccination rate as at the date of the committee meeting and with the expectation of achieving the target of 70% for the first time in Trust history.

Workforce Strategy

11. The Committee received an update on the Workforce Business Plan that gave assurance that agreed objectives are on track at this time. Following feedback from the Board the column ‘measuring outcomes’ had been revised for comments at the Committee. It is intended that the description in this column provides greater level of assurance that the objectives supporting the strategy are measurable.

12. The Committee received an update regarding the Staff Survey with compliance rate at a disappointing 35% with only 1 day before the survey closes.

Workforce Change

13. The Committee were provided confirmation that the MTI recruitment process has now been initiated alongside our colleagues in Pakistan. It was reported that practical difficulties have been encountered with the process and that the first candidates will now commence in February 2018. The Director of HR and Medical Director will receive weekly updates on progress with this recruitment.

Decisions Made / Items Approved
1. The Committee agreed to set the terms and conditions for apprentices so that they are consistent with Agenda for Change and also consistent with other Black Country NHS Trusts. **2.** To recommend a change to the risk associated to Gaps in Medical Rota.
Actions to come back to Committee (items the Committee is keeping an eye on)
1. The Committee require further feedback regarding: • Update on Leadership Programme; • Diversity report associated to all protected characteristics; • Outcome of training needs analysis.
Items referred to the Board for decision or action
The Committee on this occasion does require any decision from the Board.

Enclosure 18

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors
7 December 2017

TITLE:	Trust Constitution		
AUTHOR:	Glen Palethorpe Director of Governance/Board Secretary	**PRESENTER:**	Jenni Ord Trust Chair

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE(S)
SO6: Deliver a vaible future.

The Trust's constitution is subject to review every year. As part of this review the Chair has been considering in consultation with the Trust's CEO and other Non Executive Directors the current composition of the Board of Directors.

There have been, and continue to be, increasing demands made on Non Executive Director's time. The dedication of the current Non Executives Directors and their time commitment to the expanding demands as has been discussed with the Council of Governors Appointments and Remuneration Committee has not been an issue. However, reliance on this is no longer a sustainable approach.

STP wide transformation projects expect Non Executive involvement, this is seen through the Pathology Transformation which is only the first of such STP wide initiatives. There will be more demands on their time that require a different approach. The MCP will also likely require representation from the Trust Board Non Executives on its Board of Directors. The increasing focus on well led the sector regulators sets an expectation for more independent corroboration of reported information to the Board and whilst the current Non Executives take an active role in internal quality and safety reviews / non executive walk arounds the number of these will be very likely to be expected to increase.

Therefore it is being proposed that the Board composition is to increase to 6 voting NEDs plus the chair and matched with an increase to 6 voting Executives. This is an increase of ONE voting NED and ONE voting executive.

Other minor amendments to the Constitution include

- the removal of any references to the superfluous mention of appointment / removal of initial directors and NEDs
- the removal of references to monitor and have these replaced with references to NHS Improvement
- the removal of a need for a member to obtain two sponsors from the current membership to support their election nomination. This is possible as changes have been made to the model election rules which now remove a practical barrier to members standing for election as the Trust does not and would not wish to make its register of members of public document.
- changes to the Trust's declaration of interest criteria relating to share ownership be adjusted to align to that within the Trust's revised Standards of Business Conduct Policy (which was updated in this year to take account of revised department of health mandatory guidance)

Whilst not a constitutional change it should be noted that should any further non voting NEDs be considered for that appointment, then the Governors Appointments & Remuneration Committee will be involved in the process.

IMPLICATIONS OF PAPER:			
RISK	**No**		**Risk Description:**
	Risk Register:		**Risk Score**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	Details: links to well led
	NHSLA	**N**	Details:
	NHS I	**Y**	Details: in that it supports the Trust being properly governed
	Other	**N**	

ACTION REQUIRED OF BOARD:

Decision	**Approval**	**Discussion**	**Other**
	✓		

RECOMMENDATIONS FOR THE BOARD:

- To approve the revisions to the Trust's constitution and recommend these changes to the Council of Governors.

The Dudley Group
NHS Foundation Trust

FOUNDATION TRUST CONSTITUTION

December 2017

The Dudley Group NHS Foundation Trust Constitution

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Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006.

Words importing the singular shall import the plural and vice-versa.

The 2006 Act is the National Health Service Act 2006.

The 2012 Act is the Health and Social Care Act 2012.

Council of Governors means the Council of Governors as constituted in this constitution, which has the same meaning as 'Council of Governors' in the 2006 Act.

NHS Improvement is the regulator that replaced Monitor who was previously the independent regulator , as provided by Section 61 of the 2012 Act.

Terms of Authorisation are the terms of authorisation issued by NHS Improvement

Voluntary organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

The Accounting Officer is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

1. Name

The name of the foundation trust is The Dudley Group NHS Foundation Trust (the Trust).

2. Principal purpose

2.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

2.2 The Trust does not fulfill its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

2.3 The Trust may provide goods and services for any purposes related to –

2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

2.3.2 the promotion and protection of public health

2.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

3. Powers

3.1 The powers of the Trust are set out in the 2006 Act, subject to any restrictions in the Terms of Authorisation.

3.2 The powers of the Trust shall be exercised by the Board of Directors on behalf of the trust.

3.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4. Membership and constituencies

The Trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1 a public constituency or

4.2 the staff constituency

5. Application for membership

An individual who is eligible to become a member of the trust may do so on application to the trust.

6. Public Constituency

6.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

6.2 Those individuals who live in an area specified for any public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of Members in each area for the Public Constituency is specified in Annex 1.

7. Staff Constituency

7.1 An individual who is employed by the Trust under a contract of employment with the trust may become or continue as a member of the Trust provided:

7.1.1 he or she is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 he or she has been continuously employed by the trust under a contract of employment for at least 12 months.

7.2 Individuals from Partner Organisations who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, and who work in The Dudley Group premises or in premises specifically serving the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. Organisations whose employees may be entitled to become Members of the staff constituency, as at the date of adoption of this constitution, by virtue of exercising functions for the Trust include those listed at Annex 2.

7.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.4 The Staff Constituency shall be divided into 5 descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

7.5 The minimum number of Members in each class of the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.6 An individual who is not from a partner organisation and who is;

7.6.1 eligible to become a member of the Staff Constituency, and

7.6.2 invited by the trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the trust that he does not wish to do so.

8. Restriction on membership

8.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 9 – Further Provisions.

9. Council of Governors – composition

9.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

9.2 The composition of the Council of Governors is specified in Annex 4.

9.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

10. Council of Governors – election of Governors

10.1 Elections for elected Members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.

10.2 The Model Rules for Elections, as may be varied from time to time, form part of this constitution and are attached at Annex 5.

10.3 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this constitution. For the avoidance of doubt, the trust cannot amend the Model Rules.

10.4 An election, if contested, shall be by secret ballot.

10.5 A vacant Governor post may be filled without an election where permitted by the Model Rules as they apply to the Trust or by paragraph 9 of Annex 9

11. Council of Governors - tenure

11.1 An elected governor and appointed governor may hold office for a term of up to 3 years.

11.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

11.3 An elected governor shall be eligible for re-election at the end of his or her term, subject to a maximum period of office of 9 years

12. Council of Governors – disqualification and removal

12.1 The following may not become or continue as a member of the Council of Governors:

12.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

12.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it;

12.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him or her.

12.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

12.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

12.4 The constitution is to make provision for the removal of Governors set out in Annex 6.

13. Council of Governors – meetings of Governors

13.1 The Chairman of the Trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 20.1 or paragraph 21.1 below) or, in his or her absence, the Deputy Chairman (appointed in accordance with the provisions of paragraph 22 below), shall preside at meetings of the Council of Governors.

13.2 Meetings of the Council of Governors shall normally be open to members of the public. Members of the public may be excluded from the whole or part of a meeting for special reasons, either by resolution of the Council of Governors or at the discretion of the chair of the meeting.

14. Council of Governors – standing orders

14.1 The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time, are attached at Annex 7.

15. Council of Governors - conflicts of interest of governors

15.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he or she becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

16. Council of Governors –expenses

16.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

17. Council of Governors – further provisions

17.1 Further provisions with respect to the Council of Governors are set out in Annex 6.

18. Board of Directors – composition

18.1 The Trust is to have a Board of Directors, which shall comprise both executive and Non-executive directors.

18.2 Subject to paragraph 8 of Annex 9, the Board of Directors is to comprise:

18.2.1 a Non-executive chairman

18.2.2 6 other Non-executive directors; and

18.2.3 6 executive directors.

18.3 One of the executive directors shall be the chief executive.

18.4 The Chief Executive shall be the accounting officer.

18.5 One of the executive directors shall be the finance director, with qualifications approved by the Consultative Committee of Accountancy Bodies (CCAB).

18.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

18.7 One of the executive directors is to be a registered nurse.

19. Board of Directors – qualification for appointment as a non-executive Director

A person may be appointed as a voting or non-voting Non-executive director only if –

19.1 he or she is a member of the Public Constituency,

19.2 he or she is not disqualified by virtue of paragraph 25 below.

20. Board of Directors – appointment and removal of chairman, deputy chairman and other non-executive directors

20.1 The Council of Governors only at a general meeting of the Council of Governors can they appoint or remove the chairman, deputy chairman of the trust and the other voting Non-executive directors.

20.2 Removal of the chairman, deputy chairman or another voting Non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

20.3 The chairman and the voting Non-executive directors are to be appointed in accordance with paragraph 21 below.

21. Board of Directors – appointment of chairman and other voting Non-executive directors

21.1 The Council of Governors has the power to appoint the other voting Non-executive directors of the Trust.

21.2 The Council of Governors only at a general meeting of the Council of Governors can they appoint or remove the chairman, deputy chairman of the trust and the other voting Non-executive directors.

21.3 The criteria for qualification for appointment as a voting and non-voting Non-executive director is set out in paragraph 19 above (other than disqualification by virtue of paragraph 25 below).

21.4 The power of the Council of Governors to re-appoint Non-executive directors is to be exercised, so far as possible, by re-appointing up to a maximum of nine years terms and for exceptional approval would be required in cases that exceed this period.

22. Board of Directors – appointment of deputy chairman

22.1 The appointment of the Deputy Chair is made by the Governors from the voting Non-executive Directors.

23. Board of Directors - appointment and removal of the Chief Executive

and other executive directors

23.1 The voting Non-executive directors shall appoint or remove the Chief Executive.

23.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

23.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

23.4 A person deemed to be fit and proper as set out in the CQC Fit and Proper Persons requirements except with the approval in writing of NHS Improvement. Removal may be triggered by a person who fails to meet the fit and proper requirements (FPPR).

24. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

24.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

24.2 a person who has made a composition or arrangement with, or granted a trust deed for, his or her creditors and has not been discharged in respect of it.

24.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him or her.

24.4 Removal may be triggered by a person who fails the meet the fit and proper person requirements (FPPR).

25. Board of Directors – standing orders

25.1 The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time, are attached at Annex 8.

26. Board of Directors - conflicts of interest of directors

26.1 If a director has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors, the director shall disclose that interest to the members of the Board of Directors as soon as he or she becomes aware of it. The Standing Orders for the Board of Directors make provision for the disclosure of interests and arrangements for the exclusion of a director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

27. Board of Directors – remuneration and terms of office

27.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other voting Non-executive directors in light of any recommendations made by the Appointments and Remuneration Committee.

27.2 The Trust shall establish a committee of voting non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

27.3 the terms of office shall be reflective of any guidance issued by NHS Improvement .

28. Registers

The Trust shall maintain:

28.1 a register of Members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

28.2 a register of members of the Council of Governors;

28.3 a register of interests of Governors;

28.4 a register of directors; and

28.5 a register of interests of the directors.

29. Registers – inspection and copies

29.1 The trust shall make the registers specified in paragraph 28 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

29.2 The trust shall not make any part of its s register of member available for inspection by members of the public, if the member so requests.

29.3 So far as the registers are required to be made available:

29.3.1 they are to be available for inspection free of charge at all reasonable times; and
29.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

29.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

30. Documents available for public inspection

30.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

30.1.1 a copy of the current constitution;
30.1.2 a copy of the current authorisation;
30.1.3 a copy of the latest annual accounts and of any report of the auditor on them;
30.1.4 a copy of the latest annual report and quality accounts;
30.1.5 a copy of the latest information as to its forward planning; and
30.1.6 a copy of any notice given under section 52 of the 2006 Act.

30.2 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

30.3 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

31. External Auditor

31.1 The trust shall have an external auditor.

31.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

32. Audit committee

32.1 The trust shall establish a committee of voting non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as is appropriate.

33. Accounts

33.1 The trust must keep proper accounts and records in relation to the accounts

33.2 NHS Improvement may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

33.3 The accounts are to be audited by the trust's auditor.

33.4 The trust shall prepare in respect of each financial year annual accounts in such form as NHS Improvement may, with the approval of the Secretary of State direct.

33.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

34. Annual report and forward plans and non-NHS work

34.1 The Trust shall prepare an Annual Report and send it to NHS Improvement.

34.2 The trust shall give information as to its forward planning in respect of each financial year to NHS Improvement.

34.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

34.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

34.5 Each forward plan must include information about –

34.5.1 the activities other that the provision of goods and services for the purposes of health service in England that the trust proposes to carry on, and

34.5.2 the income it expects to receive from doing so.

34.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub paragraph 34.1, the Council of Governors must –

34.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of it principal purpose or the performance of its other functions, and

34.6.2 notify the directors of the trust of its determination.

34.7 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, this shall not be implemented unless more than half of the members of the Council of Governors of the Trust approve its implementation.

34.8 For a statutory transaction more than half the members of the Council of Governors must approve any application by the Trust to:

- merge with or acquire another trust
- separate the Trust into two or more new foundation trusts
- be dissolved

35. Meeting of Council of Governors to consider annual accounts and reports

The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

35.1 the annual accounts

35.2 any report of the auditor on them

35.3 the annual report and quality account

36. Instruments

36.1 The trust shall have a seal.

36.2 The seal shall not be affixed except under the authority of the Board of Directors.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 6.1 and 6.3)

Constituency	**Minimum Number of Members**
Dudley	
Brierley Hill	50
Central Dudley	50
North Dudley	50
Stourbridge	50
Halesowen	50
Others	
Rowley Regis and Tipton	24
South Staffordshire and Wyre Forest	24
Rest of West Midlands	12

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 7.1 and 7.2)

Class	Minimum Number of Members
Medical and Dental	44
Nursing and Midwifery	157
Allied Health Professionals and Healthcare Scientists	79
Non-Clinical Staff	58
Partner Organisations' Employees from for example: Summit Healthcare (Dudley) Limited Interserve fm Siemens Healthcare Systems Commissioners– Dudley, Sandwell, Worcestershire, South Staffordshire Local Authorities – Dudley MBC, Sandwell MBC, Wyre Forest District Council, South Staffordshire District Council	10

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no patients' constituency.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 9.2 and 9.3 and Notes 13 to 18)

Constituency/Class	No. of Governors
Public	
Brierley Hill Ward	2
Central Dudley Ward	2
North Dudley Ward	2
Stourbridge Ward	2
Halesowen Ward	2
Rowley Regis and Tipton Ward	1
South Staffordshire and Wyre Forest Ward	1
Rest of West Midlands	1
Total Public	***13***
Staff	
Medical and Dental	1
Nursing and Midwifery	3
Allied Health Professionals and Healthcare Scientists	2
Non-Clinical Staff	1
Partner Organisations' staff	1
Total Staff	***8***
Appointed (by a statutory or partnership organisation)	
Dudley Clinical Commissioning Group	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***
Grand Total	***25***

Note: Appointed governors are appointed by a statutory or partnership organisation in accordance with the 2006 Act Schedule 7 para 9(7).

ANNEX 5 –THE MODEL RULES FOR ELECTIONS

(Paragraph 10.2)

Model Rules for Elections

Reviewed October 2017

CONTENTS

Part 1 - Interpretation

1. Interpretation

(1) In these rules, unless the context otherwise requires –

"the Trust"	means the public benefit corporation subject to this constitution;
"election"	means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;
"the regulator"	means the Independent Regulator for NHS foundation trusts; and
"the 2006 Act"	means the National Health Service Act 2006.

(2) Other expressions used in these rules and in Schedule 7 to the National Health Service Act 2006 have the same meaning in these rules as in that Schedule.

Part 2 – Timetable for election

2. Timetable

The proceedings at an election shall be conducted in accordance with the following timetable.

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

(1) In computing any period of time for the purposes of the timetable –

(a) Saturday or Sunday;
(b) Christmas day, Good Friday, or a bank holiday, or
(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3 – Returning officer

4. Returning officer

(1) Subject to rule 64, the returning officer for an election is to be appointed by the Trust.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

The Trust is to pay the returning officer –

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the Trust may determine.

7. Duty of co-operation

The Trust is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election

The returning officer is to publish a notice of the election stating –

(a) the constituency, or class within a constituency, for which the election is being held,
(b) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
(c) the details of any nomination committee that has been established by the Trust,
(d) the address and times at which nomination papers may be obtained;
(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,
(f) the date and time by which any notice of withdrawal must be received by the returning officer
(g) the contact details of the returning officer, and
(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

(1) Each candidate must nominate themselves on a single nomination paper.

(2) The returning officer-

(a) is to supply any member of the Trust with a nomination paper, and
(b) is to prepare a nomination paper for signature at the request of any member of the Trust, but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's consent and particulars

(1) The nomination paper must state the candidate's -

(a) full name,

(b) contact address in full (which should be a postal address), and constituency or class within a constituency, of which the candidate is a member. An e-mail address may also be provided for the purposes of electronic communication).

11. Declaration of interests

The nomination paper must state –

(a) any financial interest that the candidate has in the Trust, and

(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

The nomination paper must include a declaration made by the candidate–

(a) that he or she is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

The nomination paper must be signed and dated by the candidate, indicating that –

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination

(1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer-

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination paper is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds -

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of nominated candidates –

(1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show –

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the Trust as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers

(1) The Trust is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15 (4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the Trust is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates

A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

(1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of Members to be elected to the council of Governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of Members to be elected to the council of Governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of Members to be elected to be council of Governors, then –

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the Trust.

Part 5 – Contested elections

19. Poll to be taken by ballot

(1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper

(1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify –

(a) the name of the Trust,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of Governors to be elected from that constituency, or class within that constituency,
(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) instructions on how to vote,
(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity public constituency

(1) In respect of an election for a public constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter is the person to whom the ballot paper was addressed,
(b) that the voter has not marked or returned any other voting paper in the election, and
(c) for a member of the public constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,
(b) the address of the voter,
(c) the voter's signature, and
(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

(1) The Trust is to provide the returning officer with a list of the Members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll

The returning officer is to publish a notice of the poll stating–

(a) the name of the Trust,
(b) the constituency, or class within a constituency, for which the election is being held,
(c) the number of members of the council of Governors to be elected from that constituency, or class with that constituency,
(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
(f) the address for return of the ballot papers, and the date and time of the close of the poll,
(g) the address and final dates for applications for replacement ballot papers, and
(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer

(1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the Trust named in the list of eligible voters–

(a) a ballot paper and ballot paper envelope,
(b) a declaration of identity (if required),
(c) information about each candidate standing for election, pursuant to rule 59 of these rules, and
(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25.1 E-voting systems

25.1.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

25.1.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

25.1.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

25.1.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

25.1.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in

respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

25.1.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

26. Eligibility to vote

An individual, who becomes a member of the Trust on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance

(1) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers

(1) – If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she –

(a) is satisfied as to the voter's identity, and
(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers") –

(a) the name of the voter, and
(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers

(1) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement ballot paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she –

(a) is satisfied as to the voter's identity,
(b) has no reason to doubt that the voter did not receive the original ballot paper, and
(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers") –

(a) the name of the voter, and
(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper

(1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers") –

(a) the name of the voter, and
(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers public constituency

(1) In respect of an election for a public constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration –

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and

(b) of the particulars of that member's qualification to vote as a member of the public constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for –

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents

(1) Where the returning officer receives a –

(a) covering envelope, or

(b) any other envelope containing a declaration of identity if required, a ballot paper envelope, or a ballot paper, before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to –

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper

(1) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to –

(a) put the declaration of identity if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to –

(a) mark the ballot paper "disqualified",

(b) if there is a declaration of identity accompanying the ballot paper, mark it as "disqualified" and attach it the ballot paper,

(c) record the unique identifier on the ballot paper in a list (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper public constituency

Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to –

(a) mark the declaration of identity "disqualified",
(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and
(c) place the declaration of identity in a separate packet.

35. Sealing of packets

As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing–

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the declarations of identity if required,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

36. Interpretation of Part 6

In Part 6 of these rules –

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot paper –

(a) on which no second or subsequent preference is recorded for a continuing candidate, or
(b) which is excluded by the returning officer under rule 44 (4) below,

"preference" as used in the following contexts has the meaning assigned below–

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,
(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which

clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule 41 below,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable papers from the candidate who has the surplus,

"stage of the count" means –

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"transferable paper" means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with paragraph (4) or (7) of rule 42 below.

37. Arrangements for counting of the votes

The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count

(1) The returning officer is to –
(a) count and record the number of ballot papers that have been returned, and
(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

39. Rejected ballot papers

(1) Any ballot paper –

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,
(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

40. First stage

(1) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

41. The quota

(1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 44 has been complied with.

42. Transfer of votes

(1) Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped –

(a) according to next available preference given on those papers for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of nontransferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (1) above.

(3) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1) (a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall be at a value (“the transfer value”) which –

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred

by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped –

(a) according to the next available preference given on those papers for any continuing candidate, or
(b) where no such preference is given, as the sub-parcel of nontransferable votes.

(6) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5) (a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at –

(a) a transfer value calculated as set out in paragraph (4) (b) above, or
(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are –

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

43. Supplementary provisions on transfer

(1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if –

(a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule 42 above –

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,
(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
(d) compare—
(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule 42 or 44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be, all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule 42 or 44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a nontransferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

44. Exclusion of candidates

(1) If—

(a) all transferable papers which under the provisions of rule 42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred, and
(b) subject to rule 45 below, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where paragraph (12) below applies, the candidates with the then lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels so that they are grouped as—
(a) ballot papers on which a next available preference is given, and
(b) ballot papers on which no such preference is given (thereby including ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule 43 above, transfer each sub-parcel of ballot papers referred to in paragraph (2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule 45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which

that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule —

(a) record –
    (i) the total value of votes, or
    (ii) the total transfer value of votes transferred to each candidate,
(b) add that total to the previous total of votes recorded for each candidate and record the new total,
(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
(d) compare—
    (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
    (ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule 42 and rule 43.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest—

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

45. Filling of last vacancies

(1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

46. Order of election of candidates

(1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 42

(10) above.

(2) A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

Part 7 – Final proceedings in contested and uncontested elections

47. Declaration of result for contested elections

(1) In a contested election, when the result of the poll has been ascertained, the returning officer is to—

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
(b) give notice of the name of each candidate who he or she has declared elected –
    (i) where the election is held under a proposed constitution pursuant to powers conferred on the Dudley Group of Hospitals NHS Trust by section 4(4) of the 2006 Act, to the chairman of the NHS Trust, or
    (ii) in any other case, to the chairman of the Trust, and
(c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make –

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,
(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
(d) the order in which the successful candidates were elected, and
(e) the number of rejected ballot papers under each of the headings in rule 39 (1),

available on request.

48. Declaration of result for uncontested elections

In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election –

(a) declare the candidate or candidates remaining validly nominated to be elected,
(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the Trust, and
(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8 – Disposal of documents

49. Sealing up of documents relating to the poll

(1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets –

(a) the counted ballot papers,
(b) the ballot papers endorsed with “rejected in part”,
(c) the rejected ballot papers, and
(d) the statement of rejected ballot papers

(2) The returning officer must not open the sealed packets of –
(a) the disqualified documents, with the list of disqualified documents inside it,
(b) the declarations of identity,
(c) the list of spoilt ballot papers,
(d) the list of lost ballot papers,
(e) the list of eligible voters, and
(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of –
(a) its contents,
(b) the date of the publication of notice of the election,
(c) the name of the corporation to which the election relates, and
(d) the constituency, or class within a constituency, to which the election relates.

50. Delivery of documents

Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, the returning officer is to forward them to the chair of the Trust.

51. Forwarding of documents received after close of the poll

Where –
(a) any voting documents are received by the returning officer after the close of the poll, or
(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

52. Retention and public inspection of documents

(1) The Trust is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53 (1), the documents relating to an election that are held by the Trust shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the Trust, and the Trust is to provide it, and may impose a reasonable charge for doing so.

53. Application for inspection of certain documents relating to an election

(1)The Trust may not allow the inspection of, or the opening of any sealed packet containing

(a) any rejected ballot papers, including ballot papers rejected in part,
(b) any disqualified documents, or the list of disqualified documents,
(c) any counted ballot papers,
(d) any declarations of identity, or
(e) the list of eligible voters,

by any person without the consent of the regulator.

(2) A person may apply to the regulator to inspect any of the documents listed in (1), and the regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

(3) The regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,
(b) time,
(c) place and mode of inspection,
(d) production or opening,

and the Trust must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), –

(a) in giving its consent, the regulator, and
(b) and making the documents available for inspection, the Trust,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and
(ii) that the regulator has declared that the vote was invalid.

Part 9 – Death of a candidate during a contested election

54. Countermand or abandonment of poll on death of candidate

(1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to –

(a) publish a notice stating that the candidate has died, and
(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
  (i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
  (ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49 (1) (a).

Part 10 – Election expenses and publicity Election expenses

55. Election expenses

Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the Regulator under Part 11 of these rules.

56 Expenses and payments by candidates

A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to –

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100 (to be reviewed after first elections).

These expenses are to be met by the candidate, not by the Trust.

57. Election expenses incurred by other persons

(1) No person may -

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the Trust from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58. Publicity about election by the Trust

(1) The Trust may –

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the Trust about the candidates, including information compiled by the Trust under rule 59, must be –

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates (as far as the information provided by the candidates so allows),
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the Trust proposes to hold a meeting to enable the candidates to speak, the Trust must ensure that all of the candidates are invited to attend,

and in organising and holding such a meeting, the Trust must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59. Information about candidates for inclusion with voting documents

(1) The Trust must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2) The information must consist of –

(a) a statement submitted by the candidate of no more than 200 words, and

(b) a passport type photograph of the candidate

if provided by the candidate.

60. Meaning of "for the purposes of an election"

(1) In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part 11 – Questioning elections and the consequence of irregularities

61. Application to question an election

(1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the regulator by -

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must –

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

a. The regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the regulator.

b. The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the Trust, the applicant and the Members of the constituency (or class within a constituency) including all the candidates for the election to which

the application relates.

c. The regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12 – Miscellaneous

62. Secrecy

(1) The following persons –

(a) the returning officer,
(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to –

(i) the name of any member of the Trust who has or has not been given a ballot paper or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the candidate(s) for whom any member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63. Prohibition of disclosure of vote

No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification

A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is –

(a) a member of the Trust,
(b) an employee of the Trust,
(c) a director of the Trust, or
(d) employed by or on behalf of a person who has been nominated for election.

65. Delay in postal service through industrial action or unforeseen event

If industrial action, or some other unforeseen event, results in a delay in –

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the regulator.

66. Effect of administrative or clerical errors on election

Elections shall not be invalidated by any administrative or clerical error on the part of the Trust or any acts or omissions of the returning officer or the independent scrutineer acting in good faith on the basis of any such error.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

1. they are a Director of the Trust, or a Governor or Director of another NHS Body, or of an independent/private sector health care provider. These restrictions do not apply to Appointed Partnership Governors;

2. they are under sixteen years of age;

3.being a member of a public constituency, they were or were entitled to be a member of one of the classes of the staff constituency at any point during the preceding two years;

4. being a member of one of the public constituencies, they refuse to sign a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

5. they are the subject of a sex offender order;

6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, expiry of a fixed term contract, disability, ill health or age from any paid employment with a health service body. In other cases of dismissal, such as capability, an individual may be permitted to become a governor, at the discretion of the trust, and subject to full disclosure of the relevant circumstances and facts concerning that dismissal;

7. they are a person whose tenure of office as the Chairman or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for nonattendance at meetings, or for non-disclosure of a pecuniary interest;

8. they have had their name removed, by a direction under section 46 of the 1977 NHS Act from any list prepared under Part II of that Act or have otherwise been disqualified or suspended from any healthcare profession, and have not subsequently had their name included in such a list or had their qualification re-instated or suspension lifted (as applicable);

9. they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs;

10. they are an elected governor and they cease to be a member of the constituency or class by which they were elected. This may include, but is not restricted to, the reasons for ceasing to be a member identified in Annex 9;

11. they are a non elected governor and they cease to be sponsored by their organisation. A person who ceases to be a governor could continue to attend the Council of Governors in an advisory capacity, if the Council of Governors so wishes, although they would not have voting rights;

12. they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;

13. they are a member of a local authority's Overview and Scrutiny Committee covering health matters;

14. they are a member of the Healthwatch relating to this Foundation Trust;

15. they fail to or indicate that they are unwilling to act in the best interests of the Trust and in accordance with The Seven Principles of Public Life laid out by the Committee on Standards in Public Life in its First Report as amended from time to time.

16. they fail to agree (or, having agreed, fail) to abide by the values of the Trust Principles set out in Annex 10.

17. Governors are required to attend mandatory training, as defined from time to time, provided by the Trust on their role and function.

18. consistently and unjustifiably fail to maintain attendance at Full Council of Governor meetings as defined within the Code of Conduct for Governors.

19. if in applying for a Staff Governor position their contract of employment is shorter that the prescribed term of office for that role.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 14)

Standing Orders
Council of Governors

September 2015

CONTENTS

1. INTRODUCTION

Statutory Framework

The Dudley Group NHS Foundation Trust is a statutory body which became a public benefit corporation following its approval as an NHS Foundation Trust by the Independent Regulator of NHS Foundation Trusts (Independent Regulator) pursuant to the National Health Service Act 2006 (the 2006 Act).

The principal places of business of the Trust are:

- Russells Hall Hospital, Pensnett Road, Dudley, West Midlands, DY1 2HQ
- Corbett Hospital Outpatient Centre, Vicarage Road, Stourbridge, West Midlands, DY8 4JB
- Guest Hospital Outpatient Centre, Tipton Road, Dudley, West Midlands, DY1 4SE

NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 Act, by their constitutions and by terms of their authorisation granted by the Independent Regulator (Regulatory Framework).

The functions of the Trust are conferred by the Regulatory Framework. As a body corporate it has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

The Regulatory Framework requires the Council of Governors to adopt Standing Orders (SOs) for the regulation of its proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Trust Secretary).

2.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in the interpretation and in addition:

"TRUST" means The Dudley Group NHS Foundation Trust.

"COUNCIL OF GOVERNORS" means the Council of Governors of the Trust as defined in the Constitution.

"BOARD OF DIRECTORS" means the Chair, Executive and Non-Executive Directors of the Trust collectively as a body.

"CHAIR OF THE BOARD" or "Chair of the Trust" is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expressions "the Chair of the Board" and "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" means the Chief Executive Officer of the Trust.

"COMMITTEE" means a committee of the Council of Governors

"CONSTITUTION" means the constitution of the Foundation Trust.

"COMMITTEE MEMBERS" means the Chair and the Governors or Directors formally appointed by the Council of Governors or Board of Directors to sit on or to chair specific committees.

"DEPUTY CHAIR" means the non-executive director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

"EXECUTIVE DIRECTOR" means a Member of the Board of Directors who holds an executive office of the Trust.

"MEMBER OF THE COUNCIL" means a Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the Chair).

"NON-EXECUTIVE DIRECTOR" means a member of the Board of Directors who does not hold an executive office with the Trust. These may be referred to as voting and non-voting where appropriate.

"OFFICER" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

"SOs" means these Standing Orders.

“SECRETARY TO THE TRUST” means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust’s compliance with the Regulatory Framework and these standing orders.

3. THE COUNCIL OF GOVERNORS

3.1 Composition of the Council of Governors

3.1.1 In accordance with the Constitution of the Foundation Trust, the composition of the Council of Governors shall be reviewed from time to time and currently comprises:

- 13 Public Governors
- 8 Staff Governors
- 1 Primary Care Trust Governor
- 1Local Authority Governor
- 1 University Governor
- 1voluntary organisation Governor
  -

3.2 Role of the Chair

3.2.1 The Chair is not a member of the Council of Governors. However under the Regulatory Framework, he or she presides at meetings of the Council of Governors and has a casting vote.

3.2.2 Where the Chair of the Trust has died or has ceased to hold office, or where he or she has been unable to perform his or her duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes his or her duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform his or her duties, be taken to include references to the Deputy Chair.

3.3 Role and Responsibilities of the Council of Governors

3.3.1 The role and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust Constitution, are:

- To appoint and remove the Chair and other voting Non-executive Directors of the Foundation Trust at a general meeting. To approve (by a majority of members of the Council of Governors) the appointment by the Non-Executive Directors of the Chief Executive
- To appoint or remove the auditor at a general meeting
- To be consulted by the Trust's Board of Directors on forward planning and to have the Council of Governors' views taken into account
- To be presented with, at a Members' general meeting, the Annual Report and Accounts and the report of the auditor

3.3.2 The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its Directors. The Council of Governors does not have the right to veto decisions made by the Board of Directors.

3.3.3 The Council of Governors, and individual Governors, are not empowered to speak on behalf of the Trust, and must seek the advice and views of the Chair concerning any contact from the media or any invitation to speak publicly about the Trust or their role within it. For the

avoidance of doubt, in this context the Chair acts as Chair of the Trust not as Chair of the Council of Governors and in his or her absence Governors should seek the advice and views of the Deputy Chair of the Trust or another non-executive Director of the Trust.

4. MEETINGS OF THE COUNCIL

4.1 Admission of the Public

4.1.1. The public shall be afforded facilities to attend all formal meetings of the Council of Governors except where the Council resolves:

(a) That members of the public be excluded from the remainder of a meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public; and/or

(b) That in the interests of the public order the meeting adjourn for a period to be specified in such resolution to enable the Council to complete business without the presence of the public.

4.1.2 Nothing in these Standing Orders shall require the Council to allow members of the public to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council.

4.2 Calling Meetings

4.2.1 Ordinary meetings of the Council shall be held at such times and places as the Board may determine and there shall be not less than 3 or more than 4 formal meetings in any year except in exceptional circumstances.

4.2.2 The Chair of the Trust may call a meeting of the Council at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one third of the whole number of members of the Council, has been presented to him or her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him or her at Trust's Headquarters, such one third or more members of the Council may forthwith call a meeting.

4.3 Notice of Meetings

4.3.1 Before each meeting of the Council, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on his or her behalf shall be delivered to every Member of the Council, or sent by post to the usual place of residence of such Member of the Council, so as to be available to him or her at least three clear days before the meeting.

4.3.2 Want of service of the notice on any Member of the Council shall not affect the validity of a meeting.

4.3.3 In the case of a meeting called by members of the Council in default of the Chair, the notice shall be signed by those Members of the Council and no business shall be transacted at the meeting other than specified in the notice.

4.3.4 Agendas will be sent to Members of the Council before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency.

4.3.5 Before each meeting of the Council a public notice of the time and place of the meeting shall be displayed at the Trust's offices at least three clear days before the meeting.

4.4 Setting the Agenda

4.4.1 The Council may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

4.4.2 A Member of the Council desiring a matter to be included on an agenda shall make his or her request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

4.5 Petitions

4.5.1 Where a petition has been received by the Trust, the Chair of the Council shall include the petition as an item for the agenda of the next Council meeting.

4.6 Chair of Meeting

4.6.1 At any meeting of the Council, the Chair of the Trust, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if he or she is present, shall preside. If the Chair and Deputy Chair are absent such Non-Executive Director as the Members of the Council present shall choose shall preside. Where the Chair of the Trust, Deputy Chair and other Non-Executive Directors are all absent or have a conflict of interest, the Council of Governors shall select one of their number to preside at the meeting. The person presiding at the meeting shall have a casting vote.

4.6.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive Director as the Members of the Council present shall choose, shall preside. Where the Chair, Deputy Chair Lead Governor and other Non-Executive Directors are all absent or have a conflict of interest, an appropriate representative will be appointed from amongst the Council of Governors to preside at the meeting and have a casting vote.

4.7 Notices of Motion

4.7.1 A Member of the Council desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the

appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

4.8 Withdrawal of Motion or Amendments

4.8.1 A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.9 Motion to Rescind a Resolution

4.9.1 Notice of a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Member of the Council who gives it and also the signature of four other Council Members. When any such motion has been disposed of by the Council, it shall not be competent for any member other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if he or she considers it appropriate.

4.10 Motions

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

4.10.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Council to move:

- an amendment to the motion
- the adjournment of the discussion or the meeting
- that the meeting proceed to the next business (*)
- the appointment of an ad hoc committee to deal with a specific item of business
- that the motion be now put. (*)
- a motion resolving to exclude the public under SO 4.1.1.

(*) In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Member of the Council who has not previously taken part in debate and who is eligible to vote.

No amendment to the motion shall be admitted, if in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

4.11 Chair's Ruling

Statements of Members of the Council made at meetings of the Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.12 Voting

4.12.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Members of the Council present and voting on the question and, in the case of number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

4.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Council present so request.

4.12.3 If at least one-third of the Members of the Council present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Council present voted or abstained.

4.12.4 If a Member of the Council so requests, his or her vote shall be recorded by name upon any vote (other than paper ballot).

4.12.5 In no circumstances may an absent Member of the Council vote by proxy. Absence is defined as being absent at the time of the vote.

4.13 Minutes

4.13.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding as Chair at it.

4.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the meeting.

4.13.3 Minutes shall be circulated in accordance with the members' wishes. Minutes will be published on the Trust website within six weeks of the full Council of Governors meeting.

4.14 Suspension of Standing Orders

4.14.1 Except where this would contravene any statutory provision or any direction made by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, including two public Governors, and that a majority of those present vote in favour of suspension.

4.14.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.14.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Members of the Council.

4.14.4 No formal business may be transacted while Standing Orders are suspended.

4.15 Variation and Amendment of Standing Orders

4. 15.1 These Standing Orders shall be amended only if:

- a notice of a motion under Standing Order 4.7 has been given; and
- no fewer than half the total of the Corporation's Governors vote in favour of amendment; and
- at least two-thirds of the Council Members are present; and

- the variation proposed does not contravene a statutory provision or direction made by the Independent Regulator.

4.16 Record of Attendance

4.16.1 The names of the Chair and Members of the Council present at the meeting shall be recorded in the minutes. Apologies received from Members of the Council shall also be recorded in the minutes.

4.17 Quorum

4.17.1 No business shall be transacted at a meeting unless at least eight Governors are present of which at least five are public Governors.

4.17.2 If a Member of the Council has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6, 7 or 8) he or she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5. COMMITTEES

5.1 Subject to the Regulatory Framework and such guidance as may be issued by the Independent Regulator, the Council may, and if so required by the Independent Regulator, shall, appoint committees of the Council to assist the Council in the proper performance of its functions under the Constitution and the Regulatory Framework, consisting wholly of the Chair and Members of the Council of Governors.

5.2 A committee appointed under this regulation may, subject to such guidance as may be given by the Independent Regulator or restriction imposed by the Council, appoint sub-committees consisting wholly of members of the committee.

5.3 The Standing Orders of the Council, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council. In which case the term "Chair" is to be read as a reference to the Chair of the Committee as the context permits, and the term "Member of the Council" is to be read as a reference to a member of the committee also as the context permits.

5.4 Subject to Standing Order 5.5, each sub-committee shall have such terms of reference and power and be subject to such conditions (as to reporting back to the Council), as the Council shall decide and shall be in accordance with the Regulatory Framework and any guidance issued by the Independent Regulator. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Council may not delegate any decision-making or executive powers to any committee or sub-committee.

5.6 The Council shall approve the appointments to each of the committees which it has formally constituted.

5.7 The committees and sub-committees established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

6.1.1 The Regulatory Framework requires Council Members to declare interests which are relevant and material to the Council of which they are a Member. All existing Council Members should declare such interests. Any Council Members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as "relevant and material" are defined in the Trust's Constitution as follows:

any pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors

6.1.3 At the time Council Members' interests are declared, they should be recorded in the Council minutes. Any changes in interests should be declared at the next Council meeting following the change occurring.

6.1.4 Council Members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.1.5 There is no requirement for the interests of Council Members' spouses or partners to be declared. However Standing Order 7, which is based on the regulations, requires that the interests of Members of the Council's spouses, if living together, in contracts should be declared. Therefore the interests of Council Members' spouses and cohabiting partners should also be regarded as relevant.

6.1.6 If during the course of any meeting, a conflict of interest arises as defined at para 6.1.2, it is the responsibility of the Chair to ensure the meeting is held in such a way as to ensure free and full debate, without undue or improper influence from any interested party, and that all parties present are fully aware of the interests of all other Governors of the Foundation Trust.

6.1.7 In pursuance of the above the Chair may take any or all of the following steps;

1. The Chair may remind the meeting of the role and responsibility of the Governors, as set out in the FT Constitution and these Standing Orders.
2. The Chair may require any Governor to remind the meeting of his or her interest.
3. The Chair may require any Governor that the Chair considers has a conflict to play no part during any discussion on the relevant issue.
4. The Chair may require any Governor that the Chair considers has a conflict to withdraw from the meeting room during the relevant discussion or debate.

Before taking the steps 3 or 4, the Chair shall allow representations from the Governor concerned. The decision of the Chair on these matters is final.

6.1.8 If any person believes that any Governor has any conflict of interest that has not been declared, or is trying to exert undue or improper influence on any other person in any way, in

any matter connected with the Foundation Trust, that person may make representations to the Trust Chair. Representations may be verbal or in writing and shall detail the nature of the alleged conflict or undue influence complained of.

6.1.9 Upon receipt of such a representation, the Chair will communicate with the Governor concerned, and allow that Governor an opportunity to respond fully to the representation. Upon receipt of the response he or she shall make a decision about the contribution of that Governor at subsequent meetings, and shall have the range of options as detailed at para. 6.1.7 above.

6.2 Register of Interests

6.2.1 The Secretary to the Trust will ensure that a Register of Interests is established to record formally declarations of interests of Council Members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by Council Members, as defined in Standing Order 6.1.2.

6.2.2 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared will be incorporated.

6.2.3 The Register will be available to the public and the Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.2.4 In establishing, maintaining, updating and publicising the Register, the Trust shall comply with all guidance issued from time to time by the Independent Regulator.

7. DISABILITY OF CHAIR AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chair or another Member of the Council has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he or she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council may exclude the Chair (or Member of the Council) from a meeting of the Council while any contract, proposed contract or other matter in which he or she has pecuniary interest, is under consideration.

7.3 For the purpose of this Standing Order the Chair or Member of the Council shall be treated, subject to SO 7.4, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

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

or

(b) he or she, is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration. And in the case of married persons living together or persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also the interest of that partner.

7.4 The Chair or a member of the Council shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

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

(b) of an interest in a company, body or person with which he or she is connected as mentioned in SO 7.3 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Member of the Council in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.5 Where a Governor:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he or she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him or her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his or her duty to disclose his or her interest.

7.6 The Standing Order applies to a committee or sub-committee and to a joint committee as it applies to the Council and applies to a Member of the Council of any such committee or sub-committee as it applies to a Member of the Council.

8. STANDARDS OF BUSINESS CONDUCT POLICY

8.1 Governors should comply with the Trust Constitution, the NHS principles of conduct, as defined by the NHS Appointments Commission, the NHS Constitution, the NHS Foundation Trust Code of Governance, published by the Independent Regulator, the requirements of the Regulatory Framework, the Trust Code of Conduct for Governors, and any guidance and directions issued by the Independent Regulator. In addition, they must adhere to the Trust Principles, given as Annex 10 to the Foundation Trust Constitution and the Trust's Policy on Business Conduct.

8.2 Interest of Governors in Contracts

8.2.1 If it comes to the knowledge of a Governor that a contract in which he or she has any pecuniary interest not being a contract to which he or she is a party, has been, or is proposed to be, entered into by the Trust he or she shall, at once, give notice in writing to the Secretary of the Trust of the fact that he or she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.2.2 A Governor should also declare to the Secretary of the Trust any other employment or business or other relationship of his or hers, or of a cohabitating spouse, which might reasonably be predicted could conflict with the interests of the Trust.

8.3 Canvassing of, and Recommendations by Members of the Council in Relation to Appointments

8.3.1 Canvassing of Governors of the Trust or of any Committee of the Council of Governors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment.

8.3.2 A Member of the Council shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Member of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.4 Relatives of Members of the Council or Officers

8.4.1 Candidates for any staff appointment under the Trust, shall when making application, disclose in writing to the Trust whether they are related to any Member of the Board of Directors or Council of Governors or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him or her liable to instant dismissal.

8.4.2 The Chair and every Member of the Council and officer of the Trust shall disclose to the Chief Executive any relationship between him or herself and a candidate of whose candidature that Member of the Council or Officer is aware.

8.4.3 On appointment, Members of the Council (and prior to acceptance of an appointment in the case of officer members) should disclose to the Council whether they are related to any other Member of the Council or holder of any office in the Trust.

8.4.4 Where the relationship to a Member of the Council of the Trust is disclosed, the Standing Order headed Disability of Chair and Members of the Board in proceedings on account of pecuniary interest (SO 7) shall apply.

9. MISCELLANEOUS

9.1 Standing Orders to be given to Members of the Council

9.1.1 It is the duty of the Secretary to the Trust to ensure that existing Members of the Council and all new appointees are notified of and understand their responsibilities within these Standing Orders. New Members of the Council shall be informed in writing and shall receive copies where appropriate in Standing Orders.

9.2 Review of Standing Orders

9.2.1 Standing Orders shall be reviewed annually. The requirements for review extends to all documents having the effect as if incorporated in Standing Orders.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 26 and Note 26)

Standing Orders for the Practice and Procedure of the Board of Directors

September 2015

(Reviewed October 2017)

FOREWORD

NHS Foundation Trusts are obliged by NHS Improvement to have Standing Orders for their Board of Directors in relation to the disclosure of interests and arrangements for exclusion of a director disclosing an interest from discussion or consideration of the matter in respect of which an interest has been disclosed. It is also suggested by NHS Improvement that Standing Orders be adopted relating to other aspects of the Board's practice and procedure.

The following revised Standing Orders and attached Scheme of Delegation, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfill the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework. All executive directors and voting and non-voting Non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

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INTRODUCTION

Statutory Framework

The Dudley Group NHS Foundation Trust (the Trust) is a body corporate which became a public benefit corporation following its approval as an NHS Foundation Trust by the Independent Regulator of NHS Foundation Trusts (Independent Regulator) pursuant to the National Health Service Act 2006 (the 2006 Act).

The principal places of business of the Trust are Russells Hall Hospital, Corbett Outpatient Centre, Guest Outpatient Centre and the Community of Dudley.

NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 Act, by their constitutions and by the terms of their authorisation granted by the Independent Regulator (the Regulatory Framework).

The functions of the Corporation are conferred by the Regulatory Framework.

As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit. Delegated Powers are covered in a separate document (Scheme of Delegation). That document has effect as if incorporated into the Standing Orders.

1 INTERPRETATION

1.1 Save as permitted by law and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he or she should be advised by the Trust Secretary).

1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and where there is a conflict between the 2006 Act and another legislative provision the 2006 Act interpretation shall prevail (unless, in either case, the context otherwise requires) and in addition:

"ACCOUNTING OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. He or she shall be responsible for ensuring the proper stewardship of public funds and assets and performing the functions delegated to him or her by the Constitution in relation to the Trust's accounts. For this Trust it shall be the Chief Executive.

"TRUST" means the The Dudley Group NHS Foundation Trust.

"BOARD OF DIRECTORS" and (unless the context otherwise requires) "BOARD" shall mean the Chairman and other non-executive directors, and the executive directors appointed by the relevant committee of the Trust.

"BOARD OF GOVERNORS" means the Council of Governors of the Trust.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"CHAIRMAN" is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" shall mean the Chief Executive Officer of the Trust.

"COMMITTEE" shall mean a committee of the Board of Directors.

"COMMITTEE MEMBERS" shall be the directors formally appointed by the Trust to sit on or to chair specific committees.

"CONSTITUTION" means the constitution of the Trust.

"DEPUTY CHAIRMAN" means the non-executive director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

"DIRECTOR" shall mean a person appointed as a director in accordance with the Constitution and includes the Chairman.

"FINANCE DIRECTOR" shall mean the chief finance officer of the Trust.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds on trust at its date of authorisation as an NHS Foundation Trust or chooses subsequently to accept. Such funds may or may not be charitable.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"OFFICER" means an employee of the Trust.

"SFIS" means Standing Financial Instructions.

"SOS" means Standing Orders.

"SECRETARY TO THE TRUST" means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the Regulatory Framework and these standing orders.

2. THE TRUST

2.1 All business shall be conducted in the name of the Trust.

2.2 The Trust has the functions conferred on it by the Regulatory Framework.

2.3 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. Those powers and decisions delegated by the Board are set out in the "Scheme of Delegation", which has effect as if incorporated into the Standing Orders.

2.6 **Composition of the Board** - In accordance with, but always subject to, the provisions of the Constitution, the composition of the Board shall be:

- The Chairman of the Trust
- Up to 5 other non executive directors excluding the Chairman
- 5 Executive directors including:
  - The Chief Executive (and accounting officer)
- The Director of Finance
  - A medical or dental practitioner
  - A registered nurse
  - The Director of Operations

2.7 **Appointment of the Chairman and other voting and Non-executive Directors** - The Chairman and the other voting and Non-executive Directors are appointed by the Council of Governors.

2.8 **Appointment of the Executive Directors** - The Chief Executive is appointed by the Non-executive Directors, subject to the approval of the Council of Governors. The other Executive Directors are appointed by a committee consisting of the Chairman, the other Non-executive Directors and the Chief Executive.

2.9 **Terms of Office of the Chairman and other Directors** - The regulations setting out the period of tenure of office of the Chairman and other Directors and for the termination or suspension of office of the Chairman and other Directors are contained in the Constitution of the Trust.

2.10 **Appointment of Deputy Chairman** - Subject to SO 2.11 below, the Council of Governors will appoint one of the Non-Executive Directors to be Deputy Chairman, for such period, not exceeding the remainder of his or her term as a Director, as they may specify on appointing him or her.

2.11 Any Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Council of Governors may thereupon appoint another

Non-executive Director as Deputy Chairman in accordance with the provisions of Standing Order 2.10

2.12 **Powers of Deputy Chairman** - Where the Chairman of the Trust has died or has ceased to hold office, or where he or she has been unable to perform his or her duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his or her duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his or her duties, be taken to include references to the Deputy Chairman.

2.13 **Appointment and Powers of Senior Independent Director** - Subject to SO 2.14 below, the Chairman (in consultation with the Non-executive Directors and the Council of Governors) may appoint any Director, who is also a Non-executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his or her term as a Director, as they may specify on appointing him or her. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Job Description", as amended from time to time by resolution of the Board.

2.14 Any Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman. The Chairman (in consultation with the Non-executive Directors and the Council of Governors) may thereupon appoint another Member of the Board as Senior Independent Director in accordance with the provisions of Standing Order 2.13.

2.15 The role of the Deputy Chairman will include deputising for the Chairman during absences. The Senior Independent Director will act as a conduit for concerns to be raised by Governors if the usual mechanisms of contact and discussion have been exhausted, and making arrangements for the annual evaluation of the performance of the Chairman. The process to achieve this evaluation and its outcome will be agreed with and reported to the Council of Governors.

2.16 If the Senior Independent Director is also the Deputy Chairman and he or she is acting in the capacity of the Chairman, another Non-executive director will be identified by the Board of Directors as fulfilling the role of Senior Independent Director on a temporary basis. Where there is a need for the Deputy Chairman to act in the capacity of Chairman for an extended period, the Board of Directors will agree the appointment of a different Senior Independent Director with the Council of Governors, until the Deputy Chairman is able to resume this role.

3. MEETINGS OF THE TRUST

3.1 **Calling Meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine.

3.2 The Chairman may call a meeting of the Board at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him or her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him or her, at the Trust's Headquarters, such one third or more directors may forthwith call a meeting.

3.3 **Notice of Meetings** - Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer of the Trust authorised by the Chairman to sign on his or her behalf shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to him or her at least three clear days before the meeting.

3.4 Lack of service of the notice on any director shall not affect the validity of a meeting.

3.5 In the case of a meeting called by directors in default of the Chairman, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.6 Failure to serve such a notice on more than three directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.7 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

3.8 A director desiring a matter to be included on an agenda shall make his or her request in writing to the Chairman at least 10 clear days before the meeting, subject to Standing Order 3.3. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.9 **Chairman of Meeting** - At any meeting of the Board, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he or she is present, shall preside. If the Chairman and Deputy Chairman are absent such Non-executive director as the directors present shall choose shall preside.

3.10 If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

3.11 **Notices of Motion** - A director of the Board desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible

under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to Standing Order 3.5.

3.12 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

3.13 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the director(s) who gives it and also the signature of 3 other directors. When any such motion has been disposed of by the Board, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within 6 months; however the Chairman may do so if he or she considers it appropriate.

3.14 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.15 When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.

No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

3.16 **Chairman's Ruling** - Statements of directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.17 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question. In the case of any equality of votes, the Chairman shall have a further or casting vote.

3.18 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.19 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.20 If a director so requests, his or her vote shall be recorded by name upon any vote (other than by paper ballot).

3.21 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

3.22 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.23 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.24 Minutes shall be circulated in accordance with directors' wishes.

3.25 **Waiver of Standing Orders** - Except where this would contravene any statutory provision or any guidance issued by the Independent Regulator, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-eExecutive Director, and that a majority of those present vote in favour of suspension.

3.26 A decision to waive Standing Orders shall be recorded in the minutes of the meeting.

3.27 The Audit Committee shall review every decision to waive Standing Orders.

3.28 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any guidance issued by the Independent Regulator, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive director and one non-executive director, and that a majority of those present vote in favour of suspension.

3.29 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.30 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

3.31 No formal business may be transacted while Standing Orders are suspended.

3.32 The Audit Committee shall review every decision to suspend Standing Orders.

3.33 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.11 has been given; and

- no fewer than half the total of the Trust's non-executive directors vote in favour of amendment; and

- at least two-thirds of the directors are present; and

- the variation proposed does not contravene a statutory provision or guidance issued by the Independent Regulator.

3.34 **Record of Attendance** - The names and titles of the directors present at the meeting shall be recorded in the minutes.

3.35 **Quorum** - No business shall be transacted at a meeting of the Trust unless at least one-third of the whole numbers of the directors are present including at least one executive director and one non-executive director.

3.36 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) he or she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration Committee).

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Regulatory Framework and such guidance as may be issued by the Independent Regulator, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chairman. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board for minuting.

4.3 **Delegation to Committees** - The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

4.4 The Chief Executive shall prepare a Scheme of Delegation identifying his or her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.

4.5 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director or other executive director to provide information and advise the Board in accordance with any statutory requirements or guidance issued by the Independent Regulator.

4.6 The arrangements made by the Board as set out in the "Scheme of Delegation" shall have effect as if incorporated in these Standing Orders.

4.7 Overriding Standing Orders – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Trust Secretary as soon as possible.

5. COMMITTEES

5.1 **Appointment of Committees** - Subject to the Regulatory Framework and any guidance as may be issued by the Independent Regulator, the Board may and, if so required by the Independent Regulator, shall appoint committees of the Board, consisting wholly of directors of the Board.

5.2 A committee appointed under SO 5.1 may, subject to any guidance issued by the Independent Regulator and to any restriction imposed by the Board, appoint sub-committees consisting wholly of one or more members of the committee.

5.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board.

5.4 Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 The Board shall approve the appointments to each of the committees which it has formally constituted.

5.7 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.8 A director shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of Interests** - The Regulatory Framework requires directors to declare interests which are relevant and material to the board of which they are a director. All existing directors should declare such interests. Any directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are to be interpreted in accordance with the Regulatory Framework:

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of trust in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.

g) Any other commercial interest in the decision before the meeting.

6.3 If directors have any doubt about the relevance of an interest, this should be discussed with the Chairman.

6.4 At the time directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

6.5 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.6 During the course of a board meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.7 There is no requirement for the interests of board directors' spouses or partners to be declared. [Note however that SO 7 requires that the interest of directors' spouses, if living together, in contracts should be declared].

6.8 **Register of Interests** - The Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interests of directors. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both executive and non-executive directors, as defined in SO 6.2.

6.9 These details will be kept up to date by means of a monthly review of the Register in which any changes to interests declared during the preceding twelve month will be incorporated.

6.10 The Register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.11 In establishing, maintaining, updating and publicising the Register, the Trust shall comply at all times with the Regulatory Framework and any guidance issued by the Independent Regulator. In the event of conflict between these Standing Orders and the Regulatory Framework or guidance issued by the Independent Regulator, the latter shall prevail.

6.12 Standing Order 6 applies to a committee or sub-committee of the Board as it applies to the Board.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he or she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Board shall exclude a director from a meeting of the Board while any contract, proposed contract or other matter in which he or she has a pecuniary interest, is under consideration.

7.3 Any remuneration, compensation or allowances payable to a director by the Trust or otherwise by virtue of paragraph 9 of Schedule 2 to the NHS & CC Act 1990 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order a director shall be treated, subject to SO 7.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

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

or

(b) he or she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration and in the case of married persons living together or persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also the interest of that partner.

7.5 A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

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

(b) of an interest in any company, body or person with which he or she is connected as mentioned in SO 7.4 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where a director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) all significant shareholding and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is, or might do business with the NHS

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he or she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him or her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his or her duty to disclose his or her interest.

7.7 Standing Orders 7 apply to a committee or sub-committee of the Board as it applies to the Board.

8. STANDARDS OF BUSINESS CONDUCT

8.1 **Policy** - Staff must comply with the Trust's Policy on Business Conduct which embraces national guidance and requirements, and any guidance issued by the Independent Regulator. In addition, they must adhere to the Trust Principles as stated in Annex 10 of the Foundation Trust Constitution.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself or herself a party, has been, or is proposed to be, entered into by the Trust he or he shall, at once, give notice in writing to the Chief Executive of the fact that he or she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his or her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Chief Executive will ensure that such declarations are formally recorded.

8.4 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of directors or Governors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.5 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him or her liable to instant dismissal.

8.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.9 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office within the Trust.

8.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

9. TENDERING AND CONTRACT PROCEDURE

9.1 **Duty to comply with Standing Orders** - The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 3.26 (Waiver of SOs) is applied).

9.2 **EU Directives Governing Public Procurement** - Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders.

9.3 The Trust shall comply as far as is practicable with the requirements of the DH "Capital Investment Manual". In the case of management consultancy contracts the Trust shall comply as far as is practicable with DH and Treasury guidance. In all cases, the Trust shall comply with any relevant guidance issued by NHS Improvement.

9.4 **Formal Competitive Tendering** - The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services; for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

9.5 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive, as identified in the schedule "Authorised Limits" appended to Standing Financial Instructions. This authority is subject to formal identification of the reason for such waiver, which would normally be one or more of the following reasons:-

(a) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with; or

(b) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

(c) specialist expertise or products is required and is available from only one source; or

(d) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

(e) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

The limited application of the waiver rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

9.6 Except where SO 9.5, or a requirement under SO 9.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, in most cases this will mean a minimum of four firms/individuals but this may differ when there are a limited number of firms/individuals in a specific product/service marketplace, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

9.7 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists (see Annex Section 5). Where in the opinion of the officer responsible for procuring the supply it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see Annex).

9.8 Tendering procedures are set out in the Annex.

9.9 **Quotations** - where the intended expenditure or income is in line with the sum agreed by the Board and incorporated into the Appendix 1 ("Authorised Limits") to the Trust's Standing Financial Instructions.

9.10 Where quotations are required under SO 9.9 they should be obtained from at least three firms/individuals as per the Annex based on specifications or terms of reference prepared by, or on behalf of, the Board.

9.11 Quotations should be in writing unless the Chief Executive or his or her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

9.12 All quotations should be treated as confidential and should be retained for inspection.

9.13 The Chief Executive or his or her nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

9.15 **Where tendering or competitive quotation is not required**

Where tenders or quotations are not required, because expenditure is below the threshold referred to in 9.9 above the Trust shall procure goods and services in accordance with procurement procedures approved by the Board.

9.16 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering (SO 11).

9.17 **Private Finance** - When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) The proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to vires.

(c) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

9.18 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) these Standing Orders;

(b) the Trust's SFIs;

(c) EU Directives and other statutory provisions;

(d) any relevant directions issued by the Regulator;

(e) such of the NHS Standard Contract Conditions as are applicable.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.19 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

9.20 **Personnel and Agency or Temporary Staff Contracts** - The Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of and to authorise regrading of staff, and to enter into contracts for the employment of agency staff or temporary staff.

9.21 **Healthcare Services Contracts** - Unlike contracts made by an NHS Trust, contracts made between an NHS Foundation Trust and other NHS bodies do give rise to contractual rights and liabilities. This rule applies to all types of contract, including for example partnership agreements and contracts for the supply of healthcare.

9.22 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

9.23 **Other Contracts for Services Provided by the Trust -** the Chief Executive shall nominate officers with powers to negotiate such contracts and will ensure that contract documentation is signed by a duly authorised officer.

9.24 **Cancellation of Contracts** - Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved or adopted for use by the Trust and in accordance with Standing Orders 9.2 and 9.3, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward

for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or her or acting on his or her behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him or her or acting on his or her behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916 and other appropriate legislation.

9.25 **Determination of Contracts for Failure to Deliver Goods or Material** - There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

9.26 **Contracts Involving Funds Held on Trust** – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

10. DISPOSALS

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his or her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the procurement policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000.

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which guidance has been issued by the Independent Regulator but subject to compliance with such guidance.

(f) Pharmaceutical and hazardous waste.

(g) IT equipment where disposal requires the specialised removal or destruction of sensitive information stored on such devices.

11. IN-HOUSE SERVICES

11.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer(s) and specialist(s).

(b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support.

(c) Evaluation group, comprising at minimum, a specialist officer, a procurement officer and a representative of the Finance Director. The requirement for Trust Board representation in the evaluation group will be determined by the potential contract value and by reference to the Appendix ("Authorised Limits") to the Trust's Standing Financial Instructions.

11.2 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

11.3 The evaluation group shall make recommendations to the Board.

11.4 The Chief Executive shall nominate an officer to oversee and manage the contract.

12. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

12.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

12.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or otherwise under the authority of the Board through a resolution of the Board formally delegating such authorisation.

12.3 The seal shall be attested by at least two directors and the authorisation may specify which directors shall attest the seal on that occasion.

12.4 **Register of Sealing** – The Trust Secretary will ensure that an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

13. SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

13.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

14. MISCELLANEOUS

14.1 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

14.2 **Documents having the standing of Standing Orders** - Standing Financial Instructions and Scheme of Delegation shall have the effect as if incorporated into SOs.

14.3 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs.

Annex

TENDERING PROCEDURE

1. Invitation to Tender

1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

(a) a plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

(b) in a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

1.2 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 1.3 and 1.4 below.

1.3 Every tender for building and engineering works, except for maintenance work only where Estmancode guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DH.

1.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

2. Receipt, Safe Custody and Record of Formal Tenders

2.1 Formal competitive tenders shall be addressed to the Chief Executive.

2.2 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

2.3 The Chief Executive shall designate an officer or officers, not from the originating department, to receive tenders on his or her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.

3. Opening Formal Tenders

3.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two senior officers designated by the Chief Executive and not from the originating department.

3.2 Every tender received shall be stamped with the date of opening and initialed by two of those present at the opening.

3.3 A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

(a) the names of firms/individuals invited;

(b) the names of and the number of firms/individuals from which tenders have been received;

(c) closing date and time;

(d) date and time of opening;

and the record shall be signed by the persons present at the opening.

3.4 Except as in Section 3.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialed by two of those present at the opening.

3.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure Section 3.4 unreasonable.

4. Admissibility and Acceptance of Formal Tenders

4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

4.2 Tenders received after the due time and date will not be considered unless it is clear that the reason for late receipt is due entirely to an internal failing within the Trust.

4.3 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his or her own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.

4.4 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his or her offer.

4.5 Necessary discussions with a tenderer of the contents of his or her tender, in order to elucidate technical points etc., before the award of a contract, need not disqualify the tender.

4.6 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

4.7 Where only one tender/quotation is received the Trust shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

4.8 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless for good and sufficient reason the Board or a delegated officer decides otherwise and record that decision in their minutes.

4.9 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.

4.10 All Tenders should be treated as confidential and should be retained for inspection.

5. Lists of Approved Firms

5.1 The Trust shall compile and maintain, and the officers responsible for procuring the supply shall keep, lists of approved firms and individuals from whom tenders may be invited, as provided for in SO 9.7, and shall keep these under review. The lists shall be selected from all firms which have applied for permission to tender provided that:

(a) in the case of building, engineering and maintenance works, the Chief Executive is satisfied on their capacity, conditions of labour, etc., and that the Finance Director is satisfied that their financial standing is adequate.
(b) in the case of the supply of goods, materials and related services, and consultancy services the Chief Executive or the nominated officer is satisfied as to their technical competence etc., and that the Finance Director is satisfied that their financial standing is adequate.
(c) in the case of the provision of healthcare services to the Trust by a private sector provider, the Finance Director is satisfied as to their financial standing and the Chief Executive is satisfied as to their technical/medical competence.

5.2 The Trust shall arrange for advertisements to be issued as may be necessary, in trade journals, OJEU Website and national newspapers inviting applications from firms for inclusion in the prescribed lists.

5.3 If in the opinion of the Chief Executive or the Finance Director it is impractical to use a list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of firms invited to tender or quote.

5.4 A permanent record should be made of the reasons for inviting a tender or quote other than from an approved list.

ANNEX 9 – FURTHER PROVISIONS

1. A person may not become a member of the Foundation Trust if within the last five years they have been involved as a perpetrator in an incident of violence or abuse at any NHS hospital or facilities; against any NHS employees or other persons who exercise functions for the purposes of the NHS; against registered volunteers; against patients or the public on NHS premises; or if they are the subject of a security alert. Also, any person may not become or remain a member of the NHS Foundation Trust if in the opinion of the Council of Governors, there are reasonable grounds to believe that they are likely to behave in a way detrimental to the interests of the Trust.

2. A member shall cease to be a member if:

- they resign by notice to the Secretary;
- they die;
- they are expelled from membership under this constitution;
- they cease to be entitled under this constitution to be a member of any of the public constituencies or of any of the classes of the staff constituency;
- if after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they wish to continue to be a member of the Trust.

3. A member may be expelled by a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a General Meeting. The following procedure is to be adopted:

- Any member may complain to the Trust Secretary that another member has acted in a way detrimental to the interests of the Trust.
- The Chair of the Council of Governors, assisted by the Trust Secretary, will judge the manner in which the complaint should be managed.
- If appropriate, the Council of Governors will consider the complaint having taken such steps as it considers appropriate to ensure that the point of view of the members involved is heard and may either:
    - dismiss the complaint and take no further action; or
    - arrange for the complaint to be considered at the next General Meeting of the Council of Governors.
- Details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the next General Meeting of the Council of Governors.
- At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.
- If the member complained of fails to attend the meeting without reasonable cause the meeting may proceed in their absence.
- The Council of Governors will take a view on the complaint and may decide to expel the member from membership of the Foundation Trust. To effect expulsion from membership, the Council of Governors will adopt a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a General Meeting.
- A person expelled from membership will cease to be a member upon the declaration by the Chairman of the meeting that the resolution to expel them is carried.

4. A member who is expelled may apply for re-admission to membership. This application is to be made in writing to the Chairman, who will arrange for the application to be considered by the next

General meeting of the Council of Governors. No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the members of the Council of Governors present and voting at a General Meeting.

5. The Trust will have a Trust Secretary, who may be appointed and removed by resolution of the Board of Directors.

6.. The Trust Secretary and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly and the Trust may also take out and maintain for their benefit insurance against such risks. Any costs arising in this way will be met by the Trust.

6.1. The Council may make amendments to this Constitution but where these can not be agreed with both the Board and Council then these will be made subject to approval of NHS Improvement, subject to paragraph 6.2 below.

6.2. No proposals for amendment of this Constitution will be put to NHS Improvement unless it has been approved by three quarters of those Governors present and voting at a meeting of the Council of Governors.

7. The validity of any act of the Trust is not affected by any vacancy among the directors or the Governors or by any defect in the appointment of any director or governor.

8.1 If:

(a) an executive director is temporarily unable to perform his or her duties due to illness or some other reason (the "Absent Director"); and

(b) the board of directors agree that it is inappropriate to terminate the Absent Director's term of office and appoint a replacement director; and

(c) the board of directors agree that the duties of the Absent Director need to be carried out;
then the non-executive directors may appoint an acting director as an additional director to carry out the Absent Director's duties temporarily.

8.2. For the purposes of paragraph 8.1 of this Annex, the maximum number of directors that may be appointed under paragraph 18.2 of the Constitution shall be relaxed accordingly.

8.3. The acting director will vacate office as soon as the Absent Director returns to office.

8.4. An acting director shall be responsible for his or her own acts and defaults and he or she shall not be deemed to be the agent of the Absent Director.

9. When a vacancy arises for one or more elected Governors, the Council of Governors shall have the option to take from the list of members who stood for election at the most recent election of Governors for the class or constituency in question whichever member who was not elected as a governor at the recent election but had secured the next most votes at that time. This procedure, which shall be an uncontested election for the purposes of the Model Rules for Elections as they apply to the Trust, shall be available to the Governors on 2 occasions within 12 months of the

previous election. Governors appointed in this way shall hold office for a minimum of 6 months from their appointment but, subject thereto, shall hold office until the earlier of the conclusion of the next election of Governors and (except where the vacancy arose through expiry of a term of office) the date on which would have expired the term of office of that Governor whose cessation of office gave rise to the vacancy.

10. The minimum age for membership of this Trust is 14 years old. There is no upper age limit.

ANNEX 10 – TRUST PRINCIPLES

Trust Principles of Conduct

The Seven Principles of Public Life, also known as the 'Nolan Principles' of selflessness, integrity, objectivity, accountability, openness, honesty and leadership should be upheld by all employees and elected and appointed Governors of the Dudley Group of Hospitals NHS Foundation Trust

The **Seven Principles of Public Life** which apply to everyone engaged in public service are:

Selflessness Holders of public office should act solely in terms of the public interest. They should not seek to gain financial or other benefits for themselves, their family or their friends.

Integrity Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit. This includes a commitment to promote racial and religious tolerance, and to be aware of community diversity and to be trained in that context.

Accountability Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office. Everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.

Openness Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands. There should be sufficient transparency about the Trust's activities to promote confidence between the Trust and its staff, patients and the public.

Honesty Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest. There should be an absolute standard of honesty in dealing with the assets of the Trust: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of employment.

Leadership Holders of public office should promote and support these principles by leadership and example.

It is an offence under the Prevention of Corruption Acts 1906 and 1916 for an employee corruptly to accept any inducement or reward for doing, or refraining from doing anything, in his or her official capacity, or corruptly showing favour, or disfavour, in the handling of contracts

Further Guidance

Employees and Governors are expected to:

- ensure that the interests of patients remain paramount at all times
- act impartially in all their work
- adhere to the regulations as set out in the prevailing legislation relating to the Bribery Act
- refuse gifts, benefits, hospitality or sponsorship of any kind (including attendance at conferences) which might reasonably be seen to compromise their personal judgment or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused
- declare and register gifts, benefits, or sponsorship of any kind, in accordance with time limits agreed locally, (provided that they are worth at least £25), whether refused or accepted. In addition gifts should be declared if several small gifts worth a total of over £100 are received from the same or closely related source in a 12-month period
- declare and record financial or personal interest (e.g. company shares, research grant) in any organisation with which they have to deal, and be prepared to withdraw from those dealings if required, thereby ensuring that their professional judgment is not influenced by such considerations
- make it a matter of policy that offers of sponsorship that could possibly breach these principles and guidance will be reported to the Board
- not misuse their official position or information acquired in the course of their official duties, to further their private interests or those of others
- ensure professional registration (if applicable) and/or status are not used in the promotion of commercial products or services
- beware of bias generated through sponsorship, where this might impinge on professional judgment and impartiality
- neither agree to practice under any conditions which compromise professional independence or judgment, nor impose such conditions on other professionals.

Anyone requiring further advice should contact their line manager in the first instance, or for Governors, the Foundation Trust Secretary. If the line manager is unable to decide then the Foundation Trust Secretary should be consulted.

Failure to adhere to the Trust's rules may lead to disciplinary action up to and including dismissal, or for Governors, disqualification from becoming or continuing as a Governor.

Change History

Date	Reason	Change summary	Review date	Approval
March 2013	Monitor request	To reflect changes as set out the Health and Social Care Act 2012	April 2013	2nd May 2013 Council of Governors
April 2013	Annual review	Minor amendments to update Appointed Governor organisation names	April 2014	12th September 2013 Annual Members Meeting
April 2014	Annual Review			
September 2015	Annual Review			
May 2016	Annual Review	To reflect changes to include electronic voting		5th May 2016 Council of Governors
October 2017	Annual Review	To reflect change from Monitor to NHS Improvement, Elections nominations process to no longer require supporters and to allow the use of non-voting non executives. To remove references to 'initial' pre FT activity relating to appointment of execs and NEDS. To adjust the size of the Board from 11 to 13 (an additional ONE NED and ONE exec)		7th December2017

Enclosure 19

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on the 7th December 2017

TITLE:	**Guardian of safe working report**		
AUTHOR:	**Mr Babar Elahi – Guardian of safe Working Hours**	**PRESENTER**	**Mr Babar Elahi – Guardian of safe Working Hours**

CORPORATE OBJECTIVES:

SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have

The report covers the following elements:

- Guardian's quarterly report with ongoing challenges
- Progress to date

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Implementation of revised JD contract may adversely impact on rotas**
	Risk Register: Y COR102		**Risk Score: 16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links to safe, caring and well led domains**
	Monitor	**N**	**Details:**
	Other	**Y**	**Details: national requirement for effective guardian role**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the actions taken by the Trust and its appointed guardian of safe working.

The Dudley Group NHS
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report December 2017

Purpose

To give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)
- Locum bookings (data provided by Finance Department)

Background and Links to Previous Papers

The role of Guardian of Safe Working Hours (GSW) is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and work schedules for JDTs
- Provide Boards with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure the fair distribution of any financial penalty income, to the benefit of JDTs.

This is the fourth quarterly GSW report and covers the period of 18th August 2017 to 1st November 2017. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

In October, 2017, all199 junior doctors in the Trust transferred onto the new contract. The table below shows the number of junior doctors posts which converted to the new contract since December 2016.

Site	No of posts which converted in December 2016	No of posts which converted in February 2017	No of posts which converted in April 2017	No of posts which converted in August 2017	No of posts which converted in Oct 2017
RHH	27	4	30	104	34

Challenges

Engagement

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage junior doctors, which involves.

- Introduction to Guardian and his role by attending Junior Doctor Induction Day
- Attending junior doctor forum arranged by Postgraduate Clinical Tutor
- Attending junior doctors' operational forum
- Creating a dedicated Guardian email in the trust
- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

As mentioned in the last GSW board report, there continues to be improvement in the engagement by the Educational Supervisors (ES) and Clinical Supervisors (CS) towards exception reports.

Trust Exception Reporting Policy

Guardian in collaboration with the medical workforce department has helped draft the trust exception reporting policy. This policy reflects the true spirit of the new junior doctors contract. As mentioned in the last report it is still awaiting its approval from JLNC.

Software System

As mentioned in the previous guardian reports, the Allocate does not 'speak' to payroll and as a result all requests for additional payment for hours worked have to be administered manually. Guardian has contacted the software provider and in his capacity as a Regional Chair has engaged with them to improve the software.

Junior Doctors Forum

The Guardian junior doctor forum was held on 23rd November 2017. This time it was a joint forum by the trust Guardian and Clinical Tutor. Trust Chief Executive and Medical Director along with Director of Medical Education attended this forum. Forum was a great success with excellent junior doctor engagement. More than 25 junior doctors from across all specialities and grades were present. The engagement by the Trust Chief Executive and Medical Director was encouraging and highly appreciated by the junior doctors. Trust senior management addressed all their concerns and showed willingness to attend future forums.

Exception Reports and Fines.

We have received 11 exception reports by 5 doctors

- There was 1 immediate Safety Concern reported.
- 2 exception reports have been completed with no further action agreed by the supervisor and the junior doctor.
- 7 have resulted in compensation: overtime payment.

- 1 has been agreed as compensation: time off in lieu.
  1 is still pending. However, meeting between trainee and supervisor scheduled for 16th November.

Exception Reports by Department – From 18th August – 1st November 2017 total = 11

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
None	11	10	1	EAU – 1 Gen Medicine – 7 Anaesthetics – 1 Surgery - 2

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1		2		
ST3	7			
CT2				1
ST7		1		

Response Time

Within 48 hours	Within 7 days	Longer than 7 days	Still open
7	3		1

High level data

Number of doctors/dentists in training (total): **199**

Number of doctors/dentists in training on 2016 TCS (total): **199**

Admin support provided to Guardian: How many hours are allocated to Medical Workforce for Guardian? **NIL**

Hours Monitoring Exercise for doctors

There is one outstanding monitoring in ED from July 17 that has yet to calculated, as the forms were mislaid.

Vacancies

Rota Gaps per speciality per Grade as of 6th December 2017

Speciality / Grade	FY1	FY2	ST 1-2	GPVTS	ST 3-8	Trust SHO	Trust Middle Grade	Total	Notes
Cardiology					2			2	**Pakistani MTI- Currently in progress**
Diabetes	1		1					2	
Elderly Care				1	1		1	3	
EAU			1					1	
Gastro	1				1			2	**Pakistani MTI- Currently in progress**
ED				3		2		5	**2 MTI's currently in progress- Calcutta**
General Surgery	1		1		1			3	
Vascular Surgery	1		1					2	
Haematology	2				1			3	
T & O			1					1	
Obs & Gynae				1				1	
Paeds			1					1	
Pathology					1			1	
Plastics						1		1	
Respiratory							1	1	**Pakistani MTI- Currently in progress**
Stroke					1			1	**Pakistani MTI- Currently in progress**
Urology	1							1	
Total	**7**	**0**	**6**	**5**	**8**	**3**	**2**	**31**	

Next Steps

1. To encourage wider junior doctor engagement by the Guardian.
2. To use the Trust HUB to promote the role of Guardian in the Trust.

The Dudley Group NHS
NHS Foundation Trust

1. Conclusion

Guardian can give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

2. Recommendation

The Board are asked to read and note this report from the Guardian of Safe Working

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**26th November 2017**