The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 6th June, 2019 at 11.40am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Item Related to Strategic Objective	Action	Time
11.	**Chairmans Welcome and Note of Apologies**		Y Buckland		To Note	11.40
12.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		Y Buckland		To Note	11.40
13.	**Announcements**		Y Buckland		To Note	11.40
14.	**Minutes of the previous meeting**					
	14.1 Thursday 2 May 2019	Enclosure 10	Y Buckland		To Approve	11.40
	14.2 Action Sheet 2 May 2019	Enclosure 11	Y Buckland		To Action	11.45
15.	**Patient Story**	Video	L Abbiss		To Note & Discuss	11.50
16.	**Chief Executive's Overview Report**	Enclosure 12	D Wake	All	To Discuss	12.00
17.	**Safe and Caring**					
	17.1 Chief Nurse Report	Enclosure 13	M Sexton	SO1&2	To note assurances & discuss any actions	12.10
	17.2 Quality Accounts	Enclosure 14	M Sexton	All	To note & discuss	12.20
	17.3 Staffing Skill Mix Review Update	Presentation	M Sexton	All	To note assurances & discuss actions	12.30
	17.4 Clinical Quality, Safety, Patient Experience Committee Report	Enclosure 15	C Holland		To note & discuss	12.40

	17.5 Patient Safety Strategy	Enclosure 16	J Hobbs		To Approve	12.50
	17.6 Freedom to Speak Up Guardian's Report	Enclosure 17	D Eaves/P Brazier		To note & discuss	1.00
	17.7 Guardian of Safe Working Report	Enclosure 18	B Elahi		To note & discuss	1.10
18.	**Responsive and Effective**					
	18.1 Integrated Performance Dashboard	Enclosure 19	K Kelly	SO1,2,4,5,6	To note assurances & discuss any actions	1.20
	18.2 Finance and Performance Committee Exception report	Enclosure 20	J Hodgkin	SO6	To note assurances & discuss actions	1.30
	18.3 Annual Audit Committee Report 2018/19	Enclosure 21	R Miner		To note assurances & discuss actions	1.40
	18.4 Audit Committee Report	Enclosure 22	R Miner		To note & discuss	1.50
19.	**Well Led**					
	19.1 Brexit Report	Enclosure 23	K Kelly		To note assurances & discuss any actions	2.00
	19.2 Research and Development Report	Enclosure 24	J Neilson		To note & discuss	2.05
	19.3 7 Day Services Update Report	Enclosure 25	P Hudson		To note & discuss	2.15
	19.4 Trust Constitution and Scheme of Delegation	Enclosure 26	G George		For noting	2.25
20.	**Any other Business**		Y Buckland			
	20.1 Board Licence Self Certification	Enclosure 27	G George			2.35
21.	**Reflection on Meeting**		Y Buckland			2.45
22.	**Date of Next Board of Directors Meeting** 4th July, 2019 Clinical Education Centre		Y Buckland			2.45

23.	**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).		Y Buckland			2.45

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

Enclosure 10

The Dudley G
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 2nd May, 2019, in the Clinical Education Centre.

Present:

Julian Atkins, Interim Chairman
Richard Miner, Non Executive Director
Karen Kelly, Chief Operating Officer
Andrew McMenemy, Director of HR
Diane Wake, Chief Executive
Mary Sexton, Interim Chief Nurse
Catherine Holland, Non Executive Director
Jonathan Hodgkin, Non Executive Director
Julian Hobbs, Medical Director
Tom Jackson, Director of Finance

In Attendance:

Helen Forrester, EA
Gilbert George, Interim Director of Governance
Natalie Younes, Director of Strategy and Business Development
Adam Thomas, Acting Chief Information Officer
Liz Abbiss, Head of Communications
Yve Buckland, Chairman Designate
Liz Rees, Director of Infection Prevention and Control (item 19/058.2)

19/051 Note of Apologies and Welcome
11.33am

No apologies received.

The Chairman welcomed Yve Buckland, Chair Designate to the meeting.

19/052 Declarations of Interest
11.33am

There were no declarations of interest.

19/053 Announcements
11.34am

There no announcements to note.

19/054 Minutes of the previous Board meeting held on 4th April, 2019 (Enclosure 8)
11.35am

The minutes were amended as follows:

Page 6, 3rd paragraph, to read "Dr Hopkin stated that ambulance crews where somewhat risk adverse".

With this amendment the minutes were agreed as a correct record of the meeting and signed by the Chairman.

19/055 Action Sheet, 4th April, 2019 (Enclosure 9)
11.45am

19/023.3 Clinical Quality, Safety, Patient Experience Committee

The item was noted to be completed and could be removed from the action sheet.

19/046.1 Clinical Quality, Safety, Patient Experience Committee

The Board noted that the CQC Report is expected by 7th May, 2019.

All other actions were noted to be complete, work in progress or not yet due.

19/056 Patient Story
11.37am

The Head of Communications presented the patient story. This was from a parent of a patient with autism who attends the Trust on a regular basis.

There had been issues with communication and this had resulted in a formal complaint being submitted.

The story highlighted the positive and negative aspects of care in the Trust and acknowledged the positive work of the Learning Disability Team.

The story suggested ways in which improvements in communication and the care of patients with learning disabilities could be made.

Mrs Holland, Non Executive Director, confirmed that it was good to see a story where there were issues that had then been addressed and asked how the Board could take assurance from the learning. The Chief Nurse confirmed that a number of actions were being taken across the Trust on Learning Disabilities including ward level information and work on national campaigns. There had been a visit from Paula McGowan the previous week, a national figure who is raising awareness of autism and learning disabilities.

The Chief Executive confirmed that she reads all complaints and had only seen 2 complaints in relation to the care provided to patients with learning disabilities.

Mrs Holland, Non Executive Director, highlighted the importance of good communication and good customer care particularly for patients that have different needs.

The Medical Director confirmed that there is real learning from processes such as this that are fragile and this can be used to improve the experience for all patients.

The Director of Governance asked about staff uniforms and how the Trust should communicate what the different uniforms mean to patients and members of the public. The Board noted that actions were underway to advertise on the hub and within the organisation the different types of uniform and how to recognise different staff groups.

The Chairman said that the Trust should also consider how the organisation identifies the Learning Disability Champions and suggested the wearing of a badge.

The Chief Nurse confirmed that special needs are flagged on the electronic patient system and that this is checked each morning so the Learning Disability Team can be proactive with their management of patients.

The Chairman asked how feedback in relation to Interserve staff is dealt with. The Chief Nurse confirmed that Interserve management attend the Patient Experience Group.

The Chairman and Board welcomed the story and asked that their thanks were passed on to the patient's mother and staff mentioned in the story.

Board's thanks to be passed to the patient's mother and those staff mentioned in the story.

19/057 Chief Executive's Overview Report (Enclosure 10)
12.05pm

The Chief Executive presented her Overview Report given as Enclosure 10. This included the following highlights:

- Vital Signs Guiding Board: National programme on quality improvement; the organisation is one of only 7 Trust's involved in the programme. As part of the Dudley quality improvement programme the Trust is working with Ophthalmology to look at how it can improve its service.

- Healthcare Heroes: The Frailty Assessment Unit were awarded 'team of the month' and the individual award was given to Holly Robinson, PA to the Medical Division.

- Nurses Day: 12th May and a week of activities are planned within the organisation.

- Committed to Excellence Awards: Nominations are now open.

- Charity: Board members are encouraged to participate in the Neon Run in June. The Board noted that the Director of Human Resources completed a marathon at the previous weekend and was an advocate for health and wellbeing.

The Chairman and Board noted the report.

19/058 Safe and Caring

19/058.1 Chief Nurse Report (Enclosure 11)
12.10pm

The Interim Chief Nurse presented the Chief Nurse Report given as Enclosure 11.

The Board noted the following key issues:

- Progress made with refreshing the Nursing Strategy and will be relaunched the following week as part of National Nurses Day.

- AHPs: Participating in a piece of national work with Nottingham University.

- Safer Staffing: Discussed in detail at the Finance and Performance Committee. March data included in the report.

- Falls: One to note resulting in a fractured femur.

The Chief Nurse confirmed that some patients had been sectioned under the Mental Health Act. Mr Miner, Non Executive Director, asked about patients needing to be restrained. The Chief Nurse confirmed that all uses of restraints are recorded and the appropriate use of restraints are monitored.

Mr Hodgkin, Non Executive Director, asked about agency usage. The Chief Nurse confirmed that an agency reduction programme comes into place in July.

The Chairman confirmed that he was pleased to see the potential mechanism for assessing staffing levels.

The Chairman asked about the Head of Safeguarding being on long term sick leave. The Chief Nurse confirmed that the person had now resigned from the post and the Trust was in the process of appointing a replacement.

Mr Miner, Non Executive Director, asked about CSW bank usage. The Chief Nurse confirmed that most of the use is due to the requirement of 1:1 patient support and this area is being reviewed with ward staff.

The Chairman and Board noted the report and the actions underway.

19/058.2 Infection Control Report (Enclosure 12)
12.16pm

The Director of Infection Prevention and Control presented the quarterly Infection Control Report given as Enclosure 12.

The Board noted the following key issues:

- Hygiene Code: Need to improve compliance against mandatory training.

- Hygiene Code Action Plan: Updated plan in the report with one outstanding area as described above.

- CDiff: 20 lapses in care cases against the trajectory of 28 cases.

- MRSA: 1 case in October, action plan was put in place.

- Other healthcare associated infections: The Trust continues to work on the management of cases.

The Chairman asked about the issue relating to mandatory training. The Director of Infection Prevention and Control (DIPC) confirmed that she believed that all staff should complete training before their appraisal was signed off. The Chairman agreed that this was a good idea. The Chief Executive thanked the DIPC for her efforts in getting staff trained.

The Chief Executive commented on the excellent performance for infection control at the Trust.

The Director of Strategy and Business Development asked about the new target. The DIPC confirmed that it is within the Trust's own gift to achieve the target and that ensuring staff have received mandatory training will ensure that there are no lapses in care as a result of this. The Chief Executive asked that a patient safety bulletin is circulated to staff so they understand the new target and that this is also highlighted at team brief the following day.

The Chairman and Board noted the report.

19/058.3 Staffing Skill Mix Review (Enclosure 13)
12.27pm

The Interim Chief Nurse presented the Staffing Skill Mix Review given as Enclosure 13.

The Board noted the following key issues:

- The Trust is fully compliant with the national quality board expectations.

- The Trust is moving away from professional judgement being the only tool for assessing patients to ensure the correct skill mix is provided.

- The Trust is utilising the Safer Nursing Care Tool to establish the recommended nursing establishment.

- A number of check and challenge sessions have taken place.

- Inpatient Ward Areas: Other activities taking place produce anomalies in the figures.

- Model Hospital Data: Some anomalies due to specialist nurses being included in the data.

- The tool identifies a number of areas across the Trust that have a too high nurse to patient ratio.

- Occupancy: Every ward is running at 100% plus occupancy and therefore is running constantly “hot”.

- Sickness: significantly higher than average for the Nursing workforce

- 30 Day acuity dependency data collection taking place during May.

There will be an update to the June Board with a staffing proposal.

The Chief Nurse confirmed that she was quietly confident that agency spend could be reduced without comprising the quality patient care and safety.

Mr Miner, Non Executive Director, asked about the assurance around compromising quality and safety. The Chief Nurse confirmed that the tool provides a level of assurance but a large cultural and organisational change needs to take place within the Trust and there is further work to be done around this. The Chief Nurse felt that the nurse staffing shortfall figure was assumed to have been identified from data but that was not robust and in reality stood at a lower level.

The Director of Finance welcomed the report and that the Trust was moving closer to a common narrative. He asked about alignment of budgets and anomalies with nurse specialists. The Chief Nurse confirmed that a separate piece of work was being undertaken around clinical nurse specialists and she is also meeting with senior nurses and Matrons with a view to them all undertaking regular clinical shifts.

Mr Hodgkin, Non Executive Director, asked about potential cost savings. The Chief Nurse confirmed that savings are being established through the use of transformation schemes. Mr Hodgkin stated that we need to be clear where and how savings are identified and the monitoring process. The Chief Nurse confirmed that this was currently taking place and the Chief Executive confirmed that this will be tracked through the Financial Improvement Group. The Director of Finance confirmed that the new budget will become the control measure for the process.

The Chairman and Board noted the report and the positive piece of work.

Nurse staffing proposal to be presented to the June Board but would be provided late or as a presentation due to the availability of the data.

19/058.4 Clinical Quality, Safety, Patient Experience Committee Report (Enclosure 14) 12.55pm

Mrs Holland, Committee Chair, presented the Clinical Quality, Safety, Patient Experience Committee Report, given as Enclosure 14, including the following key issues:

- There had not been a formal meeting in April but the Chair of the Committee and Chief Nurse had met to look at the effectiveness of the Committee.

- Need to consolidate reports from the multiple groups that feed into the Committee.

- Work is in progress and will be presented to the Committee in May.

- 4 Matters were escalated to the Executive Lead including the annual Inpatient Survey, Maternity CNST, Mental Health Act usage and receipt of the CCQ report.

The Chairman and Board noted the report.

19/058.5 Learning from Deaths Report (Enclosure 15)
12.58pm

The Medical Director presented the Learning from Deaths Report given as Enclosure 15.

All measures of mortality have improved over the last reporting period.

Changes had been made to our baseline in 2017, and all measures had improved in the period since.

It was reported that we have seen the lowest number of deaths recorded at the Trust despite the increased number of attendances and in particular the Board noted the significant improvement relating to sepsis mortality.

Learning from other Trusts had been considered.

Further training for staff had been implemented around mortality reviews.

Assurance had been received from the Auditors in relation to the Trust's mortality processes.

NHSI have provided funding to support work the CCG is undertaking to address DNA CPR and improve end of life care.

Mr Miner, Non Executive Director, asked if a clinical Non Executive Director is required to provide oversight on the Board around mortality. The Medical Director stated that there is value for someone non clinical to provide scrutiny away from the medical process. We need to demonstrate insight into this subject.

The Director of Finance stated that the health economy needs to look at the needs of the population and the preferred place for people to die. The Chief Operating Officer confirmed that the Ambulance Service can override DNARs and bring patients to hospital.

Updates on palliative care will be presented to the Board in an overarching annual report.

The Chairman and Board noted the report and positive performance.

Update on Palliative Care to be included in an overarching annual report.

19/058.6 Patient Experience Report (Enclosure 16)
1.11pm

The Interim Chief Nurse presented the Patient Experience Report given as Enclosure 16.

The Board noted the following key issues:

- Report to quarter 4 of the previous year.
- Received first cut of urgent and emergency patient care survey: This has been recalled due to some data issues at the centre.
- Friends and Family Test: Challenge in improving response rates:
- Complaints: Significant improvement to backlog in responses. Further work to do on the quality of responses.
- MP cases: No further cases received.
- Compliments: Working on capturing positive responses.

The Chairman welcomed the reduction in the backlog of complaint responses.

Mr Miner, Non Executive Director, raised the number of complaints and lessons learnt and asked what the 3 key elements would be to reducing complaints. The Chief Nurse commented that this would be communication, information and patient care. A number of actions were undertake to improve patient experience. A complaint learning group meets on a regular basis and a new approach is going to be taken to focus on learning.

The Chairman and Board noted the report and actions underway to improve patient experience.

19/059 Responsive and Effective

19/059.1 Integrated Performance Report (Enclosure 17)
1.18pm

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 17.

The Board noted the following key issues:

- Performance for March 2019.
- ED Emergency Access Standard: Looking at actions to improve the position including enhancing the workforce and collocating the frailty unit to the front door. Working with system partners on health and social care and GPs to tackle admissions. A bed base review is being undertaken along with the ED reconfiguration in the next 2 years. An ED away day took place on Monday to work with the team to effect change.

- Cancer key metrics: Good performance. Seen national rise in breast referrals and this had resulted in failing the breast symptomatic target. Actions have been put in place to recover the position. Attended meeting the previous day to look at what support can be offered across the STP.

- RTT: Continued excellent performance between 4th and 12th nationally.

- DM01: Continue to perform well against target.

- DNA: Below national average.

- CT Replacement Programme commencing in June.

- Appraisals: Window opened on 1st April and will continue until the end of June. Looking to achieve 95% compliance rate.

- Mandatory Training: Positive performance at just under 90%.

- Sickness Absence: Reduced for March.

- Turnover: Achieved green for the first time in a number of years.

More detail around staff engagement to be included in future reports.

The Chairman requested that a broad forward view trend analysis be included in future reports.

Mr Miner, Non Executive Director, commented that we need to consistently reduce sickness absence to deliver cost improvement.

The Board noted the Annual Plan summary included in the Integrated Performance Report.

The Chairman and Board noted the report, actions and performance against key performance indicators.

A broad forward view and trajectory to be included in future performance reports.

19/059.2 Finance and Performance Committee Exception Report (Enclosure 18) 1.32pm

Mr Hodgkin, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 18.

The Board noted the following key issues:

- Satisfactory end to the year which awarded a further PSF payment.
- Deficit of £1.1m after PSF. Puts us in the top quartile of Trusts.
- Control total target is deficit of £2.8m.
- Issue remains around cash.
- CIP areas still to be identified.
- Terms of Reference updated and appended to the report. There will be a quarterly deep dive for each division.

The Chief Executive highlighted the gap in funding for urgent and emergency care. The Director of Finance confirmed that urgent and emergency care is significantly underfunded by around £10-12m. As part of the contract settlement process there has been agreement to fairly fund urgent and emergency care and a baseline assessment will take place by the end of quarter 2.

The Chairman and Board noted the report, financial position and approved the revised terms of reference.

19/060 Well Led

19/060.1 Brexit Report (Enclosure 19)
1.37pm

The Chief Operating Officer presented the Brexit Report given as Enclosure 19.

The Board noted the following key issues:

- Twice daily reporting has stopped.
- Fortnightly meetings continue.
- Paper will continue to be presented to Board to provide a general update.

Mr Miner, Non Executive Director, confirmed that there will be no “no deal”. The Chief Operating Officer confirmed that the Trust is awaiting national guidance.

Continuity exercises continue to take place.

The Chairman and Board noted the report and current position.

19/061 Any Other Business
1.40pm

The Board noted that Dr Hopkin's term of office had ceased at the end of April with mutual consent.

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

19/062 Date of Next Meeting
1.42pm

The next Board meeting will be held on Thursday, 6th June, 2019, in the Clinical Education Centre.

Signed ……

Date …….....

Enclosure 11

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 2 May 2019

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
19/033.1	Staff Survey Presentation	Update on the Staff Survey to the Board in 6 months.	AM	5/9	Not Due.
19/033.5	Patient Safety Strategy	The Patient Safety Strategy to be presented back to the April Board for formal approval.	JH	6/6	To June Board. On Agenda
19/023.3	Digital Trust Committee Report	Population Health to be included on a future Board Workshop agenda.	AT/GG	May/ June	Not Due
19/046.1	Clinical Quality, Safety, Patient Experience Committee	Next Committee report to reflect position on COSHH compliance. The Chief Executive, Interim Chief Nurse and Committee Chair to consider the proposals for engagement following receipt of the draft CQC report, with subsequent report to Board.	DW/MS/CH	6/6 May 19	On Agenda Report Received. Factual Accuracy checks taking place.
18/139.5	Research and Development Report	The next report to Board to include further detail on commercial opportunities and comparisons with research levels undertaken at other Trusts.	JN	6/6	On Agenda
19/033.4	7 Day Services	Update on 7 Day Services to the Board in June	P Hudson	6/6	On Agenda
19/035.2	Workforce Committee Exception Report	Workforce Strategy to be presented to the June Board.	AM	6/6	On Agenda
19/035.3	Freedom to Speak Up Guardian's Report	The Chief Executive to consider how the Board sees triangulation around learning and adaptation and for the approach to be brought back to the Board.	DW	6/6	On Agenda

19/048.4	Trust Constitution and Scheme of Delegation	The Director of Governance to check the issues in question in relation to Governors and present the updated Constitution and Scheme of Delegation to the June Board for approval.	GG	6/6	On Agenda
19/048.6	Board and Committee Effectiveness Review	Director of Governance to consider improvement actions required in response to Board Effectiveness Review and provide plan to the Chair/Chief Executive.	GG	May 19	Due Date now July 19
19/056	Patients Story	The Board's thanks to be passed to the patient's mother and those staff mentioned in the story.	LA	May 19	Done
19/058.3	Staffing Skill Mix Review	Nurse staffing proposal to be presented to the June Board but will be provided late or as a presentation due to the availability of data.	MS	6/6	On Agenda
19/059.1	Integrated Performance Report	A broad forward view and trajectory to be included in future performance reports.	KK	6/6	IPR On Agenda
19/058.5	Learning from Deaths	Update on Palliative Care to be included in an overarching Learning from Deaths Annual Report.	JH	5/9	Not Due
19/021.4	Organ Donation Report	Results of work on tissue donation to be included in the next report.	K Lazenby	Jan 2020	Not Due

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6th June 2019

TITLE:	**Public Chief Executive's Report**		
AUTHOR:	**Diane Wake, Chief Executive**	**PRESENTER**	**Diane Wake, Chief Executive**

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.*

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

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
X High level of confidence in delivery of existing mechanisms / objectives	☐ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

The Board are asked to note and comment on the contents of the report.

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- Visits and Events
- Improvement Practice Update
- Recruitment Update
- Committed to Excellence
- Freedom to Speak Up Surgeries
- Sunrise Launch
- Healthcare Heroes
- Iftar Dinner
- Smoke Free
- Steve Ford Memorial
- Charity Update

- Organ Donation Ambition
- Acute Stroke Care Report 2018/19
- National News
- Regional News

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – June 2019

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

1st May	Black Country Cancer System Review Meeting
2nd May	Board of Directors
	Extraordinary Council of Governors
3rd May	Team Brief
7th May	Achieving World Class Cancer Outcomes Event
8th May	Transition Board
	MCP Engagement Event
9th May	Dudley System Oversight and Assurance Group
10th May	Paediatric Away Day
13th May	Collaborative Leadership Team
15th May	Simon Stevens/Dido Harding NHS Midlands Event
20th May	Board Workshop
	Trust Management Group
21st May	Steve Ford Memorial
	Transition Board
22nd May	Ophthalmology Away Day
29th May	Partnership Board
30th May	Black Country STP Health Partnership Meeting

Improvement Practice Update – Care Better Every Day

The 2019 scope for Dudley Improvement Practice defined at the Value Stream Analysis event in October at the Copthorne included outpatients, ward discharge, emergency theatre and End of Life Care. These improvement teams are being set up via Practice Events and A3 development sessions.

Ophthalmology is the outpatient speciality with the highest activity and so it is likely that improvement made there can be replicated to other specialties.

The Ophthalmology Practice Event was held at the beginning of May and saw a reduction is door to door appointment time for a Macular clinic from 2 hr 7 mins to 50 mins. There were many other improvements made which patients have fed back as be better for privacy and patient flow.

Planning is now in early stages for the next Practice Event to facilitate early discharge in August on ward C3, again the intention is to use the event as an intense burst of improvement activity and the results to then be used to benefit other wards.

Dudley Improvement Practice is also supporting teams in Specialist Palliative Care and a system-wide team looking at Core Palliative Care working with GPs, care homes and the Hospice.

More detail on the Improvement Practice work is available on the Executive wall or the Improvement Room in the Clinical Education Centre.

Recruitment Update

We received 18 applications for the post of Non-Executive Director (x2), following the shortlisting process 4 candidates have been invited to attend an interview and stakeholder panel scheduled for 4th June 2019.

Staff Awards - Committed to Excellence 2019

Our annual staff awards, Committed to Excellence, has attracted almost 600 nominations from staff, visitors and patients. In honour of Steve Ford, we have renamed the award for volunteers, the Steve Ford Volunteer Award. Shortlisting begins soon and the winners will be announced at The Copthorne Hotel, Brierley Hill on 5th July. The event is, for the second year, hosted by BBC Midlands Today presenter Nick Owen. We wish all individual and teams who have received a nomination the very best of luck. The awards are our way of saying a big thank you for their dedication and commitment to providing the best possible care to our patients. They also shine the light on non-clinical staff who provide invaluable back office functions.

Freedom to Speak Up Surgeries

We are holding a series of Freedom to Speak Up surgeries for our staff to give them a further opportunity to raise any concerns they may have in a safe and confidential environment. There are two drop-in sessions in June and are being led by non-executive director Julian Atkins. Staff have a number of ways to raise concerns confidentially, and they are encouraged to do so, without fear of reprisal. We have two Freedom to Speak Up Guardians who are supported by 20 speak up champions.

Sunrise Launch

We are very pleased that Dudley and Kinver Running Club are on board for this year's Neon Dash 5k charity race at Himley Hall on Sunday 9th June. DK are kindly planning the route around the country park and providing marshals to keep everyone on track. There is still time to register to take part. Go the front page of our website – dgft.nhs.uk for details on how to enter. If you can't take part in the run, we would encourage everyone to come along anyway and offer their support. All funds raised will go to our neonatal unit. It's a great family day out.

Healthcare Heroes May 2019

Congratulations to May's healthcare heroes! The Community Ears, Nose and Throat department received this month's team award due to the team pulling together and supporting each other through a very tragic time for one of the team members. During this time the ENT doctors also played a key role in keeping the clinics operating despite the change in the support they received. This meant that patients continued to be treated.

Fiona Freeman, a Lead Nurse in the Acute Pain team, received the individual award after attending to a collapsed gentleman on the side of the road, who at this time had no pulse and had stopped breathing. Due to Fiona's quick thinking and resuscitation skills, this meant that CPR was administered in a timely manner which ultimately saved the patient's life.

Iftar Dinner

Along with the Executive team, colleagues across the Trust came together on Wednesday 29th May 2019 to take the opportunity to meet and chat with fellow colleagues whilst enjoying some Indian cuisine.

Smoke Free Trust

The Trust goes smoke free on Monday 3rd June. Smoking shelters will be removed as we promote a healthy environment for staff, patients and visitors. We will be working with Solutions4Health, which provides lifestyle services to Dudley residents, to provide free, on-going support for anyone who wants to take this opportunity to quit, and there will be more information to follow on this.

Patients, visitors and contractors will also not be able to smoke anywhere on Trust premises, including in your cars while on Trust property. This includes vaping and applies to all Trust sites. This applies to the Russells Hall Hospital site, and Guest and Corbett outpatient centres.

Director of Workforce Andrew McMenemy is pre-recording an interview with Free Radio on Friday, which will be broadcast on Monday (time to be confirmed).

Public Health England, backed by NICE, is encouraging trusts to become health promoting environments. Smoking remains the leading cause of premature death in the UK.

Steve Ford Memorial Event

We held a memorial event on 21st May to honour the memory of Steve Ford who volunteered on the children's ward at Russell's Hall Hospital for 35 years. We were honoured to welcome Steve's family to a service in the prayer centre where Steve's closest friend delivered moving eulogies.

The service, led my lead chaplain Stephen Bentley was followed by the unveiling of a plaque outside the play room on the children's ward where Steve made so many young patients' dreams come true. Through his Wishing Well charity, Steve used his many contacts in the Dudley borough to brighten the lives of poorly young patients.

DGFT Charity Update

We are very pleased that Dudley and Kinver Running Club are on board for this year's Neon Dash 5k charity race at Himley Hall on Sunday 9th June. DK are kindly planning the route around the country park and providing marshals to keep everyone on track. There is still time to register to take part. Go the front page of our website – dgft.nhs.uk for details on how to enter. If you can't take part in the run, we would encourage everyone to come along anyway and offer their support. All funds raised will go to our neonatal unit. It's a great family day out.

Organ Donation Ambition

The Trust has received a letter from Anthony Clarkson, Director of Organ Donation Transplantation at NHS Blood and Transplant. This letter thanks the Trust for helping the UK with the ambition of becoming world class in the area of organ donation and transplantation and explains how the Trust can further help with this ambition by ensuring the best quality care in organ donation on every possible occasion. The letter is attached at Appendix one.

Acute Stroke Care Report 2018/19

The Trust has received the Quarter 4 Report for Acute Stroke Care and is pleased to confirm that it has achieved Level A status. The Board is asked to note this positive performance. Benchmarking data will be available in the next few weeks.

National NHS News

'Punitive' tax and pension rules forcing senior doctors to reduce hours or work part-time, warns BMA

The BMA has warned of a "perfect storm" created by NHS pension and tax rules which are forcing senior doctors to reduce their hours, retire early or leave the NHS.

In a letter to the chancellor Philip Hammond, the BMA has warned that doctors will keep reducing their working hours to avoid disproportionately large tax charges unless there is tangible reform to the NHS pension scheme.
National Health Executive (26.04.19)

Concern over 'alarming' stats showing 300 suicides by NHS nurses in past seven years
Data from the Office for National Statistics shows that more than 300 nurses killed themselves over the seven-year period from 2011 to 2017. There were 32 suicides recorded in 2017 - down from the 51 nurses aged between 20 and 64 who took their own life in 2016. But, the report shows that there was more than one nurse committing suicide every week in 2014. The statistics were described as 'alarming' by Shadow Health secretary Jonathan Ashworth who called for a Government inquiry into the issue. **Express (29.04.19)**

NHS in grip of staff crisis: Experts warn 50,000 medics urgently needed
FIFTY thousand hospital doctors and nurses are needed to solve a critical NHS staffing crisis, campaigners reveal. Experts warn today that failure to recruit enough frontline workers will see the health service placed "on life support" with patients waiting longer in A&E, for routine operations and to see their GP. The crisis is most acute in nursing, which is missing 40,000, and linked to a higher chance of dying on hospital wards. But the problem runs deeper as there are also 7,000 too few family GPs. The NHS – Europe's biggest employer – has a workforce of 1.1 million but 100,000 jobs remain unfilled. Unless urgent action is taken it is feared that figure could jump to 250,000 by 2035. Latest NHS England figures show there are 39,148 nursing vacancies and 8,953 unfilled medical staff jobs including doctors, oncologists and paediatricians. **Express (30.05.19)**

All NHS hospitals and GP practices to be equipped with fibre optic internet
As part of the NHS Long-Term Plan's bid to improve connectivity and modernise healthcare services, all NHS organisations will get the fastest broadband available in order to improve the range and quality of digital services offered to patients. Matt Hancock said nearly 40% of NHS organisations are currently using slow and unreliable internet supplied through copper lines which restricts the ability to offer digital services to patients. He declared that every patient will now get the right to choose a "digital first" approach to primary healthcare, and more than 307 million patient consultations with GPs each year will be offered online as well as face to face in the future. Under the NHS 10-year plans, hospital outpatient clinics will also be redesigned with 'virtual clinics' involving video consultations, and cloud-based patient records will help clinicians access crucial information anywhere in the country.
National Health Executive (01.05.19)

NHS set to launch global recruitment strategy to bring in thousands of foreign nurses
The NHS is set to begin a global recruitment drive to recruit tens of thousands of foreign nurses over the next five years in a bid to fill a void of 40,000 skilled workers. According to the staffing strategy, seen by The Times, NHS Improvement is targeting 5,000 new foreign nurses every year until 2024 to fill the widely reported NHS workforce crisis.

The report says the NHS needs to rapidly increase international recruitment, and that recruitment undertaken by individual hospitals could be centralised on a regional level with the help of national guidance on hiring staff from abroad.

The strategy acknowledges that the current workforce is overworked and overstretched and is being driven out of the profession, which was the message from the BMA in a report last month warning that eight out of 10 doctors are at substantial risk of a burnout. **National Health Executive (07.05.19)**

NHS to offer landmark multiple sclerosis drug after negotiating manufacturer's price down
NHS England has reached a deal with a drug manufacturer to provide patients with multiple sclerosis (MS) with a "landmark" drug after NHS bosses pressured the company to lower its price. Ocrelizumab will be the first available medicine that can modify or change the course of an early primary progressive form of the disease after NHS England struck a deal with manufacturer Roche, paving the way for its approval by NICE.

This comes after NICE rejected the drugs last September due to its high costs, which led to an outcry and a petition to reverse the decision signed by more than 20,000 people, with several MPs taking up the cause. But NHS England said that after tough negotiations it had secured a commercial in confidence deal with Roche, which is in the range that NICE considers an acceptable use of NHS resources. The 'shelf' price for ocrelizumab is £19,000 a year, but clinical trial results show that it can slow the worsening of disability in people with the condition to the extent that it can delay wheelchair use by seven years. **National Health Executive (09.05.19)**

Surgeon says knife crime is having 'ripple effect' across entire NHS
The UK's knife crime epidemic is causing all patients to suffer across the NHS, a leading surgeon has warned. Rising numbers of stabbings are believed to be having a 'ripple effect' across hospitals, leading to cancelled operations and strains on the ambulance service. Professor Chris Moran, national clinical director for trauma at NHS England, also told the Daily Mail police have even had to be deployed on some wards to stop potentially armed gangs who hoped to 'finish the job' in hospital. The warning comes after figures last month showed police in England and Wales recorded 40,829 offences involving knives or sharp objects in 2018 – the highest number since 2010 to 2011. Research by NHS England also shows the number of teenagers admitted to hospital has increased by 54 per cent, from 656 admissions in 2012 to 2013, to 1,012 between 2017 and 2018. **Metro (11.05.19)**

NHS staff shortage: How many doctors and nurses come from abroad?
The UK's National Health Service (NHS) will soon begin a major campaign to recruit health workers from other countries to meet growing staff shortages. Reports suggest a strategy has been drawn up to target a number of countries around the world, including poorer nations outside Europe. One estimate in March this year said the NHS will need 5,000 extra nurses every year - three times the figure it currently recruits annually. But what about the countries that it will recruit from - what impact will it have on them? Where do non-UK staff come from?

The NHS already recruits globally to meet its staffing needs. More than 12% of the workforce reported their nationality as not British, according to a report published last year. The biggest group of foreign NHS workers are from the EU - 56 in every 1,000. **BBC (13.05.19)**

'Pink drink' cancer treatment that helps surgeons spot brain tumours rolled out across NHS

A new innovative brain cancer treatment aid that allows surgeons to identify areas of the brain affected by cancer has been rolled out across the NHS and could save up to 2,000 patients a year. Known as the 'pink drink', 5-ALA uses fluorescent dye and ultraviolet light to make cancerous cells glow under UV light, meaning surgeons can accurately identify the affected areas of the brain. The government made the announcement one year after the death of Baroness Tessa Jowell, the Labour MP who was diagnosed with glioblastoma, the most cancerous brain tumour in adults. Health secretary Matt Hancock said she had "fought passionately and courageously for more recognition of rare brain cancers before she tragically passed away last year." **National Health Executive (13.05.19)**

NHS failure to agree child sepsis alert system 'risking lives'

Thousands of children have died or been left disabled because NHS bosses have dithered for at least a decade over introducing a checklist to spot sepsis, nurses and campaigners have claimed. NHS chiefs in England stand accused of inaction for not ordering hospitals to bring in a standard system to detect the condition, which kills between 1,000 and 4,000 children under five every year in the UK. Sepsis, also known as blood poisoning or septicaemia, is hard to detect because many of its symptoms, such as a high temperature, are also indicators of other illnesses. It can be the result of a severe infection and without rapid treatment can lead to organ failure, loss of limbs or death because the body's immune system reverses its usual role and starts to attack organs and tissues. **The Guardian (21.05.19)**

NHS invests £5 million into learning disabilities

The NHS invests an additional £5 million to fund reviews to improve care for people with a learning disability and emphasise their commitment to tackling serious national issues. The world's first programme to review the deaths of everyone with a learning disability is being expanded to speed up the spread of best practice. Thousands more reviews will be carried out over the next 12 months, driving local improvements to help save and improve lives. England's top doctor Professor Stephen Powis has also written to leading doctors and nurses across the NHS to ensure that a learning disability or down syndrome should never be a reason to issue a do not resuscitate order or cause of death certificate. As the third annual report that reviews the deaths of people with a learning disability and action plan is published, the NHS has committed to national action to tackle the major killer conditions among people with a learning disability based on lessons learned from reviews. **Open Access Government (22.05.19)**

Free social care for over-65s 'would save NHS £4.5bn every year', new report claims
Giving free social care to the over-65s could save the NHS £4.5bn every year, a leading think tank has said. In a new report, the Institute For Public Policy Research (IPPR) claims it would make for a more efficient health service by allowing more elderly people to get help in the community instead of needing to be in hospital. As it stands, many people who have dementia have to pay for their own care, whereas cancer patients get free treatment through the NHS.

By replicating that benefit, IPPR believes the number of people with access to state-funded care would increase from 185,000 to 440,000. Although the report predicts spending on adult social care for the over-65s will rise from £17bn a year to £36bn in 2030, it says £11bn of that increase would arise without the changes and the amount would be offset by benefits - including an extra 70,000 full-time jobs. **Wessex FM (23.05.19)**

Fewer now dying from strokes, but numbers having them go up in the young
"Stroke deaths in England halved in a decade," reports The Guardian, but the Sun warns us that, "Stroke rates are rocketing among young Brits due to obesity and cocaine use". Both headlines were prompted by a new study where researchers looked at NHS stroke data from between 2001 and 2010. They found the number of people in England dying from stroke fell sharply during this time, with drops each year of about 6%. A stroke happens when the brain is damaged by an interruption of blood supply.

This can be the result of a clot blocking a blood vessel or bleeding in the brain. Depending on how bad the damage to the brain is, stroke can be fatal or cause lasting disability. A reduction in deaths from stroke could be because fewer people are having strokes, or because more people are surviving them. The researchers' analysis showed most of the reduction in stroke deaths came from more people surviving strokes, possibly because of better stroke care. But while the number of stroke deaths fell among older age groups, there was a worrying increase in people aged 35 to 54 who had strokes, at a rate of around 2% more each year.
www.nhs.uk (23.05.19)

Health secretary reveals plans to update NHS tech
Secretary of State for Health and Social Care Matt Hancock has said that NHS digital healthcare advancements have been stalled by ‘legacy issues’, and has introduced new plans designed to create better relationships between clinicians and patients. Speaking at the King’s Fund Digital Health and Care Congress the MP explained that the NHS infrastructure is “locked in to something that was cutting-edge when [he] was at university.” “There is no technical reason why NHS systems can’t work in the same way," he said, calling the problem "organisational, not technological." Hancock said that these outdated NHS systems were a results of a “culture of risk aversion” and a false belief that tech is a matter for an IT department rather than a matter fundamental to an organisation. In the speech, he announced the ‘GP IT Futures’ contract, designed to ensure that patients and the NHS can safely and securely access and share primary care data in real-time.

The new standards set out will require NHS systems to provide better access to patient data on easily upgradeable systems which also offer secure cloud hosting. **Business Cloud (24.05.19)**

Elderly patients with progressive diseases see NHS funding withdrawn
Vulnerable pensioners with progressive and crippling diseases are having NHS funding for their care withdrawn under cost-cutting measures. An investigation by The Telegraph reveals that more than 7,000 patients whose care and nursing fees were covered by the health service have had their funding revoked since the "stealth cuts" were introduced.

Under national rules, any patient with a significant health problem should have such fees paid in full - if the condition is deemed to be the main reason they need such help. **The Telegraph (25.05.19)**

NHS bosses accused of breaking law in cancer scanning privatisation
NHS bosses stand accused of endangering patients, "flagrant" lawbreaking and intimidating a leading hospital trust over their controversial privatisation of cancer scanning services. Oxfordshire councillors have warned that cancer patients in Thames Valley will receive a poorer service because NHS England has decided to take a contract for PET-CT scanning away from Oxford University Hospitals (OUH) Trust and hand it to the private firm InHealth. They have heavily criticised NHS England's behaviour and judgment over the contract in an unusually strong letter to the health secretary, Matt Hancock. He now has to decide whether to back NHS England's decision, which has sparked an outcry from MPs, patients and doctors, or risk legal action from InHealth by ordering a rerun of the tendering process.
The Guardian (26.05.19)

Regional NHS News

Concern as a quarter of NHS 111 calls end at A&E
The number of people sent to hospital after calling the number has risen 18 per cent in five years. Today concern was raised about pressures being placed on A&E units in the region. The latest NHS England figures show the West Midlands call centre, which covers Shropshire, sent 23,089 people to A&E in March 2019 – 25 per cent of all callers. This is up significantly from March 2014, when 11,802 patients were referred to A&E. That was in the first year of full service for NHS 111. NHS 111 is a 24-hour helpline for patients who need medical help but do not need to call 999. The service took the place of NHS Direct and some GP out-of-hours services in 2014.

Most calls are dealt with by staff with no clinical background working to a set script, although around a fifth of callers are referred to nurses or paramedics. Shropshire's A&E departments, at Royal Shrewsbury Hospital and Princess Royal Hospital Telford, have both been under considerable pressure in recent months. In January it was revealed that the trust which manages the hospitals, Shrewsbury & Telford Hospital NHS Trust, had the second worst performance in the country against the four hour waiting time target. **Shropshire Star (27.04.19)**

Hospitals in Birmingham and Black Country 'spent nearly £500,000 on taxis' last year

Hospitals in Birmingham and the Black Country are spending thousands of pounds every year on taxis for their patients. One hospital spent a staggering £257,000 on taxis to ferry patients to and from appointments. Some hospitals even use cabs to send letters, it has also been claimed. The staggering findings have been revealed in a Freedom of Information request made by the Liberal Democrats.

They found that:

* Birmingham's Queen Elizabeth Hospital shelled out the most - £257,000 in 2018.
* The combined taxis bill for Good Hope, Heartlands and Solihull hospitals in the same period was £190,000.
* The Royal Wolverhampton Hospital NHS Trust spent £35,000.

Elsewhere in the region, Coventry and Warwickshire NHS Trust shelled out £75,882 on taxis, and the University Hospitals of North Midlands - which runs centres in Stoke and Stafford - spent £266,343. **Birmingham Live (29.05.19)**

New boss announced for Dudley's Russells Hall Hospital

Dame Yve Buckland has been brought in to help lead The Dudley Group NHS Foundation Trust, which runs Russells Hall Hospital, following criticism of serious A&E failings and claims of bullying - of which it was later cleared.

The "experienced" health boss is currently chair of the Royal Orthopaedic Hospital (ROH) in Birmingham and is due to take the role for six months.

Dame Yve replaces Jenni Ord who said she was leaving in order to "regain a better work life balance". **Express and Star (01.05.19)**

Shropshire ambulances no longer always taking patients to nearest hospital

Changes to Shropshire's ambulance services mean patients are no longer taken to the hospital closest to where they fall ill. West Midlands Ambulance Service (WMAS) is now operating a system where it can look at how busy hospitals are and can choose to take patients to a hospital where they can be seen more quickly. Bosses say it depends on the patients' condition and will not affect those needing to go to major trauma centres in the region. It is hoped it will reduce handover times and improve patient experience. Jeremy Brown, from West Midlands Ambulance Service, said: "We are trying to improve the overall patient experience. "We are trying to improve the number of patients that we don't need to convey to any emergency department to try and utilise some of those excellent services that are out there in our communities – the district nurses, the GP referrals, the out-of-hours services, to prevent that emergency department conveyance. "We are trying to offer a service whereby we give the patients the best possible experience. "Going to an emergency department where you can be waiting a long time outside, then to be seen, that whole experience can be quite frustrating.

"We are trying to balance things out a little bit, within reason, to transport those patients to where there is capacity and their overall experience will be improved." **Shropshire Star (01.05.19)**

More than 100 emergency services staff assaulted in five months
A total of 103 emergency services staff were assaulted between November 2018 and March 2019. The West Midlands Police figures show that 103 emergency workers were assaulted between November 2018 and March 2019. The crime figures were revealed as part of a Freedom of Information request to the force by Wolverhampton Liberal Democrats. It showed that only two cases were logged during November 2018, but increased to 29 cases in December 2018. In January and February 22 cases were reported and in March 28 attacks on emergency staff were logged. Eighty of the assaults were carried out against male emergency staff, while 22 were against female staff. **Express and Star (07.05.19)**

Dudley consultant uses Hillsborough experience to train surgeons
A Black Country consultant's first-hand experience of the Hillsborough tragedy has inspired him to help train surgeons across the world deal with critically ill patients.

Neil Molony, an ear, nose and throat consultant with the Dudley Group NHS Foundation Trust, has just returned from the UAE where he taught leading medics how to train their own staff. Neil was a patient in hospital in Liverpool when critically injured football fans were brought into his ward following the FA Cup semi-final disaster back in 1989. He was in hospital recovering from life-saving neurosurgery after falling from a horse. Many of the victims of Hillsborough did not die at the scene, but succumbed to their injuries later in hospital. As a result, a new training programme for surgical doctors was developed and Neil has been involved in delivering the training since it began in 2001. Care of the Critically Ill Surgical Patient (CCrISP) is now a compulsory course for all junior doctors in surgical specialities. Since 2014, Neil has 'trained the trainers' – and this year, is sharing his expertise as course co-director around the world. He said: "I have just returned from Sharjah, Dubai, and will soon be going to. **Express and Star (08.05.19)**

Free bikes to be prescribed to NHS patients amid obesity crisis
Free bikes are to be prescribed to NHS patients for the first time in a bid to improve the health of obese patients. The initiative launches this week and will mean GPs in Cardiff, Wales will be able to assign six months of bike hire subscriptions on prescription for patients. The news follows a new report, published by the NHS, which reveals there has been a 15 per cent increase in the number of UK hospital admissions where obesity is the main or secondary reason. Of the total number of admissions recorded in 2017/18, 10,660 had a primary diagnosis of obesity and 74 per cent of these were women. "Nextbike on prescription allows people to have a go at cycling around Cardiff and realise how this can help to support their overall wellbeing." Nextbike launched in May 2018 and has 500 bikes at 27 sites across the UK in locations such as Warwick, Stirling, and the West Midlands.
Independent (10.05.19)

Spinal muscular atrophy: Spinraza approval delights family
The mother of a girl with a muscle-wasting disease is delighted a drug that may slow her daughter's condition has been approved for use on the NHS.

NHS England said it has agreed the use of Spinraza to treat spinal muscular atrophy (SMA). Heidi Prescott-Booth, 11, from Wolverhampton, was diagnosed with the condition when she was three. Her mother, Katie Prescott, said they are "over the moon" that she will be able to access the drug. SMA is a genetic condition which affects the nerves in the spinal cord, weakening muscles and causing problems with movement, breathing and swallowing. It can significantly reduce life expectancy when it develops in babies and toddlers. For Heidi, the condition means she struggles to walk. Mrs Prescott said: "We are speechless, it is incredible. When Heidi found out she just cried her eyes out." **BBC (15.05.19)**

No-deal Brexit: Secret reports reveal hospitals fear medicine shortages and inability to treat patients
Managers warn of inability to ‘deliver services adequately’ and wards ‘under extreme pressure’ – in documents they were told not to release. Hospitals have raised the alarm about a critical shortage of medicines and an inability to treat patients after a no-deal Brexit, in secret reports the government sought to suppress.

Managers said they feared running out of imported isotopes to detect cancers, staffing shortages and having to abandon clinical trials – as well as a surge in racism and xenophobia. Crashing out of the EU without an agreement has been given a “catastrophic” risk rating by the Dudley Group of hospitals, in the West Midlands, which warned of an inability to “deliver services adequately”. **Independent (16.05.19)**

Cancer patient scans cancelled over equipment problems
Hundreds of cancer patients at West Midlands hospitals have had scans cancelled due to equipment problems. The PET scans are given to patients with advanced stages of the disease including prostate, lung and bowel cancers to see how far it has spread. Alliance Medical, a company contracted to supply isotopes needed to perform the scans, has admitted production problems has led to a shortage. The Royal College of Radiologists said the supply issues were "worrying". Positron Emission Tomography (PET) scans produce 3D images of the inside of the body. They need radioactive isotopes, the commonest of which is fludeoxyglucose (FDG), which has a short life and must be used within hours.

Hospitals with scanners in Birmingham, Coventry and Stoke-on-Trent have reported a 10-month shortage of FDG and about 10% of tests have been cancelled since August 2018. Meanwhile, prostate cancer patients in Birmingham have seen appointments cancelled from a lack of FEC, another isotope. The trust that runs several hospitals in the city, including the Queen Elizabeth, has cancelled about 25% of these prostate cancer scans in the past 10 months. **BBC News (16.05.19)**

Campaigners fear this A&E will close after 12-week NHS 'public conversation' in Staffordshire
Fears over the closure of an A&E have been reignited after health bosses released details of a '12-week public conversation'. The consultation will focus on 'simplifying the local urgent and emergency care system', which campaigners claim is a thinly veiled excuse for closing either the emergency department at County Hospital, in Stafford, or the one based at Queen's Hospital, Burton.

Stafford's A&E is currently only open from 8am to 10pm, with emergency patients at night directed to alternative centres.

This has heaped further pressure on emergency services at Royal Stoke University Hospital, which are already over-stretched. Health campaigner Ian Syme said: "One will become an urgent care centre, I can see that being Stafford. This was all in the plans for sustainability and transformation process for the whole of Staffordshire. **Stoke-on-Trent Live (21.05.19)**

Premature heart-related death rate high in Wolverhampton
Wolverhampton has the highest premature death rate for heart and circulatory diseases in the West Midlands, according to new figures. Figures from the British Heart Foundation (BHF) revealed about 210 people died from conditions including heart attack and stroke in the city before reaching their 75th birthday. About 3,900 premature deaths in the region happen each year, according to the data compiled this month, with as many as 380,000 living with undiagnosed high blood pressure.

A total of 1.5 million adults in the region – or one in three – are classed as obese, with about 380,000 adults having been diagnosed with diabetes. Simon Gillespie, chief executive at BHF, said: “In the UK we’ve made phenomenal progress in reducing the number of people who die of a heart attack or stroke. “But we’re seeing more people die each year from heart and circulatory diseases in the UK before they reach their 75th birthday. **Express and Star (21.05.19)**

Hospital volunteer Steve Ford honoured with memorial plaque
COMMUNITY champion Steve Ford will forever be remembered on the children's ward at Russells Hall Hospital where a plaque honouring his charity work has been unveiled. Steve, a former hospital radio DJ turned children's wish-maker, died suddenly at his Kingswinford home in December at the age of 60 just a few days after helping out with Dudley CVS's annual Operation Santa appeal. Such was his popularity in the community that a further service to celebrate his life and achievements was held today (Tuesday May 22) at Russells Hall Hospital where he had been a dedicated volunteer for more than 30 years. A service in the prayer room was followed by the unveiling of a commemorative plaque on the children's ward where Steve devoted countless hours to trying to bring smiles to poorly youngsters by arranging for them to live their dream for a day. **Stourbridge News (21.05.19)**

Shrewsbury and Telford hospitals to hire 200 more staff
An under-fire hospital trust plans to invest £32m to employ 200 more staff and revamp buildings and equipment. Shrewsbury and Telford Hospitals Trust (SaTH) was put into special measures last November after inspectors decided it could no longer run itself alone. Savings from across the trust and central NHS cash will be used to hire 50 extra A&E nurses, as well as other nursing staff and doctors. The trust's chief executive said it had endured a "very difficult time". Earlier this month, the trust was fined £16,000 over failures surrounding the discovery of asbestos at its Royal Shrewsbury Hospital site. Some £17m of the investment will be used to improve building safety and make them more fire proof and weather resistant. **BBC News (22.05.19)**

This part of the West Midlands has been dubbed the 'least fit place in England'
When it comes to hitting the gym and healthy eating, Wolverhampton folk are slacking - leading to the city being dubbed 'the least fit place in England'. Findings are based on an analysis of the proportion of people across the country who are physically active, eat their five a day and less likely to be overweight. And the bad news is, Wolverhampton comes out worst overall. Less than half (45 per cent) of people in the area said they ate the recommended five portions of fruit or vegetables in 2017/18. It was much lower than the 54.8 per cent across England as a whole who get their five a day. People in Wolverhampton average 2.4 portions of fruit a day, compared to 2.5 across England, and 2.4 portions of veg, compared to 2.7 nationally. As well as being less likely to eat healthily, Wulfrunians are also the least likely to be physically active. Just half (52.1 per cent) of adults said they did the recommended level of exercise in 2017/18. Nationally, 66.3 per cent of people said they were physically active. The Chief Medical Officer currently recommends that adults undertake a minimum of 2.5 hours of moderate physical activity per week, or 75 minutes of vigorous physical activity per week, or a combination of the two, in bouts of 10 minutes or more. **Birmingham Live (24.05.19)**

Himley Hall to host Neon Dash for hospital neonatal unit
Himley Hall is hosting a Neon Dash on June 9 in aid of the Neonatal Unit at Russells Hall Hospital. HIMLEY Hall and Park will be hosting a charity colour run next month to raise funds for the Neonatal Unit at Russells Hall Hospital. The 5k Neon Dash event will take place on Sunday June 9. Members of the public are invited to take part in the event along with staff from The Dudley Group NHS Foundation Trust and their family and friends. DK Running Club is coordinating the race and David Lloyd Leisure will be leading the warm up. There will also be stalls, a bouncy castle, face painting, a barista van, gourmet burgers and various charity stands. Registration starts at 9.30am and a powder blast at 11am will signal the start of the run. Anyone unable to attend event but wishing to contribute to the campaign can make a donation online at justgiving.com/campaign/NeonForNeonatal. Karen Phillips, fundraising manager for the Trust, said: “We want to encourage everyone to come along cheer on the rainbow racers as they are splattered with neon powder for this fantastic good cause." **Stourbridge News (24.05.19)**

Lack of sessions means Telford blood donor unable to give for more than year
Abi Rogansky has been unable to get an appointment in Telford. Abi Rogansky, of Newport, says she wanted to become a regular blood donor but the nearest sessions she can find are in Stafford or Wolverhampton. Last year it was announced that blood donor sessions were being dramatically scaled back in Shropshire and up to 17 members of staff would be made redundant. It emerged sessions in a number of towns including Oswestry, Telford, Bridgnorth and Shrewsbury would be cut due to a fall in demand in the amount of blood needed. But Abi, 45, says it is frustrating for anyone who may find it hard to travel to sessions further afield – if they are successful with getting an appointment in the first place. She said: "About a year and a half ago I decided I wanted to give blood. "I had no idea what blood group I was. **Shropshire Star (29.05.19)**

Appendix one

Blood and Transplant

www.nhsbt.nhs.uk

May 2019

Dear Ms Wake and Dr Hobbs,

2018/19 was another record year for organ donation in the UK with 1600 patients donating organs following their death. Every donation is a reflection of the altruism of the patient and their family and testament to the care and professionalism of colleagues across the NHS who facilitate this complex and lifesaving process. I would like to take this opportunity to thank you and your colleagues within your organisation for their dedication and commitment in achieving this number of organ donors, without which it would not have been possible.

This letter explains how your Trust contributed to the UK's success, as well as highlighting ways to maximise donation opportunities. Colleagues in England may also find the activity data provided helpful for Care Quality Commission (CQC) inspections. With the passing of Max and Keira's Law on the 15th March 2019, resulting in the introduction of deemed consent in Spring 2020, we hope donation numbers will continue to increase and the lifesaving gift of organ donation will benefit many more lives.

Taking Organ Transplantation to 2020: Trust Performance - 2018/19

From 8 consented donors, The Dudley Group Of Hospitals NHS Foundation Trust facilitated 6 actual solid organ donors resulting in 14 patients receiving a transplant during the time period. This is in comparison to 2017/18 when your Trust facilitated one actual solid organ donor from one consented donor.

Quality of care in organ donation - 2018/19

- The referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service and the presence of a Specialist Nurse for Organ Donation when approaching families to discuss organ donation are key metrics that are monitored throughout UK hospitals.

- Your Trust referred 23 patients to NHSBT's Organ Donation Services Team; 22 met the referral criteria and were included in the UK Potential Donor Audit. There were no additional audited patients that were not referred.
- A Specialist Nurse was present for 11 organ donation discussions with families of eligible donors. There was 1 occasion when a Specialist Nurse was absent for the donation discussion.
- There was 1 (3%) missed opportunity to follow best practice out of 34 during the time period, compared with 4 (25%) out of 16 in 2017/18.

For various reasons it may not always be possible to follow best practice; if there was an occasion when best practice was not followed your Organ Donation Committee Chair or Clinical Lead for Organ Donation will be able to explain the circumstances. For further information on best practice in organ donation see NICE Clinical Guidance 135.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and performance data at the Board with support from your Organ Donation Committee Chair and Clinical Lead for Organ Donation.

Why it matters

In 2018/19, 370 people benefited from a solid organ transplant in the West Midlands. However, 35 people died on the transplant waiting list during this time and 570 people were still waiting as of the 31 March 2019.

Thank you for your ongoing support for organ donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ Donation and Transplantation
NHS Blood and Transplant

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors June 2019

TITLE:	**CHIEF NURSE REPORT**		
AUTHOR:	**Carol Love-Mecrow, Deputy Chief Nurse**	**PRESENTER:**	**Mary Sexton Interim 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.*

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

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

The Board is requested to review and note the report and the work being undertaken to address areas of risk associated with complaints activity.

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:

The Chief Nurse has professional responsibility for nurses, midwives and allied health professionals (AHPs) within the Trust however, does not operationally manage the majority of these staff. The oversight and management of staff within the Trust is within the divisional management structure, which reports to the chief operating officer (COO) via the divisional directors.

Appendix 1 Provides a summary of the revised Nursing and Midwifery strategy

Celebrating Nursing Week 2019

- A series of events were held in celebration of International Nurses Day (on 12th May) to recognise and celebrate the contribution of nursing staff.
- A week of celebrations started with –
- Maternity Monday
- Toddlers Tuesday, with a visit from *Star Wars,* UK Garrison
- Wellbeing Wednesday, with tea and coffee taken to staff in wards and departments across all sites
- Conference Thursday, including launch of the revised nursing and midwifery strategy.
- Fun day Friday, which culminated in the Trusts first bed making competition, with the outpatients department claiming victory for fastest time and C7 won the prize for best team name '*Bed Heads'*.

Nursing Conference on 9th May.

- The nursing and midwifery conference was held on the 9th May with over 90 delegates representing nursing, midwifery and allied healthcare professionals. The theme of the day was pride in our nursing profession.
- Presentations showcasing current work and achievements were given from:
  - The Parkinson's Lead
  - Day case theatres
  - Nutrition
  - Maternity
  - Corbett Outpatients
  - Diabetes
  - The Enhanced Care Team
  - The Lead for Humans Factors and Patient Safety

Nursing and Midwifery Strategy

The revised strategy was launched on 9th May 2019 as part of the Trust programme of celebrations to mark 'International Nurses Day'. Appendix 1 shows the revised strategy summary

The Florence Nightingale Ceremony

The Chief Nurse, Gail Parsons, Rachel Tomkins and Claire MacDiarmid represented the Trust at the Florence Nightingale Ceremony at Westminster Abbey on 15th May 2019.

AHP Update

- First Contact Physiotherapy (FCP) is aN NHS England initiative to reduce the pressure & workload on GP appointments and offer patients early access to physiotherapists with specialist Musculoskeletal (MSK) assessment and treatment skills. Patients can book directly to see a physiotherapist for any MSK complaints such as knee osteoarthritis and low back pain rather than having to see their GP first. Studies and pilot sites have shown to reduce patient waiting times, reduce chronicity of conditions, high patient satisfaction and increased orthopaedic conversion rates in secondary care. Dudley is the early implementer site for Black Country STP and we have been running FCP since October 2018 out of six GP surgeries. Based on the success of our early implementer sites, FCP has been written into the Community MSK contract for this year. The service has recently advertised 8 additional full time posts (4 band 7 and 4 band 8a) which will support roll out FCP to all GP surgeries in Dudley. It is expected that this will continue to have a positive impact on the patient's journey, improve working relationships with GPs, reduce delays and reduce unnecessary imaging resulting in a more cost efficient service.

- With an increased demand for occupational therapy and physiotherapy student placements, it has been identified that there is a need to consider how we can work more effectively with our local universities to support the development of our future workforce. The Quality lead for AHPs canvassed local universities (Coventry, Wolverhampton, Worcester, Birmingham and Birmingham City)to see if they would be willing to meet to discuss looking at a more coordinated and equitable approach to managing occupational therapy

and physiotherapy student placements. The five universities approached have been extremely receptive and a meeting has been arranged for 5th June 2019 to discuss how we can take this forward.

Safer Staffing

- Meetings with Lead Nurses/Midwives and Matrons continue focusing on recruitment and retention of staff to deliver the reduction in bank and agency usage.

Agency Controls

- All bank and agency requests continue to be assessed daily by the Divisional Chief Nurses to ensure continued patient safety and financial balance.
- The Chief Nurse, Deputies and Divisional Chief Nurses are analysing in detail the use of bank and agency nurses and their authorisation to ensure control.
- Check and challenge meetings have been reinstated across the Divisions.

Recruitment and Retention

- The next corporate recruitment event is scheduled for the 14th June 2019 in the main reception health hub. The event is targeting experienced nurses, looking to return to the NHS from the private sector localities such as nursing homes, practice nursing and other care settings, as well as student nurses due to qualify.

- The following areas have local events booked for May and June 2019:
  - C3 - 18th May 2019
  - AMU - 23rd May 2019
  - ED - 5th June 2019
  - B3 – 19th June 2019

- At the time of the report, a total of 23 experienced staff are currently going through recruitment clearances 32 external graduates have been recruited and offered posts for September 2019 (30 adult, 1 paediatric, 1 return to practice)
- 7 newly qualified ODP`s have been recruited to commence in September 2019.
- Dudley graduates, due to qualify in September 2019 will be applying to the Trust 20th May 2019 with allocations and job offers sent in June 2019
- 7 external graduates have been recruited and offered posts for January 2020.

Professional Development

Sepsis Practitioners

- The business case for two additional sepsis practitioners to support trust wide sepsis management is awaiting confirmation of divisional support. At the time of this report this had been received from medicine with a decision from the surgical division still awaited.
- Development of the Deteriorating Patient strategy is underway. A meeting between the Chief Nurse and Medical Director has occurred and priorities agreed.

Pre-Registration

- Recruitment to the Trainee Nursing Associates role is underway. Numbers for the Wolverhampton and Worcester universities are being finalised.
- The Trust has agreed to increase the placement numbers across the Trust as part of a national programme commencing from September 2019.

Safeguarding

- Operational management of the safeguarding team continues to be undertaken by the Deputy Chief Nurse. Sadly, the Head of Safeguarding has submitted her resignation following a period of sickness absence. A review of the job description and recruitment to this post will commence shortly.

Falls

- There were no patient falls with harm reported during April 2019. Falls without harm remain below the national average.
- The introduction, this year of a fall CQUIN will place additional pressure on the Fall Practitioner to collect the required data. Discussions are underway to try and mitigate this

Mental Health Act

- During April 2019 there was one patient detained on section 5 (2). This patient was appropriately supported and transferred to Mental Health Trust services.

Patient Experience

- The Head of Patient Experience has completed a business case to increase staffing levels in complaints, PALs and the patient experience departments.

Complaints

- The Trust received 50 new complaints during April 2019; this is a slight decrease from March 2019.
- Communication continues to be the main focus for the largest number of complaints. The recently revised nursing and midwifery strategy has outlined a commitment to improve patient choice and the personalisation of care, which is hoped to improve the communication with patients and carers.

Tissue Viability

- There have been no Category 4 pressure ulcers reported as a serious incident in either in hospital or community during April 2019. There were two category 3 pressure ulcers reported as avoidable in Trust. The Tissue Viability team continues with its programme of staff development in pressure ulcer prevention.
- A joint working project with the CCG and Public Health has been launched to work with the alcohol and intravenous drug team to develop a wound care clinic in response to a local audit that identified the actual and potential risk of infection leading to amputation of limbs in this client group. The business case has been developed and this will be presented for consideration.

RISK	**Y**		**Risk Description** As detailed within the BAF under the chief nurse
	Risk Register: Y		**Risk Score** As detailed within the BAF
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details**
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

Appendix 1

Revised Nursing and Midwifery Strategy 2019

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th June 2019

TITLE:	**Quality Priorities and Report 2018/19**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER:**	Mary Sexton Interim Chief Nurse

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD / COMMITTEE / GROUP:

Decision	Approval	Discussion	Other
		X	

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐	X	☐	☐
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

To note the end of year situation with the 2018/19 quality priorities and the annual Quality Report

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:

A) A summary of the end of year position with the quality priorities from 2018/19.
Patient Experience – Partially Achieved. a) FFT Recommended scores: Achieved on 43 of the 95 published scores. b) Response Rates: Achieved on 44 of the 60 published scores. c) Local Survey results: Same score as last year so not achieved. d) Pain Management quality indicator: Improved from last year and achieved.
Avoidable Pressure Ulcers – Partially Achieved in the Hospital with zero category 4 ulcers but a slight rise in category 3 ulcers. Achieved in the Community with zero category 4 ulcers and a 60% decrease in category 3 ulcers.
Infection Control – Partially Achieved. Achieved national target in C. diff cases but one MRSA bacteraemia case occurred.
Nutrition and Hydration – Partially achieved. MUST assessment target achieved in the community but not in the hospital and the Nutrition Audit target narrowly missed.
Medications - Not achieved. Medication recording target narrowly missed and use of red wrist bands audit missed in one quarter.
Discharge Management – Partially Achieved. Delays in discharge target achieved and expected discharge date recording and early discharge targets missed.
Incident Management – Partially Achieved. Number of serious incidents target achieved with a large decrease compared to last year and the increase of 3.4% in reported incidents narrowly missed the 5% increase target.
B) The position with the production of the actual Quality Report document.
C) A one page outline of the agreed quality priorities for 2019/20

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:** Quality Report Requirements
	Other	**Y**	**Details:** DoH Quality Account requirements

THE DUDLEY GROUP NHS FOUNDATION TRUST

QUALITY ACCOUNT UPDATE – END OF YEAR 2018/19

A) End of year position with quality priorities 2018/19

Priority 1 for 2018/19: Patient experience

a) Achieve monthly response rates in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.

b) Achieve monthly scores in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.

c) Improve the overall year score from 2017/18 to 2018/19 for the following question used in our local real-time survey: Were you involved as much as you wanted to be in decisions about your care?

d) Ensure that in 95 per cent or more cases, a patient's pain score is recorded at least every four hours (unless otherwise indicated in the exception box).

Family and Friends Test

a) **Recommended scores:** For the whole year, 95 comparative national scores have been published and on 43 occasions the Trust achieved the target where the score is equal to or better than the national average percentage recommended. The areas missing the target are inpatients, A&E and outpatients for April to March, maternity antenatal for September, maternity birth for June, November and January, maternity postnatal ward for November, December and January, maternity postnatal community for September and December and community for September to March.

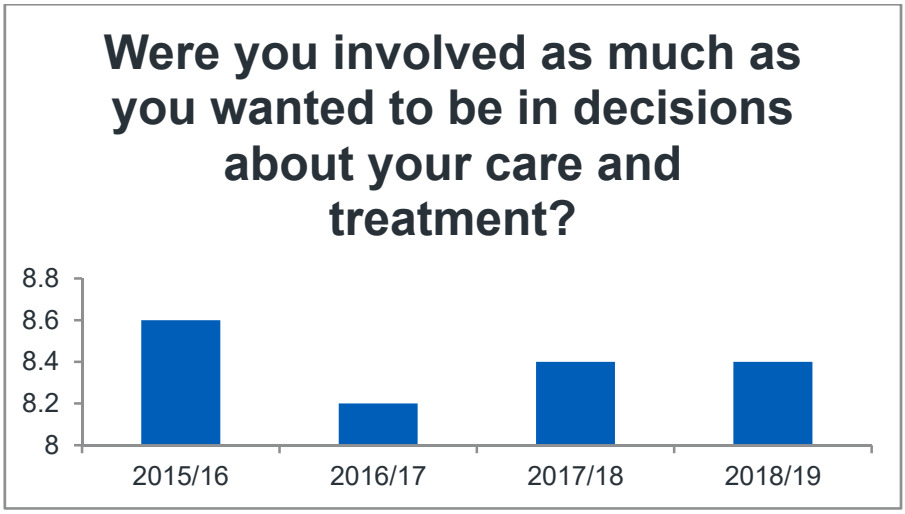
% FFT recommended Scores	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Inpatient	**95**	**93.7**	**94.4**	**94.1**	**93.7**	**93.0**	**94.1**	**94.0**	**93.1**	**94.8**	**94.8**	**93.6**
National	96	96	96	96	96	96	96	96	96	96	96	96
A & E	**82**	**77.8**	**77.1**	**76.2**	**77.1**	**75.7**	**80.2**	**76.9**	**76.3**	**75.6**	**74.3**	**71.5**
National	87	87	87	87	88	86	87	87	86	86	86	86
Maternity Antenatal	**98**	**97.5**	**100**	**98.3**	**99.1**	**94.5**	**100**	**97.2**	**96.9**	**100**	**98.3**	**98.3**
National	97	95	96	95	95	95	95	95	95	96	96	95
Maternity Birth	**99**	**97.8**	**96.5**	**100**	**98.6**	**96.8**	**100**	**96.2**	**98.3**	**94.4**	**100**	**98.8**
National	97	97	97	97	97	96	97	97	97	97	97	97
Maternity Postnatal Ward	**98**	**95.6**	**96.5**	**98.9**	**98.6**	**95.7**	**98.5**	**93.5**	**94.3**	**94.4**	**100**	**97.6**
National	95	95	95	95	95	94	95	95	95	95	95	95
Maternity Postnatal Community	**98**	**100**	**100**	**98.1**	**100**	**96.5**	**100**	**100**	**94.8**	**100**	**100**	**100**
National	*	98	98	98	98	98	98	97	98	98	98	98
Community	**96**	**95.3**	**96.7**	**95.6**	**96.2**	**93.3**	**94.1**	**93.7**	**92.7**	**93.2**	**92.8**	**92.6**
National	96	95	95	95	96	95	96	96	95	96	96	94
Outpatients	**90**	**89.4**	**90.5**	**87.4**	**91.3**	**88.9**	**90.2**	**89**	**90.2**	**91.1**	**90**	**89.1**
National	94	94	94	94	94	93	94	94	94	94	94	94

b) **Response Rates:** For the whole year, 60 comparative national scores have been published and on 44 occasions the Trust achieved the target where the percentage response rate score is equal to or better than the national average percentage response rate. The areas missing the target are maternity birth for August, community for April, May, August and February and outpatients for May 2018 to March 2019.

% response rate	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Inpatient	**32.3**	**33**	**42.4**	**35.9**	**31.9**	**35.0**	**32.5**	**35.0**	**30.5**	**32.3**	**36.2**	**34.9**
National	24.9	25.6	25.2	25.2	25	24.7	24.9	24.6	22.2	24	24.6	24.6
A &E	**17.9**	**18**	**19.1**	**18.6**	**16.6**	**18.2**	**18.6**	**17.7**	**17.5**	**18**	**18.5**	**19.5**
National	12.9	12.4	13.0	12.8	12.9	12.2	12.2	12.1	11.4	11.9	12.2	12.3
Maternity Antenatal	**20.4**	**91.4**	**70.2**	**52.4**	**56.8**	**28.7**	**26.9**	**42.3**	**16.5**	**14.3**	**44.9**	**73.1**
National	**	**	**	**	**	**	**	**	**	**	**	**
Maternity Birth	**40**	**38**	**33.6**	**27.4**	**19.9**	**27.4**	**40.6**	**29.7**	**36.3**	**47.7**	**37.7**	**26.3**
National *	23.2	22	21	20.87	20.3	20.3	21.1	20.9	18.4	21.8	22	21.6
Maternity Postnatal Ward	**39.8**	**37.5**	**34.0**	**27.6**	**19.7**	**27.6**	**40.1**	**30.0**	**36.5**	**47.7**	**37.9**	**26.4**
National	**	**	**	**	**	**	**	**	**	**	**	**
Maternity Postnatal Community	**1.3**	**15.3**	**19.5**	**24.1**	**15.8**	**18.8**	**11.8**	**11.8**	**20.9**	**6.5**	**7.7**	**4.7**
National	**	**	**	**	**	**	**	**	**	**	**	**
Community	**2.9**	**3**	**4.2**	**4.1**	**3.2**	**5.8**	**6.1**	**5.3**	**3.7**	**4.7**	**4.0**	**5.5**
National *	3.3	4.0	3.7	4.13	3.5	3.5	3.33	3.76	3.24	4.7	4.2	4.07
Outpatients*	**5.7**	**5.7**	**3.4**	**5.8**	**5.8**	**5.4**	**5.8**	**5.3**	**4.8**	**4.0**	**4.0**	**4.4**
National *	4.9	7.0	6.8	7.0	6.6	6.4	7.4	7.2	5.4	7.2	6.4	6.83

*denotes areas where no national response rate data is published. This has been calculated internally using 12 months of NHS England raw data from February 2017 to January 2018. ** No national raw data available. (Comparative figures for 2017/18 for measure a) are available in last year's report. Measure b) is a new priority this year).

c) The results of the local survey question 'Were you involved as much as you wanted to be in decisions about your care?' were 8.4 - the same as scored in the previous year (see graph below). With no improvement this means that the target has not been achieved.



This is a weighted score also known as a partial credit score consistent with the NHS Survey programme.

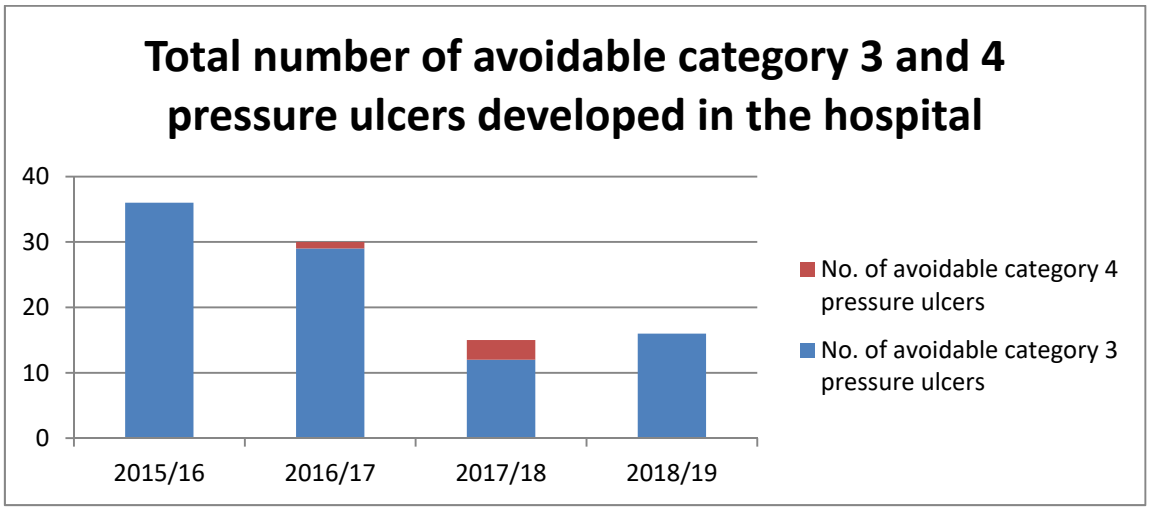
d) Pain management

The target has been met for all separate quarters and for the whole year. It has been decided to replace this target in 2019/20 with a different topic.

Quality Dashboard	2017/18	Quarter 1 2018/2019	Quarter 2 2018/2019	Quarter 3 2018/19	Quarter 4 2018/19	2018/19
Pain score	**93%**	**98%**	**98%**	**99%**	**98%**	**98%**

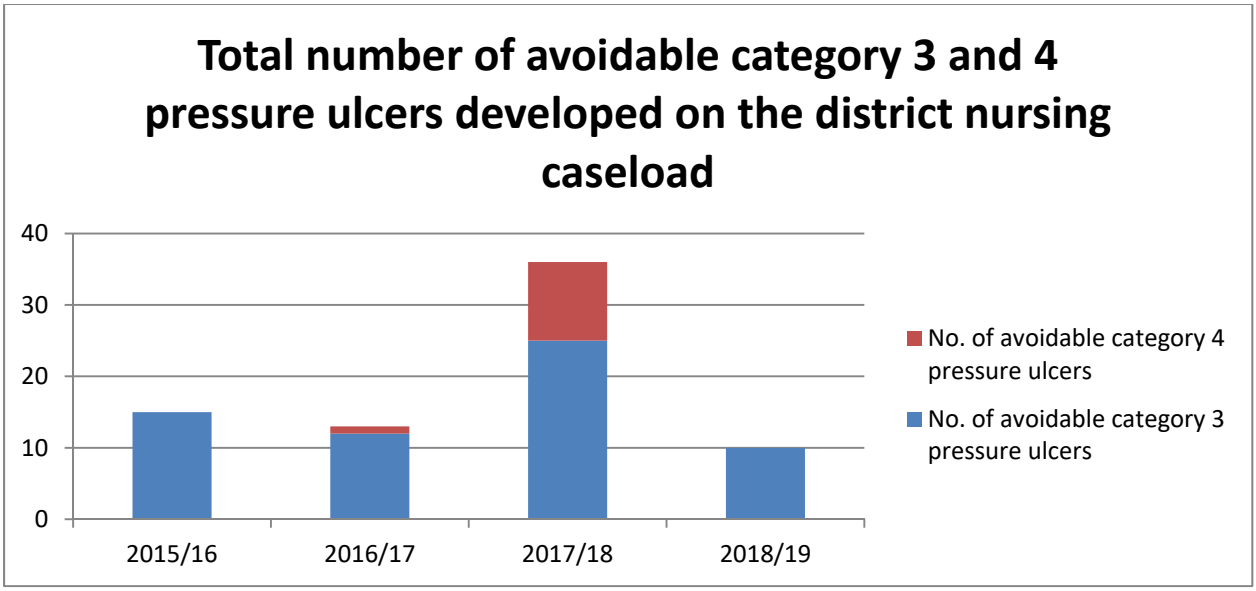
Priority 2 for 2018/19: Pressure ulcers	
Hospital	**Community**
a) Ensure that there are no avoidable category 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable category 3 hospital acquired pressure ulcers in 2018/19 reduces from the number in 2017/18 by at least 10 per cent.	a) Ensure that there are no avoidable category 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable category 3 pressure ulcers acquired on the district nurse caseload in 2018/19 reduces from the number in 2017/18 by at least 10 per cent.

The graph below shows the total number of avoidable category 3 and 4 pressure ulcers that have developed in the hospital from 2015/16 to the present. It gives an indication of the fall in numbers due to the hard work of all staff involved. While there has been a slight increase from 12 to 16 avoidable category 3 ulcers since last year there have been zero avoidable stage 4 pressure ulcers.



In the 2017/18 quality report we reported 18 avoidable category 3 ulcers. Investigations that continued after the year end found that six of these were unavoidable.

The target of there being no avoidable category 4 pressure ulcers acquired throughout the year on the district nurse caseload has been achieved. The target to reduce the number of avoidable category 3 ulcers by 10% has been achieved with a 60% decrease from 2017/18 (see graph below).

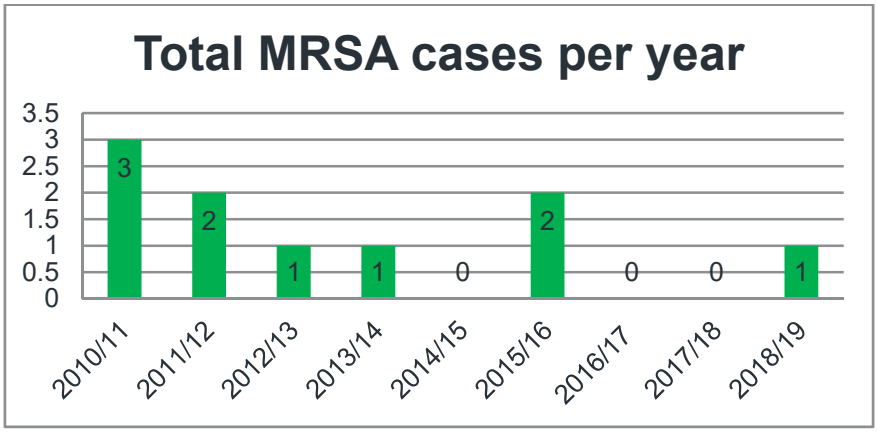


In the 2017/18 quality report we reported 24 avoidable category 3 ulcers and 10 avoidable category 4 ulcers. Investigations that continued after the year end later found a further one ulcer in both categories.

Priority 3 for 2018/19: Infection control	
Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.	
MRSA	**Clostridium difficile**
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 28 post 48 hour cases of Clostridium difficile with a lapse in care identified.

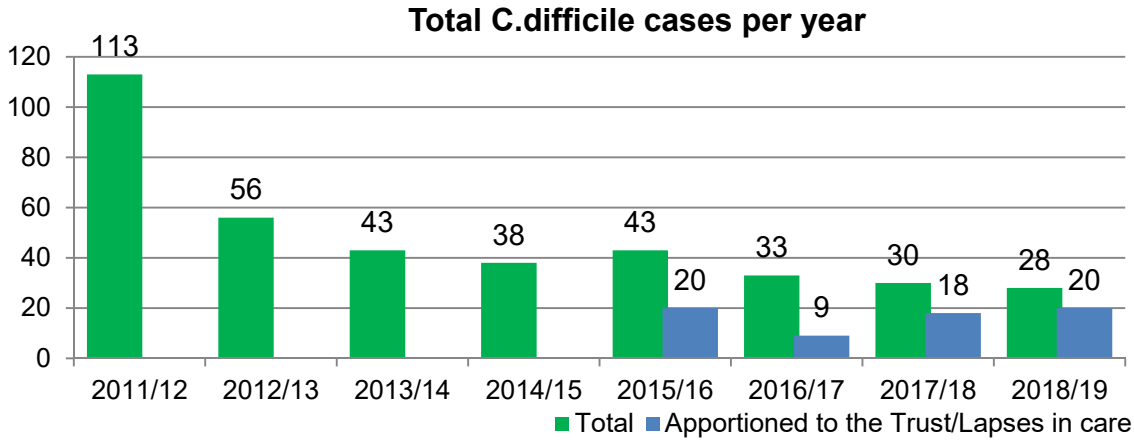
MRSA

NHS England has set a zero tolerance approach to MRSA bacteraemia. There has been one Trust assigned MRSA bacteraemia in this period. The case has undergone a root cause analysis utilising the national tool. The cause was believed to be a contaminant. The outcomes of the RCA were presented and discussed at a multidisciplinary meeting chaired by the CEO and including representatives from the Dudley Office of Public Health and Dudley CCG. Learning outcomes and actions were identified and shared at ward level via staff meeting/huddle board and with the wider Trust through divisional meetings and the infection prevention group.



Clostridium difficile

There have been 28 cases of Clostridium difficile of which 20 cases have been identified as having lapses in care and therefore count against the Trust threshold of 28 cases. Eight cases have been identified as having no lapses in care. The yearly target of 28 with lapses in care has therefore been achieved this year.



Priority 4 for 2018/19: Nutrition and hydration

Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items)
a) is 95% or above in each of the first three quarters for the Trust as a whole, and
b) has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital.

Nutrition assessments – hospital	Nutrition assessments – community
At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission using the nationally recognised MUST (Malnutrition Universal Screening Tool).	At least 95% of patients will receive a nutritional assessment on initial contact with the community health nursing team using the nationally recognised MUST (Malnutrition Universal Screening Tool).

The charts below show that we have achieved one of the three targets this year.

Quality Dashboard	2017/18	Quarter 1 2018/2019	Quarter 2 2018/2019	Quarter 3 2018/19	Quarter 4 2018/19	2018/19
Nutrition Audit Hospital	94%	94%	94%	94%	96%	94%

Wards: Qtr 4	
95% and above	11
94 to 85%	4
84% and less	0

Quality Dashboard	2017/18	Quarter 1 2018/2019	Quarter 2 2018/2019	Quarter 3 2018/19	Quarter 4 2018/19	2018/19
MUST Assessment Hospital	93%	91%	89%	89%	90%	90%

Quality Dashboard	2017/18	Quarter 1 2018/2019	Quarter 2 2018/2019	Quarter 3 2018/19	Quarter 4 2018/19	2018/19
MUST Assessment Community	96%	97%	98%	96%	98%	97%

As the content of the nutrition audit is being reviewed and as the target has nearly been achieved, it has been decided for 2019/20 to concentrate on one single element of the audit (see below). The MUST target in the hospital is being retained in 2019/20. With regards to the MUST target in the community, this has now been achieved for two years and so it has been decided to replace it by another important target for the community that comes under the Discharge Management section (see below).

Priority 5 for 2018/19: Medications

a) Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.

b) All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.

Quality Dashboard	2017/18	Quarter 1 2018/2019	Quarter 2 2018/2019	Quarter 3 2018/19	Quarter 4 2018/19	2018/19
Medications signed and dated or omission code recorded	93%	95%	92%	95%	97%	94%

This target was achieved for three of the four quarters and narrowly missed for the whole year. Due to the improved performance from 2017/18 and because in 2019/20 the Trust is introducing an electronic medication prescribing and administration system which means that it will be mandated for nurses to complete this information for each patient, it has been decided to replace this target with a different medication target in 2019/20.

	2017/18	Quarter 1 2018/2019	Quarter 2 2018/2019	Quarter 3 2018/19	Quarter 4 2018/19
Use of Red Wrist Bands	-	-	-	**90%**	**100%**

This audit was new in 2018/19. It did not commence until Q3 when it was undertaken on two wards with a result of 90%. It became part of the regular monthly quality indicator audits in Q4 when the results were 100%. Due to it not being monitored for the whole year, it has been decided to retain this target in 2019/20.

Priority 6 for 2018/19: Discharge Management

a) All patients will have an Expected Discharge Date (EDD) determined by assuming ideal recovery and assuming no unnecessary waiting.
b) Early discharge. All medical and surgical wards will discharge the following number of patients before midday: In Q1, at least one patient. In Q2 at least two patients, which will be maintained in Q3 and Q4.
c) Delays in discharge. The total number of days that patients due for discharge are delayed will reduce by the following compared to the same quarter in 2017/18: Q1 by 10 per cent, Q2 by 15 per cent, which will be maintained in Q3 and Q4.

a) Expected Discharge Date (EDD)

	Overall EDD Percentage Recorded	Monthly Range of EDD Percentage Recorded
April 18 - March 19	73.3%	67.7- 79.6%

This new target was not met this year and so will be retained for next year.

b) Early Discharge.

	Q1 (91 days)	Q2 (92 days)	Q3 (92 days)	Q4 (90 days)
Ward	Days with 1 patient Discharge 7am-12am	Days with 2 patient Discharges 7am-12am	Days with 2 patient Discharges 7am-12am	Days with 2 patient Discharges 7am-12am
A2	87	32	34	37
B1	86	8	17	18
B2 - Trauma	77	3	0	4
B2 - Hip	77	1	4	0
B3	89	25	23	18
B4	85	19	14	10
B5	72	8	11	8
B6	60	11	12	0
C1	80	5	5	5
C3	83	25	37	25
C4	56	4	26	1
C5	81	10	15	20
C6	81	27	12	16
C7	67	11	15	12
C8	83	9	10	12

A number of wards came close to achieving this new target in Q1 but it is realized that the targets set for the rest of the year were over ambitious, and that the nature of the ward and the types of patients that are assigned to it should determine a target for that specific ward.

c) Delays in discharge.
Comparison of each quarter of 2018/19 with the same periods in 2017/18

	Reimbursable delays	Total delays	% decrease (reimbursable)	% decrease (total delays)
2017/2018 Q1	2126	3856		
2018/2019 Q1	445	1464	70%	55%
2017/2018 Q2	1463	2575		
2018/2019 Q2	293	855	80%	67%
2017/2018 Q3	1370	2911		
2018/2019 Q3	576	1489	61%	49%
2017/2018 Q4	744	1740		
2018/2019 Q4	514	1145	31%	34%

(Reimbursable delays are related to social services' responsibilities while totals also include delays due to Trust processes and relatives seeking accommodation for patients medically fit for discharge).

Delays in discharge have reduced from last year for every quarter and so the target was met.

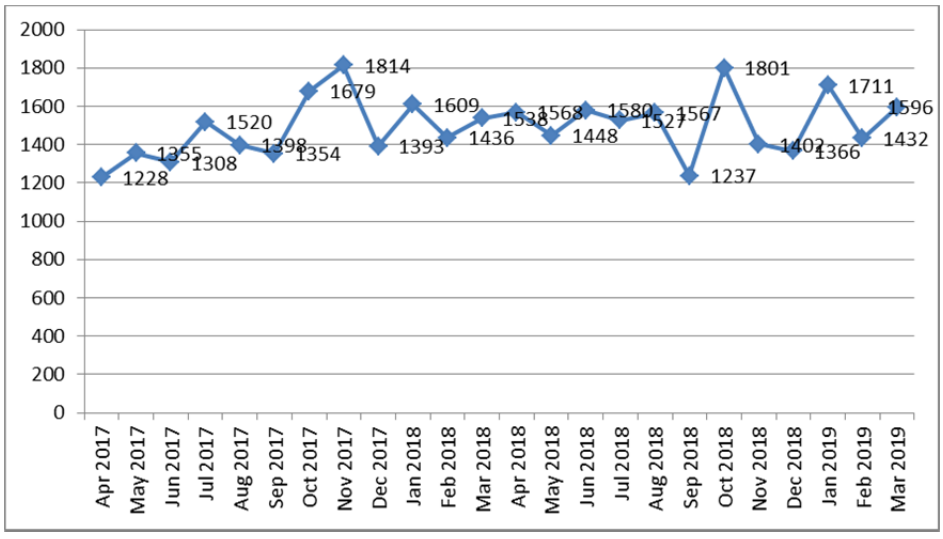
As delayed discharges are being reduced we are seeing some improvement in beds being available for emergency patients. A considerable amount of work is underway to ensure effective patient flow through the organisation. It is realized that more work is needed and so targets on discharge management will be revised and retained for 2019/20.

Priority 7 for 2018/19: Incident Management

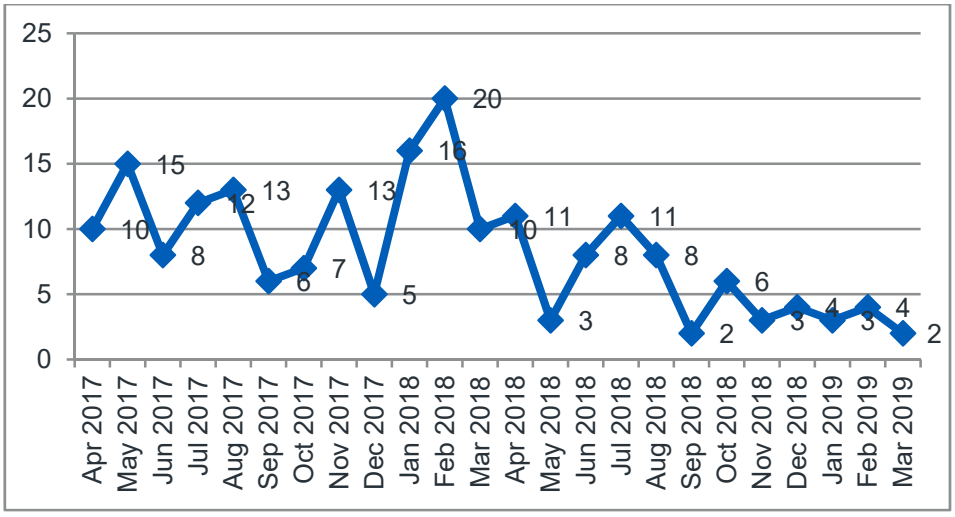
a) The Trust's reporting rate will increase every quarter, culminating in a five per cent increase for the whole year and its comparative position on the reporting rate of incidents will improve every six months.

b) In 2018/19, for the full year reduce the number of Serious Incidents (non-pressure ulcers) by five per cent compared to the numbers in 2017/18.

With regards to the number of incidents reported (see the chart below), the Trust has seen an increase over the year (April 2018 - March 2019). There has been a 3.4 per cent increase compared to 2017/2018 and so the target of a five per cent increase for the whole year has been narrowly missed.



With regards to the number of serious incidents reported (see the chart below), the Trust has seen a decrease over the year (April 2018 - March 2019). There has been a 52 per cent decrease compared to 2017/2018 and so the target of a five per cent decrease for the whole year has been achieved.



B) Position with production of Quality Report 2018/19

The first draft was commenced at the end of January and made available to Dudley Clinical Commissioning Group, Dudley Council Overview and Scrutiny Committee, Dudley Healthwatch and the Governors for their comments in early March. Their comments were returned in the first week of April. In the meantime, the Dudley Overview and Scrutiny Committee meeting was attended at the end of March and the document went through a number of further drafts. The external auditors, PwC, received a draft for their contents and consistency check during April. The final report (with some end of year data still to be completed) was presented to the Audit Committee on the 22nd May and ratified before it is submitted to NHSI.

C) Quality Priorities for 2019/20

These were agreed by the Board and a one page format of these has been produced (see next page). A poster on these for publicity to all wards/departments is presently being printed.

The Dudley Group NHS Foundation Trust - Quality Priorities 2019/20

Priority 1: Patient experience

a) Achieve monthly response rates in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.
b) Achieve monthly scores in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.
c) Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real-time survey: Were you involved as much as you wanted to be in decisions about your care?
d) Improve the overall year score from 2018/19 to 2019/20 for the following question used in our local real-time survey: When you reached the ward, were you given a 'Welcome to Russells Hall Hospital' booklet?

Priority 2: Pressure ulcers

Hospital	Community
a) Ensure that there are no avoidable category 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable category 3 hospital acquired pressure ulcers in 2019/20 reduces from the number in 2018/19 by at least 10 per cent.	a) Ensure that there are no avoidable category 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable category 3 pressure ulcers acquired on the district nurse caseload in 2019/20 reduces from the number in 2018/19 by at least 10 per cent.

Priority 3: Infection control

Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.

MRSA	Clostridium difficile
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 49 hospital onset healthcare associated cases detected three or more days after admission or community onset healthcare associate cases that occur in the community when the patient has been an inpatient in the Trust in the previous 4 weeks.

Priority 4: Nutrition and Hydration

a) At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission to the hospital using the nationally recognised MUST (Malnutrition Universal Screening Tool).
b) With regards to supported mealtimes, 95% of all of the monthly audits will have a positive response to the following three questions:
1) Has all non-essential activity stopped? 2) Is there a nominated qualified nurse overseeing the mealtime? 3) Is there a nominated person to support all patients identified as requiring assistance?

Priority 5: Medications

a) All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.
b) Achieve a 50% reduction in the number of-patients who are not prescribed analgesia for breakthrough pain when they are prescribed regular opioids for pain management

Priority 6: Discharge Management

Hospital	Community
a) All patients will have an Expected Discharge Date (EDD) determined by assuming ideal recovery and assuming no unnecessary waiting. b) All wards will achieve their individually set target for the number of discharges per day.	a) Develop an audit tool, commence monitoring and capture a baseline in Q1 b) The percentage of patients with an advanced care plan in the community is increased by 10% from the baseline by the end of the year.

Priority 7: Incident Management

a) The Trust's reporting rate will increase every quarter, culminating in a 5% increase for the whole year and its comparative position on the reporting rate of incidents will improve every six months.
b) To reduce the number of breached incident investigations by 30%.

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board 6th June 2019

TITLE:	**28th May 2019 Clinical Quality, Safety and Patient Experience Committee Effectiveness Discussion Summary**		
Author	Mary Sexton – Interim Chief Nurse	**PRESENTER**	Catherine Holland – Committee Chair

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF THE BOARD

Decision	Approval	Discussion	Other
			Y

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐ High level of confidence in delivery of existing mechanisms / objectives	☐ General confidence in delivery of existing mechanisms / objectives	☒ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

The Board should note the assurances provided by the Committee and the actions they took at the last meeting.

CORPORATE OBJECTIVE:

SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services
SO3 – Drive service improvement

SUMMARY OF KEY ISSUES:

At the May Clinical Quality, Safety & Patient Experience Committee (CQSPE)the following matters were considered:

In respect of the review of the CQSPE Terms of Reference, reporting groups, format of Governance Framework a wide ranging discussion took place and actions were agreed. A proposal paper was discussed and considered with agreement that a wider discussion was required.

The Committee received assurance in respect of

- Maternity practice in relation to performance against CNST Standards
- Update on CQC Inspection draft report findings and factual accuracy check and timeline in

relation proposed publication.

- Corporate risk register – key new risks identified.
- ED Summary dashboard an improvement plan in respect of the roll out of IT system and impact on performance.
- National Paediatrics Diabetes Audit and action plan
- Independent Service Review of Adult Emergency Medicine report and action plan
- Infection Prevention control Quarter 4 report
- Safeguarding Quarter 4 report

The committee received assurance that the issues relating to COSHH within departments had now been resolved.

Matters of concern for escalation to Board are:

- Ophthalmology waiting list for follow up appointments particularly in respect of Glaucoma patients.
- Timeliness of complaints responses and not meeting agreed timelines and concerns regarding backlog of outstanding complaint responses.
- MSA Breaches related to capacity issues
- Risk associated with number of vacant post for speech and language therapists and risk to service provision.
- External visits report - the committee received by Division an update on their delivery of actions to address external reviews/visits over last 4 years and noted there were still a number of actions that had yet to be fully completed. Plans were in place at Divisional level.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** covers many risks, key are those related to the Trust quality priorities, deteriorating patient and patient experience
	Risk Register: Y		**Risk Score:** numerous across the BAF, CRR and divisional risk registers
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Links all domains
	NHSI	**Y**	**Details:** Links to good governance
	Other	**N**	**Details:**

Enclosure 16

The Dudley Group
NHS Foundation Trust

TITLE:	Patient Safety Strategy		
AUTHOR:	Dr.N.Calthorpe Patient Safety Lead	PRESENTER	Dr. J.Hobbs Medical Director

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
N	Y	N	To note

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

To approve the Patient Safety Strategy to support the delivery of key activity over the next 3 years

CORPORATE OBJECTIVE:

SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

The Patient Safety Strategy 2019-2020 is one of a series of documents underpinning The Dudley Group NHS Foundation Trust Strategy 2019-2021. The strategy is in particular support of Strategic Objective 2 'Delivering Safe and Caring Services'.

Our strategy details 4 priority areas of focus which are aligned to the national strategy.

1. Optimising the care of the deteriorating patient
2. Improving the understanding of Human Factors and the role they have in Patient Safety
3. Developing our Patient Safety culture
4. Undertaking safe handovers of care both within hospital and community settings to external providers.

The Board are asked to note and accept the revised Patient Safety Strategy document

IMPLICATIONS OF PAPER:

RISK	N	Risk Description:
	Risk Register: N	Risk Score:

COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe and Effective**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

PATIENT SAFETY STRATEGY		
	DOCUMENT TITLE:	**PATIENT SAFETY STRATEGY**
	Name of Originator/Author /Designation & Specialty:	Dr Nicola Calthorpe, Consultant Anaesthetist and Patient Safety Lead
	Director Lead:	Dr Julian Hobbs, Medical Director
	Target Audience:	All staff, Trust wide
	Version:	V2
	Date of Final Ratification at Committee/Board of Directors:	June 2019
	Review Date:	June 2020
	Registration Requirements Outcome Number(s) (CQC)	SAFE Effective Well led
	Relevant Documents /Legislation/Standards	NICE guidance (CG 50, 169, NG 31) NHSi consultation on revised patient safety strategy 2019
	Contributors: ***Individuals involved in developing the document*.**	Designation: Patient Safety lead Medical Director
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
V1	26/03/2019	*This is a new document*
V2	22/5/2019	*Comments from Stakeholders*

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

THE DUDLEY GROUP NHS FOUNDATION TRUST

PATIENT SAFETY STRATEGY

1. INTRODUCTION

The Patient Safety Strategy 2019-2021 is one of a series of documents underpinning The Dudley Group NHS Foundation Trust Strategy 2019-2021. The strategy is in particular support of Strategic Objective 2 'Delivering Safe and Caring Services'.

"Care better every day" is a challenging and aspirational vision for the organization and encompasses the aim to deliver patient centred care, and improved outcomes through a culture of continuous improvement.

Three underlining principles are highlighted in the national consultation on patient safety and are reflected in this document. These are; a just culture, openness and transparency and continuous improvement.

As such these three elements are the cornerstones to making our Trust the safest for patient care and becoming Outstanding. The consultation document expands on this further:

"These encompass values and behaviours that are fundamental to delivering safe healthcare for patients. While they are not the only principles or ways of describing what should underpin a safety culture, we believe they are the most pertinent to the challenges we face. Together they should form a golden thread that runs through all aspects of healthcare from frontline provision and the interaction between patients and clinicians, to national leadership for the healthcare system."

National Patient Safety Consultation May 19

Our strategy details 4 priority areas of focus which are aligned to the national strategy.

1. Optimising the care of the deteriorating patient
2. Improving the understanding of Human Factors and the role they have in Patient Safety
3. Developing our Patient Safety culture
4. Undertaking safe handovers of care both within hospital and community settings to external providers.

Whilst addressing these we aim to develop the capacity to identify and describe patient safety issues at a local and system level using prospectively collected data, and have the depth of leadership and improvement skills to implement and embed change.

2. STATEMENT OF INTENT/PURPOSE

This document details a 3 year plan to ensure we put patient safety at the heart of our care delivery. This is a strategic document which will be further supported by operational and tactical plans to ensure that the visions within this document are part of every employee's working day and they feel empowered to prioritise the delivery of safe patient care.

3. DEFINITIONS

NPSA: National Patient Safety Agency
7DS: Seven day service
HANT: Hospital at night team
AQuA: Advancing Quality Alliance
HSIB: Healthcare safety Investigation Board

4. OUR STRATEGY

4.1 Process of developing our Strategy

This strategy has been compiled following feedback from the Clinical Leaders Forum, Trust wide patient safety summit (Sept 2018), Deteriorating Patient Group, Trust Board, David Fillingham NHSi improvement coach, and HSIB.

It draws on the results of Keogh 2013, Outlier mortality alerts for sepsis, AKI and ALD and the CQC report 2018.

In undertaking this consultation we acknowledge the need to introduce up to date QI and patient safety methodology but also that it is understood, adopted and championed by the staff and patients. To remain relevant and effective it needs to be frequently reviewed and updated. A shorter review date has been set to facilitate this and to respond to the imminent updated national policy. The next steps include co developing a jointly understood plan to deliver patient safety, defining behaviours and responsibilities via a series of listening events for all Trust staff. A communications strategy will form part of the operational plan for delivery.

4.2 The importance of Patient Safety

The expectation of patients, relatives, staff and wider society is that Hospitals are a place of safety where people are free from harm. Nearly two decades after the publication of the US report "To Err is Human"[1] avoidable harm and mortality remain significant healthcare issues for us today with medical error estimated as being the third leading cause of death in one study[2]. Further scandals, the most recent at Mid Staffs, Morecombe Bay and Gosport highlight the need for high quality data, a culture of curiosity and the skills to deliver improvements in patient care.

We are adopting an approach based on the following principles as highlighted in the NIHR report Patient Safety 2030[3] :

- **Bias towards action** Intervention bias is the human predisposition do something rather than nothing to try to improve a situation. This may result in

over intervention in medical care which inadvertently introduces additional risks or provides false assurance despite the introduction of an ineffective intervention. The interventions which are made should be evidence based and the subject of audit and appropriate governance.

- **Culture counts.** Those organizations where blame and punishment are the response to error have low incident reporting rates and are unable to learn from near misses due to under reporting. A clearly articulated vision based on the concept of a just and learning culture provides the best opportunity for improving patient outcomes. Michael West's work[4] around staff engagement clearly demonstrates that such a strategy results in measurable and sustainable improvements in patent safety. This strategy will be adopted from the "board to the ward" to ensure we are delivering a consistent patient safety culture message for all who provide care to patients.

- **Patients as True Partners** Having patients as true partners in the decision making related to the delivery of their care brings with it improved patient safety. Positive involvement around treatment decisions reduces disability, reduces litigation and increases patient's satisfaction with their care. Patients also understand the process of care for their condition which enables them to self-advocate and insist on always events®[5], translating person and family centred principles into the care we provide. Always events® are "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system"

- **A systems approach** to patient safety is essential to improve patient outcomes. Additionally, poor care is expensive both in terms of resource use and litigation. An aspect of the "systems approach" is demonstrated by the introduction of an EPR which offers the opportunity to provide an integrated patient record which not only ensures that the full patient record is available at the point of care but can additionally provide clinical decision support so that important information is integrated into decision making, clinical pathways are triggered, risk stratification is automated and appropriate and pre-defined order sets can provide consistent evidence based investigation and treatment.

4.3 Trust Context

The strategy reflects the Trust's agreed vision;

Trusted to provide safe, caring and effective services because people matter – care better every day.

This vision drives the pursuit of our three core values of *Care, Respect and Responsibility* each and every day.

This strategy supports the overarching strategic objectives of:

- Delivering a great patient experience
- Delivering safe and caring services
- Driving service improvement, innovation and transformation
- Be the place people choose to work
- Make the best of what we have
- Delivering a viable future

Patient Safety Strategy Vision

In order to support the Trust's overarching vision and strategic objectives we developed the vision of the Patient Safety Strategy as :

To provide the best care for our patients, with the right people in the right place at the right time.

The Priorities of the Patient Safety Strategy are outlined later in the document.

4.4 Embedding the Patient Safety Strategy Trust wide

The Patient Safety Strategy encompasses the Trust Quality Priorities. In order to embed a patient safety culture across the Trust the following actions have been initiated;

- A Quality Academy is being established where all the information relating to quality, safety and improvement initiatives are considered in one forum with multidisciplinary input so that we have an oversight of Trust activities with the ability to identify good practice and themes of work to ensure we optimise the support required and implementation of further activity.

- A 3 year plan of Quality and Safety Reviews commenced in 2018 where independent reviews of wards and departments are undertaken by the Quality Review and Improvement Lead based on the CQC key lines of enquiry with feedback and quality improvement projects as outcomes.

- We have established a partnership with the Advancing Quality Alliance (AQuA), an external body providing expertise in Quality Improvement projects including Safety Culture surveys and the identification of areas for development culminating in the establishment of a cohort of staff with QI project development skills. Initial training from board to ward will be focused on pathway improvement

- The work of the Dudley Improvement Practice will support the delivery of the strategy Trust wide. Over a five year period it is expected this methodology for improvement will become standard across the Trust.

4.5 Patient Safety Priorities

By setting out our priorities we will be focussing on care being delivered by the right person, giving the right treatment in the right place at the right time.

We have identified areas of care where there would be a beneficial outcome by considering our delivery of care from a human factors approach. Improvement of these areas of care will ensure that we are meeting our visions and values and offering the best care we can for our patients. The measurement of success over all the domains will be based on the principles proposed by Charles Vincent[6]

We have identified areas of care where there would be a beneficial outcome by considering our delivery of care from a human factors approach. Human factors has multiple meanings to different groups of people but there is increasing understanding that it must take into account the element of design required to enable people to be able to do their work (ergonomics).

Human Factors are organisational, individual, environmental, and job characteristics that influence behaviour in ways that can impact safety[7] (Clinical Human Factors Group).

The Dudley Group
NHS Foundation Trust

Priority 1 : Optimising the care of the deteriorating patient
Methods
By developing the Deteriorating Patient Pathway to ensure all patients are managed appropriately whether their initial clinical presentation is clearly defined or not. An overarching Deteriorating Patient Pathway which will encompass pre-existing pathways including sepsis, EMLAP, ACCS, Stroke. The pathways will enable staff to recognise clinical conditions, communicate care needs and initiate prompt delivery of treatment.
By ensuring our workforce strategy and staffing levels are adequate to enable the right staff to be delivering care
By adopting 7 day services to ensure treatment can be delivered by the right person at the right time
By developing a functional hospital at night service
By developing EPR and integrating associated care pathways
Measure of implementation and success
Evidence of the use of deteriorating patient pathways both clinically and via the audit process
Evidence of positive learning reports when care is delivered to a standard of excellence
Reduction in the number of Datix reports related to the deteriorating patient
Evidence of adequate staffing levels to ensure shifts and other workforce requirements are covered
Successful implementation of 7 day services (7DS) and the hospital at night team (HANT)
KPI
Year 1 Refine eOBS and eSepsis Implement AQ pathways for top 4 high risk pathways Meet 7DS QI training from board to ward for 4 high risk pathways Mortality below SHMI 100
Year 2 Implement 4 AQ pathways Adopt advanced clinical decision support SHMI less than 95
Year 3 Implement 2 AQ pathways

Priority 2 – improving the understanding of Human Factors and the role they have in Patient Safety
Methods
Introducing the concepts of Human Factors and Non-Technical Skills Trust wide and reinforcing the role they have to play in the delivery of safe patient care especially in relation to the deteriorating patient
Introducing the concepts of “Human Error” Trust wide and identifying potential threats to the delivery of safe patient care
Measure of implementation and success
Development and delivery of Trust wide, board to ward human factors, graded assertiveness and Threat and error training with analysis of numbers of staff trained and feedback on the training delivered as to the relevance to patient safety.
KPI
Year 1 Introduction of online mandatory training Nov 19 Board development Patient safety framework Trust wide listening events Incorporate Human factors framework in to RCA process
Year 2 AQuA offering for all staff involved in direct patient care Updated patient safety strategy incorporating output of safety culture survey.
Year 3 Integrated patient safety framework integrating, process change, human factors training and leadership

Priority 3 - Optimising our culture to be focussed on patient safety and to learn when we have failed to deliver the highest possible standard of care	
Methods	
Optimising our culture to be focussed on patient safety and to learn when we have failed to deliver the highest possible standard of care. An agreed concordat between patients, staff and the Trust board as to responsibilities and behaviours to support and develop a patient safety culture which is fit for purpose protecting patients and supporting staff.	
Measure of implementation and success	
Patient safety culture analysis tools	
Staff engagement surveys	
KPI	
Year 1 Adoption of Bronze level deteriorating patient diploma Complete Patient safety culture survey Share positive learning trust wide Adopt a programme of always events trust wide Repeat MES and refine engagement plan.	Dec 20 Dec 20
Year 2 Adoption of Silver level deteriorating patient diploma	Jun 20
Year 3 Adoption of Gold level deteriorating patient diploma	July 21

Priority 4 – Undertaking safe handovers of care both within hospital settings and to external agencies		
Methods		
The National Patient Safety Agency (NPSA) has defined clinical handover as a process where there is 'the transfer of professional responsibility and accountability for some or all aspects care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis'		
By ensuring that we perform consistently safe handovers at points of transition of care for patients whether receiving patients into the hospital, transfer of care between areas or teams within the hospital or discharging the patient from hospital.		
Measure of implementation and success		
Evidence of safe handover of care by reduced incidents related to the transition of care		
Evidence of safe handover of care by positive incident learning reports Achieve KPI for clinical correspondence including clinic letters and discharge summaries and ward discharge checklists.		
Engagement with external stakeholders to ascertain how they view the handover they receive when patients are discharged from DGHNHSFT.		
Audit of handovers in EPR		
KPI		
Year 1	Implementation of single eRota for medicine and surgery Hospital at night team appointed eHandover implemented	Aug 19 Oct 19 April 20
Year 2	24/7 Hospital at Night team Achieve KPI for handover documentation	
Year 3	Consolidate delivery of handover	

We will engage with external stakeholders such as the CCG, CQC, NHSE and NHSI and value their input into ensuring that we are delivering the best care that we are capable of delivering to our patient population.

5 TRAINING/SUPPORT

The engagement of our staff in these key priorities will ensure we are in the strongest position to both ensure we are delivering the best care to patients and to meet the aims of this strategy and the wider Trust strategic objectives . All staff groups will be supported in being empowered to influence the care delivered to patients and enable them to take responsibility for their own work environments. They will be empowered to act and expected to do so should they feel that their working environment is not conducive to protecting patient safety and their concerns will be valued by those responsible for ensuring we deliver safe care. Our services and care delivery needs to be clinically led which requires engagement of all groups of staff and their contribution will be vital to optimise the care we deliver.

6 PROCESS FOR MONITORING COMPLIANCE

Hard endpoints related to outcomes such as mortality are important and impactful measures of safety and are highlighted in the KPI's for the listed priorities.

Metrics related to never misses are an important barometer of the effectiveness of systems but also the reporting culture of the organization. These metrics will continue to be reported.

To understand and improve the texture of the safety culture patients and staff experience we will use the Vincent framework below (figure 1) to form the basis of the measurement of safety within the Trust and the impact of the implementation of this strategy. The five dimensions will be incorporated into our measuring and monitoring of safety at The Dudley Group NHS Foundation Trust.

- Past harm: this encompasses both psychological and physical measures
- Reliability: this is defined as 'failure free operation over time' and applies to measures of behaviour, processes and systems.
- Sensitivity to operations: the information and capacity to monitor safety on an hourly or daily basis.
- Anticipation and preparedness: the ability to anticipate, and be prepared for, problems.
- Integration and learning: the ability to respond to, and improve from, safety information.

7 EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

8 REFERENCES

1. To Err is Human Building a safer Health System Institute of Medicine (US) committee on Quality of Health Care in America Editors: L Kohn, J Corrigan and M Donaldson National Academy Press 2000 http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf

2. M Makary and M Daniels Medical Error – the third leading cause of death in the US BMJ 2016;353:i2139 https://www.bmj.com/content/bmj/353/bmj.i2139.full.pdf

3. Patient Safety 2030 Yu A, Flott K, Chainani N,. Fontana G, Darzi A . **Patient Safety 2030**. London, UK: NIHR. Imperial Patient Safety Translational Research centre 2016 https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/centre-for-health-policy/Patient-Safety-2030-Report-VFinal.pdf

4. Employee Engagement and NHS performance 2012 M West and J Dawson https://www.kingsfund.org.uk/sites/default/files/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

5. Always events https://www.england.nhs.uk/always-events/

6. A Framework for measuring and monitoring Safety The Health Foundation 2016 https://www.health.org.uk/sites/health/files/AFrameworkForMeasuringAndMonitoringSafetyPracticalGuide.pdf

7. Clinical Human Factors Group https://chfg.org/what-are-clinical-human-factors

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6th June 2019

TITLE:	**Speak Up (FTSU) Guardian Update**		
AUTHOR:	Derek Eaves, FTSU Guardian, Philippa Brazier, FTSU Guardian	**PRESENTER**	Derek Eaves, FTSU Guardian, Philippa Brazier, FTSU Guardian

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.*

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

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD:

To agree that the actions being taken are appropriate and that consideration should be made in terms of increasing the resources available

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:

This paper gives an update on:

- For the last quarter (Q4) and for Q1 up to date, numbers and types of recent concerns raised and an outline of outcomes and feedback from of these.
- Recent activities and developments which include:
    - Actions/Outcomes
    - Feedback
    - Numbers of concerns raised nationally and local Trusts.
    - Speak Up Champions
    - Attendance at local GMC Welcome to UK study session with Medical Training Initiative Doctors
    - Capsticks Report
    - FTSU Surgeries
    - Working with the staff engagement lead
    - Working with the patient safety lead
    - Improved systems for audit
    - National Freedom to Speak Up Guardian Survey 2018 – Trust response with regards to the summary of recommendations
- Updated action plan

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: SAFE, EFFECTIVE, CARING, RESPONSIVE WELL LED**
	NHSI	**N**	**Details:**
	Other	**Y/N**	**Details:**

Freedom to Speak Up (FTSU) Guardian June 2019 update

Numbers of concerns raised at the Trust

The table below indicates the numbers and types of concerns raised with the Guardians a) each full quarter in the last financial year with an annual total and b) in the first three quarters of this year and for Q4 up to the date stated. As previously noted, the National Guardian Office (NGO) has discussed the difficulties in categorising types of concerns being raised and those below are locally based. The majority of concerns being raised are regarding behaviour unrelated to patient care. We have divided the national category on this topic into two: a) perceived bullying and harassment and b) perceived unfair behaviour, the latter includes such concerns as unfair recruitment, unfair rotas and concerns about redeployment of staff. Both of these two types of concerns cover those regarding colleagues, line and senior managers.

	Number	Anonymously	Patient Safety	Behaviour: Bullying/ Harassment	Behaviour: Unfair/ Inappropriate	Other
Apr-Jun	2	0	0	2	0	0
Jul-Sep	14	3	4	8	2	0
Oct-Dec	17	0	3	8	6	0
Jan-Mar	11	2	2	4	5	0
2017/18	44	5	9	22	13	0
Apr- Jun	15	0	3	8	5	2
Jul – Sep	12	0	2	5	4	2
Oct – Dec	26	1	4	7	11	4
Jan- Mar	14	0	1	7	4	2
2018/19	67	1	10	27	24	10
Apr – May 22nd	13	0	4	5	4	0

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.

	Number	Nursing	Midwife	Medical	AHP	Clinical Scientist	Admin. /Ancillary	Unknown
Apr-Jun	2	2	0	0	0	0	0	0
Jul-Sep	14	7	2	0	1	0	3	1
Oct-Dec	17	7	0	1	0	1	8^	0
Jan- Mar	11	5	2	2	0	0	2	0
2017/18	44	21	4	3	1	1	13	1
Apr- Jun	15	9	2	2	1	0	1	0
Jul - Sep	12	8	1	1	1	0	1	0
Oct – Dec	26	10	2	3	3	0	8	0
Jan - Mar	14	6	1	2	0	0	4	1
2018/19	67	33	6	8	5	0	14	1
Apr – May 22nd	13	4	3	1*	1	0	4+	0

^1 of these was a PFI staff member, * = a group, + = 1 of 4 is a group

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 or 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. In the latest period, the FTSU Non-Executive has been involved in one case and three ongoing cases from the previous period.

The following are some latest examples of cases and actions/outcomes as a result of concerns raised:

- Discussion with local champion but person decided not to take the issue forward and has left the Trust.
- Group of junior doctors concerned about issues that included both patient safety and unfair treatment. Discussed with appropriate person in the academy and safety issue resolved and other issues being presently reviewed.
- With the involvement of the FTSU non-executive the concern was resolved with the individuals and manager.
- Two concerns raised at exit interviews with staff leaving due to the issues raised. Issues taken to respective line managers. One line manager met the person and awaiting feedback. The other issue is in the initial stage of being looked at.
- Following a concern, the discussion with the senior manager has resulted in her working in the department to assess the situation and gain views of the other staff. An outcome is awaited.

Four of the concerns this period were initially raised with champions in their substantive role due to their knowledge in that role who provided the initial advice and then they highlighted the issues with the Guardians, who took appropriate action as necessary.

Feedback
It is not always possible to get feedback from those who raise concerns but one resolved issue has resulted in appreciative thanks as have five of the presently ongoing issues. In addition, a nomination has been made as a Healthcare Hero with this:

I recently contacted Philippa as the 'freedom to speak up champion' regarding some concerns I had. She responded quickly, was approachable and I felt she listened to what I had to say. She talked me through the process and escalated these concerns appropriately

Numbers of concerns raised nationally and local Trusts.
With regards to the full Q4 (2018/19) figures there were 14 concerns raised at the Trust. The national picture showed:

- 3,406 cases were raised.
- 928 of these cases included an element of patient safety / quality of care
- 1,312 included elements of bullying and harassment
- 122 related to incidents where the person speaking up may have suffered some form of detriment
- 506 anonymous cases were received
- 5 trusts did not receive any cases through their Freedom to Speak Up Guardian
- 220 out of 227 NHS trusts sent returns
- Highest Trust had 100 cases (Local Trusts: 11, 31, 17 and 7)

Speak Up Champions: There are 13 of the original FTSU and Patient Safety Champions with the recruitment of two further ones making 15 in total at present. Dr Calthorpe has found interest from a number of other staff in the Medicine and Integrated Care Division, who are being asked to informally apply to indicate their commitment. So far two of those showing an interest have applied. A similar request has been made to the surgical division. The Champion details have been placed on the screensavers. Meetings are arranged on a 6-8 week basis for the champions. These have not been well attended in the past due to work commitments but the latest one 20th May had a good turn out and discussions were held on how better to communicate as a group.

Attendance at local GMC Welcome to UK study session with Medical Training Initiative Doctors
The Guardians were asked to attend to explain their role and be present while a relevant case study was being discussed. The session was useful in that while explaining our role

the attendees started to voice a number of concerns. These were listed and the Guardian and GMC representative relayed them to the relevant person who is following up the issues and taking advice from the appropriate authority.

Capsticks Report
Following the investigation the Trust has requested NHSI to undertake a review of the FTSU process. Actions they are taking include: gaining the views of relevant staff on how the process can be improved, undertaking an email based FTSU survey to all staff which is anonymous and undertaking focus groups on the topic. In addition, the Trust is looking at how best to triangulate the concerns that are raised through different mechanisms e.g. chaplains, HR, FTSU and Datix so that an overall picture of the situation is gained.

FTSU Surgeries
While the Freedom to Speak Up Guardians are always available to be contacted to listen to concerns and give support and advice as are the FTSU Champions, the Guardians are now starting to hold drop-in sessions with the new Non-Executive lead for FTSU, Julian Atkins. These new drop in sessions or surgeries are entirely confidential and so will be held in private areas away from the main sections of the Trust where staff will feel comfortable to visit. The initial surgeries are being held between 10.00 and 14.00 at The Undergraduate Centre, North Block on Wednesday June 26th and Thursday June 27th. It is intended to hold further surgeries later in the year. Dates already agreed are November 13th and 15th with times/venues to be agreed. Further details will be made available at the time.

Working with the staff engagement lead
The guardians and champions will be assisting the staff engagement lead who is organising an anti-bullying and harassment week in July with similar weeks later in the year.

Working with the patient safety lead
As well as having joint meetings with the patient safety lead and champions, the Guardians have assisted the lead in testing the soon to be introduced GREATix system and will be undertaking the appreciative enquiry training as a basis for agreeing the future topics to consider for such enquiries once the GREATix system is up and running.

Improved systems for audit
The Guardians have commenced recording certain data on each concern raised that take into account confidentiality that can be easily accessed and used for any future audit purposes.

Action plan
The updated action plan from the Freedom to Speak Up self-review tool for NHS trusts and foundation trusts. May 2018 and the FTSU Strategy is provided in Appendix 1.

National Freedom to Speak Up Guardian Survey 2018 - Summary of recommendations
In the last report (March 2019), we listed the above and indicated that we would formulate the Trusts position on each of these. This is provided in Appendix 2.

Appendix 1 THE DUDLEY GROUP NHS FOUNDATION TRUST - Freedom to Speak Up (FTSU) Action Plan 2018-19

Action	Source	By Whom	By When	Progress
Draft vision and strategy to be agreed and launched with assistance from Communications Team	SA	Board Guardians	July 18	Complete
Questions on FTSU are included in walkrounds. The results will be put into quarterly reports to Board.	SA/S	Guardians	July 18	Complete
Appoint Speak Up Champions to raise awareness of the Trust's commitment to speaking up	SA/S	Guardians	Sep 18	Complete
Undertake a LiA.	SA/S	Guardians	Mar 19	Deferred. Awaiting the results of the NHSI review being undertaken on FTSU processes which includes a staff survey and focus groups following the Capsticks investigation.
Liaise closely with Equality and Staff Engagement Leads.	SA/S	Guardians	Jun onwards	Complete/Ongoing. Liaison with SE lead together with Security and Fraud leads on Speak month October. Guardian is a member of newly formed Inclusion Group. Guardians assisting on anti- bullying week
Unconscious Bias Training planned.	SA/S	E & D Lead	Mar 19	This was being arranged by the previous inclusion lead but with a change in lead and with other ongoing developments this topic is to become part of new planned manager training.
A sample of cases is quality assured - To be commenced on a quarterly basis with previous Speak Up Guardian on a random number of cases	SA	Guardians	Oct 18	Commenced. One undertaken.
Engage with planned Staff Forums.	SA/S	Guardians	Jun 18	Complete. Guardians/champions attending meetings of Surgical and Medical Forums when possible.
Consider inviting National Guardian to the Trust	SA	Guardians	July 18	Complete
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. Will give wider publicity to lessons learned	SA/S	Guardians	Jul 18	Complete. Placed on Hub page but need to consider how better to publicise
Working on strengthening the processes to facilitate wider learning from concerns raised with the Guardian.	SA	Medical Director/ Chief Nurse	Mar 19	Learning is placed on Hub page and quarterly reports.
Locally organise and partake in the National Speak Up month in October	O	Guardians	Oct 18	Complete

Source: SA= Freedom to Speak Up self-review tool for NHS trusts and foundation trusts. May 2018. S = FTSU Strategy O= Other

Appendix 2

National Freedom to Speak Up Guardian Survey 2018

Summary of recommendations

• We continue to recommend that appointments to the Freedom to Speak Up Guardian role are made in a fair and open way.

Yes. The last appointed Guardian was from an open recruitment process.

• We recommend that Freedom to Speak Up Guardians undertake 'refresher' training, provided by the National Guardian's Office or guardians trained by the National Office to provide this training, every 12 months.

Yes. Both Guardians received the initial national training. The twelve month training process has just commenced on May 13th 2019 when both Guardians had other commitments so they will undertake the refresher training once further session are arranged.

• We recommend that all Freedom to Speak Up Guardians regularly assess their training and development needs using the National Guardian Office's Education and Training Guide and that their employers support them by providing the resources needed to enable them to continually develop their skills, knowledge and abilities.

Yes. As indicated in the March 2019 quarterly report.

• We recommend that regional Freedom to Speak Up Guardian networks seek local opportunities to enable all guardians to learn and improve, including sharing skills and knowledge amongst peers and seeking the support of local partners.

Yes. Guardians attend when able.

• We recommend that those in a speaking up role make an assessment of the possible conflicts that any other role that they have may bring. Following this assessment, appropriate action should be taken to mitigate against any conflict. In all cases, where the details of a particular case brought to someone in a Freedom to Speak Up role may indicate the potential for conflict, this should be made clear to the individual bringing the case and an alternative route for speaking up offered.

Partial. The situation has not arisen but the Guardians have an agreed system to pass concerns on to the other or in exceptional circumstances to one of the champions, when appropriate.

• We recommend that all organisations with a Freedom to Speak Up Guardian make a local assessment of any groups that face particular barriers to speaking up and take action to ensure that those barriers are tackled.

Partial. The champions come from a variety of areas, disciplines and bandings/seniority across the hospital and community although improvements with this can always be made. One of the Guardians is part of the newly formed Inclusion Group.

• Where a local Freedom to Speak Up network is established, action should be taken to ensure that it reflects the diversity of the workforce that it supports.

Partial – see item above.

• We recommend that all organisations with a Freedom to Speak Up Guardian make a full and honest assessment of the time required by a guardian to carry out their role and meet the needs of workers. All guardians must have the ring-fenced time they need to satisfy these basic requirements.

Partial. An increase in hours occurred a few months ago. Awaiting the outcome of the present NHSI review.

• We recommend that all organisations review their mechanisms for seeking feedback on cases raised to Freedom to Speak Up Guardians, take action to ensure that these are

compliant with NGO guidance, and ensure that sufficient time is allocated to ensure that this essential activity is undertaken.

Yes. All people raising concerns are asked for feedback. Quarterly reports include the feedback received. Outcome reports are on the Hub.

• We recommended that all organisations with a Freedom to Speak Up Guardian assess arrangements for their guardian to have direct access to their CEO and Non-Executive Director with speaking up as part of their portfolio (or equivalent roles for organisations which do not have these posts as part of their board structure). In all cases Freedom to Speak Up Guardians should have direct access to these posts.

Yes in place

• We recommend that all organisations review their Freedom to Speak Up reporting mechanisms and take action to ensure that Freedom to Speak Up Guardians report to their board in person, and are allocated sufficient time to ensure that this is done.

Yes. Attend Board quarterly.

• We recommend that guardians attend regional meetings regularly and work to ensure that their organisation is represented at every regional meeting by a guardian, or a representative of their local network. Senior leaders within their organisation should ensure that time and any necessary resource is made available to ensure that this can be achieved.

Partial. Guardians attend dependant on their other commitments. In future when both Guardians cannot attend a champion will be asked to attend.

The Dudley G
NHS Foundation Trust

Enclosure 18

Paper for submission to the Board on the 6th June 2019

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 June 2019

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)

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 Board with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure fair distribution of any financial penalty income, to the benefit of JDTs.

This is the 11th GSW report and covers the period of 1st March 2019 to 21st May 2019. 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.

Challenges

Engagement

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage junior doctors, which involves.

- Holding regular Guardian Junior doctor forum.
- 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
- Creating a webpage on the Trust HUB which carries information on Guardian role as well as

how to make exception reports.

- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

As part of the above mention strategy, Guardian has been engaging with junior doctors by one to one contact both formally and informally.

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.

Exception Reports by Department – From 1st March 2019 – 21st May 2019 total = 14 reports submitted (14 episodes).

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
0	14	14	0	2 T&O 3 O&G 9 General Surgery

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open –
FY1	4	0	6	0
FY2	0	0	1	0
ST2	0	0	3	0

Exception Reports and Fines.

- 14 exception reports by doctors
- 0 immediate safety concerns
- 9 exception reports agreed as compensation overtime payment
- 5 exception reports agreed as no further action
- No fines during this period

High level data

Number of doctors/dentists in training (total): **198** (this number includes current vacancies and MTI posts)

Number of doctors/dentists in training on 2016 TCS (total): **198**

Gaps as at May 2019

Speciality / Grade	FY1	FY2	ST 1-2	GPV TS	ST 3-8	Total	
Cardiology			1			1	Deanery vacant April-August 2019. We are moving a rotational trust doctor from AMU to over this gap.
AMU		1	1			2	CMT and FY2 posts are vacant from April 2019 to August 2019 - currently utilising trust posts/MTI posts to backfill, no recruitment activity needed.
Diabetes						0	
Dermatology			1			1	0.4 x CMT gap Apr-Aug 2019 due to LTFT in post. On-call gaps only being covered by ad-hoc locums.
Elderly Care			1		4	5	All deanery vacancies since Sept 2018. 2 long term full time locums have been in post for some months. 1 CMT vacancy Apr-Aug 2019; on-calls only being covered by ad-hoc locums
EAU						0	
Gastro			1		1	1	ST3 gap to Sept19 being supported by MTI ST1 gap vacant till Aug19 - on-calls only being covered by locum as MTIs supporting daytime cover.
ED			1	0.8	1.4	3.2	
Renal			1		1	2	CMT gap until Aug19; adhoc locums for on-call only // no recruitment for ST3 requested

General Surgery						0	
ENT						0	
Vascular Surgery						0	
Haematology						0	
T & O						0	
Obs & Gynae						0	
Paeds			2			2	There are two specialist trainee lower vacancies - 1 doctor will be returning from maternity leave in early June No recruitment requested as being covered internally.
Pathology						0	
Radiology						0	
Respiratory		1		0.4	0.2	1.6	
Rheumatology							
Stroke		1			1	2	F2 gap until Aug19. Trust Dr level 1 post closed 19/4/19; awaiting shortlist from department
Urology						0	
Ophthalmology						0	
Oral/ Max Fax						0	.
Anaesthetics		2		1		3	

Total	**0**	**5**	**9**	**2.2**	**8.6**	**24.8**	

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.

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	**28th May 2019**

Enclosure 19

The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board
On 6th June 2019

TITLE:	**Integrated Performance Report for Month 1(April)2019**		
AUTHOR:	**Informatics**	**PRESENTER**	**Karen Kelly** **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.*

ACTION REQUIRED OF COMMITTEE:			
Decision	**Approval**	**Discussion**	**Other**
N	**N**	**Y**	**N**

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐	☐	☒	☐
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery

RECOMMENDATIONS FOR THE COMMITTEE:

To note and discuss the current performance against KPIs

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
Performance in month did not achieve target with 80.9**%** for combined Type 1 and Type 3, however performance is up from 78.6% in the previous month.
Sunrise go live has resulted in a period of no external reports being submitted due to validation issues. We have informed NHSE that full resolution of this is likely to take 4 weeks. The team continue to familiarise themselves with the system and this is causing some delays to be seen within the department.

Cancer 62 day
The **provisional** performance figure for Cancer 62 day wait for the month is 86.0% as at 21st May. The Weekly Cancer Performance meeting continues to meet and a Cancer Sustainability Plan has been formulated that reviews our processes and delivery systems against 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 performance of the key target RTT Incomplete Waiting Time indicator remained above target, with performance of 93.4% in month against a target of 92%, which is an improved position of 0.5% from the previous month.

Referral to treatment – Incompletes(18 week)

Specialty	Summary of Recovery actions
General Surgery	• A locum consultant commenced in May 2019 to fill a vacancy • Strong grip to ensure the specialty utilises 23-26 theatre sessions per month
Trauma and Orthopaedics	• Strong grip on dropped weekday vacant lists • Review of total waiting list, long waiters is in the main patients waiting for lower limb arthroplasty. The specialty has distributed long waiters amongst lower limb consultants
Ophthalmology	• Additional weekend lists have been secured to manage the backlog of long waiting patients • Additional outpatient capacity has been secured to minimise patient on the Appointment Slot Issue list.
Plastic Surgery	• Additional weekend lists have been secured to manage long waiting patients.

DM01 Diagnostic Performance
Was achieved for the month with a performance of 99.1% against a national target of 99%.

Mixed sex accommodation
There were 9 MSA breaches in month.

Never Events
The Trust reported 1 never event.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description:** High level 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 (COR 079)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive, Well Lead
	NHSI	**Y**	**Details:** A sustained reduction in performance could result in the Trust being found in breach of Foundation Trust licence
	Other	**N**	**Details:**

Integrated Performance Report - Board




May 2019

Created by: Informatics.
Title of report: Integrated Performance Report

Executive Lead:	**Performance**	**Chief Operating Officer, Karen Kelly**
	Finance	**Director of Finance, Tom Jackson**
	Workforce	**Director of HR, Andrew McMenemy**

Executive Summary

Key Messages

CQSPE

FFT Response Rate

For the 12 month period April 2018 – March 2019 (60 areas were published) the Trust is achieving the target on 44 occasions where the percentage response rate score is equal to or better than the national average percentage response rate. The areas missing the target are maternity birth for August, community for April, May, August and February, and outpatients for May 2018 to March 2019.

Feedback Friday is promoted to raise awareness and capture responses and staff have set up pop up workshops in the reception area, Volunteers have concentrated on the wards and Outpatients department, to promote feedback Friday and encourage patients to fill in the FFT forms.

FFT Percentage Reccomended

For the 12 month period April 2018 – March 2019 (95 areas have been published) the Trust is achieving the target on 43 occasions where the score is equal to or better than the national average percentage recommended. The areas missing the target are inpatients, A&E and outpatients for the year, maternity antenatal for September, maternity birth for June, November and January, maternity postnatal ward for November, December and January to and community for the period September 2018 to March 2019. April's figures will show in the June report. Aprils national data not available at time of report.

Complaints & PALS

PALS received 215 concerns, 8 comments and 72 signposting contacts (signposting includes letters/emails/telephone calls/face-to-face enquiries) totalling 295 in April 2019 compared to 288 received in March 2019.

During April 2019, the Trust received 50 new complaints, in comparison to 52 opened for March 2019 and 48 opened for February 2019. This is an -3.8% decrease from March 2019 for open complaints.

The Surgical Division received 21 new open complaints for April 2019 compared to 19 for March 2019 and Medicine & Integrated Care Division received 28 new open complaints for April 2019 compared to 29 for March 2019. Clinical Support division received one new open complaint for April 2019 compared to three for March 2019.

In terms of complaints by service, Medicine & Integrated Care Division received the most complaints for the Emergency Department (ED) (11) followed by ward AMU2 (3). Surgery Division received three complaints for RHH- Orthopaedic and Fracture Outpatients, followed by Corbett Outpatient Urology (3).

There have been 6 re-opened complaints for April 2019.
The largest number of concerns raised across divisions related to communication.
At time of report, we are awaiting divisional response.

Dementia

The Trust remains above the target of 90 % for find/assess, investigate and refer.

Falls

There were no patient falls with harm reported in April 2019. Falls without harm remain below the national average.

Pressure Ulcers

There were no avoidable Category 4 pressure ulcers reported in April, however there were 2 Category 3 pressure ulcers reported as avoidable developed in the Acute Trust in April. These pressure ulcers were reported for AMU and B1.

MSA

In April there were 9 breaches. There were 1 on MHDU, 7 on SHDU and 1 on ITU. All of these were patients having been stepped down from high level care awaiting more than four hours for general beds that were not available due to capacity issues.

Infection Control

Interventions April 2019:
HII 1: Ventilator Associated Pneumonia 100%
HII 2a: Peripheral Vascular Access Devices - Insertion 98%
HII 2b: Peripheral Vascular Access Devices - Ongoing care 99%
HII 3a: Central Venous Access Devices - Insertion 100%
HII 3b: Central Venous Access Devices - Ongoing Care 98%
HII 4a: Surgical Site Infection Prevention - Preoperative 100%
HII 4b: Surgical Site Infection Prevention - Intraoperative Actions 100%
HII 5: Infection Prevention in Chronic Wounds 100%
HII 6a: Urinary Catheter - Insertion 100%
HII 6b: Urinary Catheter - Maintenance & Assessment 99%
Hand Hygiene 99%
Commode Audits 99%
There were zero C diff cases due to lapses in care reported during April 2019.

Executive Summary

Key Messages

CQSPE

VTE

Trust performance for VTE for April 19 is 95%.

To further improve VTE compliance, new magnets for whiteboard have been added to review if screening has been completed and logged, challenged at each whiteboard round by Matron, notes pulled back on SAEC to check assessments have been done but not logged and data added in retrospect, new actions due to be reviewed at confirm and challenge meetings next week.

Incidents

April has seen a 9% decrease in the number of incidents reported in April 2019, although it is acknowledged that this number is comparative to previous months.

The Trust reported 6 serious incidents to STEIS in April, this included 1 Never Event.

o 2019/7327 – Never Event, incorrect mole removed.

o 2019/7885 – Baby admitted to NNU and transferred out for cooling.

o 2019/9422 – Delay in diagnosis of a myocardial infarction

o 2019/9468 – Delay in diagnosis of a myocardial infarction

o 2 hospital acquired pressure ulcers. The RCA's will be presented at the pressure ulcer meeting

Safety Thermometer

Safety Thermometer for April 2019 – 97.08%

Deteriorating Trolley Checks

This audit is collected on the audit tool Perfect Ward, Perfect Ward will only accept Yes, No or N/A as a response to this question. If a ward has failed one patient trolley check, results appear as 0% for the month.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception

Key Messages

1 Performance Matters — Committee: F&P

A&E 4 hour wait

The combined Trust and UCC performance was below target in month at 80.93%

	Attendances	Breaches	Performance
UCC/A&E Combined (Type1+3)	14938	2848	80.93%

Cancer Waits

The Committee is reminded that due to the time required to validate individual pathways, the cancer waiting times in this report are provisional only. In addition, the reporting of patients breaching 104 days is provided 1 month retrospectively.

Cancer – 62 Day from Urgent GP Referral to Treatment performed above target for the month at 86% (Provisional as at 21st May). Previous month confirmed performance was 88.2%

Cancer - 104 days - Number of people who have breached beyond 104 days (March)

No. of Patients treated on or over 104 days (DGFT)	0
No. of Patients treated on or over 104 days (Tertiary Centre)	2
No. of Patients treated on or over 104 days (Combined)	2

2WW

The target was achieved once again in month. During this period a total of 1326 patients attended a 2ww appointment with 88 patients attending their appointments outside of the 2 week standard, achieving a performance 93.7% against the 93% target.

Referral to Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained above target, with performance of 94% in month against a target of 92%. Ophthalmology is at 86.7% up from 84.5% in the previous month. General Surgery is 89.1% up from 86.5%. There is no 52-week Non-admitted Waiting Time breaches in month.

Diagnostic waits

The diagnostic wait was above target in month with a performance of 99.1%. The number of patients waiting over 6 weeks was 62

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters — **Committee: F&P**

Deficit of £1.575m for April (including PSF) and following consolidation of the pharmacy company and other technical changes. This position is £0.679m better than the control total so the Trust remains on course to achieve PSF in Q1. The forecast position shows a deficit of £5.780m in line with the base case assumptions approved by the Board. This assumes the land sale occurs and that the Trust only earns the Q1 PSF. This forecast also necessitates the identification and delivery of an additional £3.479m of CIP over and above the current plans. This position is £8.432m worse than the control total plus a further £5.493m of lost PSF resource.

Executive Summary by Exception cont.

Key Messages

4 Workforce — Committee: F&P

Staff Appraisals

The appraisal window for all non-medical appraisals is now open across the Trust and will close on the 30th June 2019.

As of the 20th May the Trust compliance rate of completed appraisals is 24% with a further 1000 appraisals to be undertaken in June. The projection rate should all booked appraisals be completed currently stands at 73.90%. However, the current rate of compliance is consistent with the same time last year and therefore it is expected that the Trust will fulfil the target of over 90% of staff appraised.

In order to support an above 90% compliance rate twice weekly reports are being provided to all managers detailing appraisals completed and booked highlighting any current gaps. The current projected compliance rates have been flagged as a risk at all Divisional meetings and will Divisional Management teams expected to demonstrate achievement within their monthly performance report. All Managers are required to focus on completing appraisals for their staff within the appraisal window.

Mandatory Training

The compliance rate has improved and continues at the stable level of 89.21%. This represents good performance without being excellent. The areas where more concentrated efforts are required are associated with Resus, manual handling and Information Governance training. In terms of staff groups the area of highest non-compliance continues to be medical staff, their compliance rate has fallen to 80.16% at the end of April. The Clinical Support Division continues to be the team with the lowest compliance rates, however they are demonstrating improvements to 86.4%.

Adult Resuscitation, Paediatric Resuscitation, and Patient Moving and Handling are below the 80% R.A.G.-rating threshold, with potential for risk in terms of appropriate response to deterioration or cardiac arrest, or potential for harm or injury through inappropriate patient handling where this knowledge and practical competence is not maintained. These three subjects are managed via the Head of Non-Medical Education and Training, has presented current and future intended actions for improvement and the Risk and Assurance Group.

Sickness Rate

The absence rate has increased in March 2019 from 4.44% to 4.77% in April. Although sickness absence has decreased the Trust sickness absence levels remain above the Trust Target. The main areas of concern associated to staff group are Care Support staff at 7.93% and nursing & midwifery staff at 5.19%.

In terms of Divisional trends, Clinical Support Services continue to demonstrate the highest levels of absence at 5.47%. Therefore, focus is being provided on particular areas of high absence to ensure efficient turnaround of absence management and therefore staff returning to work.

Turnover Rate

The turnover rate continues to represent a positive retention of our staff and currently sits at 8.25% from 8.49% in the previous month. The Trust Turnover target is 8.5% and with this continued reduction the Trust target has been achieved for the first time in recent years. The Trust turnover rate is also below the average turnover rate for acute NHS Trusts in England. The appointment of the Staff Engagement lead has demonstrated a particular focus on understanding the feedback from exit interviews, listening to staff and developing strategies to support improved retention at the Trust. The initial feedback is very positive and this will be developed further as we develop the action plans based on the feedback from the national staff survey.

Patients will experience safe care - "At a glance"

Executive Lead: Mary Sexton

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Mar-19	Apr-19	Actual YTD	Trend	Month Status
Friends & Family Test - Response Rate							
Friends & Family Test - ED	12.3%	19.4%	19.6%	18.9%	18.9%	↓	
Friends & Family Test - Inpatients	26.9%	37.0%	34.9%	35.4%	35.4%	↑	
Friends & Family Test - Maternity - Overall	21.9%	38.0%	30.5%	21.6%	21.6%	↓	
Friends & Family Test - Outpatients	4.9%	11.9%	5.1%	4.0%	4.0%	↓	
Friends & Family Test - Community	3.3%	8.1%	5.5%	3.9%	3.9%	↓	
Friends & Family Test - Percentage Recommended							
Friends & Family Test - ED	88.7%	94.5%	71.5%	71.5%	71.5%	↓	
Friends & Family Test - Inpatients	96.7%	97.4%	93.7%	94.6%	94.6%	↑	
Friends & Family Test - Maternity - Overall	97.1%	98.5%	98.3%	99.5%	99.5%	↑	
Friends & Family Test - Outpatients	95.3%	97.4%	89.1%	88.9%	88.9%	↓	
Friends & Family Test - Community	96.2%	97.7%	92.6%	93.8%	93.8%	↑	
Complaints							
Total no. of complaints received in month			52	50	50	↓	
Complaints re-opened			13	6	6	↓	
PALs Numbers			288	295	295	↑	
Complaints open at month end			195	188	-	↓	
Compliments received			563	424	424	↓	
Dementia (1 month in arrears)							
Find/Assess		90%	97.5%	-		↑	
Investigate		90%	100.0%	-		↑	
Refer		90%	96.0%	-		↑	
Falls	National average 6.63 per 1000 bed days						
No. of Falls			67	66	66	↓	
Falls per 1000 bed days		6.63	3.78	3.72	3.72	↓	
No. of Multiple Falls			2	2	2	↔	
Falls resulting in moderate harm or above			1	0	0	↓	
Falls resulting in moderate harm or above per 1000 bed days		0.19	0.11	0	0.06	↓	
Pressure Ulcers (Grades 3 & 4)							
Hospital Avoidable		0	0	2	2	↑	
Community Avoidable		0	0	0	0	↔	
Handwash							
Handwashing			99.3%	99.6%	99.6%	↑	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Mar-19	Apr-19	Actual YTD	Trend	Month Status
Mixed Sex Accommodation Breaches							
Single Sex Breaches		0	6	9	9	↑	
Mortality (Quality Strategy Goal 3)							
HSMR Rolling 12 months (**Latest data Jan 19**)	110	105	118	115	-		
SHMI Rolling 12 months (**Latest data 18/19 Q1**)	1.10	1.05	N/A	1.13	-		
HSMR Year to date (**Not available**)					-		
Infections							
Cumulative C-Diff due to lapses in care		28	1	0	0	↓	
MRSA Bacteraemia		0	0	0	0	↔	
MSSA Bacteraemia		0	4	1	1	↓	
E. Coli - Total hospital		0	3	4	4	↑	
Stroke (1 month in arrears)							
Stroke Admissions: Swallowing Screen		75%	96.3%	-		↑	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	87.2%	-		↑	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	66.7%	-		↑	
VTE - Provisional Figures							
VTE On Admission		95%	95.2%	95.0%	95.0%	↓	
Incidents							
Total Incidents			1501	1501	1501	↔	
Recorded Medication Incidents			227	0.950476	380	↓	
Never Events			0	1	1	↑	
Serious Incidents			2	6	6	↑	
of which, pressure ulcers			0	2	2	↑	
Incident Grading by Degree of Harm							
Death			0	0	0	↔	
Severe			1	1	1	↔	
Moderate			2	5	5	↑	
Low			132	124	124	↓	
No Harm			1366	1303	1303	↓	
Percentage of incidents causing harm		28%	9.0%	13.2%	9.1%	↑	
Safety Thermometer							
Patients with harm free care (and old harms)	-	-	98.21%	97.08%	-	↓	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Mar-19	Apr-19	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)						
All Cancer 2 week waits	93%	94.44%	93.8%	93.8%	↓	
2 week wait - Breast Symptomatic	93%	84.2%	97.6%	97.6%	↑	
31 day diagnostic to 1st treatment	96%	99.4%	98.2%	98.2%	↓	
31 day subsequent treatment - Surgery	94%	100.0%	100.0%	100.0%	↔	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	88.2%	85.9%	85.9%	↓	
62 day screening programme	90%	100.0%	100.0%	100.0%	↔	
62 day consultant upgrades	85%	90.6%	90.3%	90.3%	↓	
Referral to Treatment						
RTT Incomplete Pathways - % still waiting	92%	93.5%	94.0%	94.0%	↑	
RTT Admitted - % treatment within 18 weeks	90%	86.8%	85.3%	85.3%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	95.0%	95.9%	95.9%	↑	
Wait from referral to 1st OPD	26	26	24	24	↓	
Wait from Add to Waiting List to Removal	39	42	41	41	↓	
ASI List		1857	1913	0	↑	
% Missing Outcomes RTT		0.05%	0.02%	0.0%	↓	
% Missing Outcomes Non-RTT		3.1%	2.3%	2.3%	↓	
DM01						
No. of diagnostic tests waiting over 6 weeks	0	61	62	62	↑	
% of diagnostic tests waiting less than 6 weeks	99%	99.1%	99.1%	99.1%	↓	
ED - TRUST						
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	78.6%	80.9%	80.9%	↑	
Emergency Department Attendances	N/A	9593	9220	9220	↓	
12 Hours Trolley Waits	0	6	10	10	↑	
Ambulance to ED Handover Time - TRUST						
15-29 minutes breaches			1776	1776		
30-59 minute breaches		547	411	411	↓	
60+ minute breaches		72	53	53	↓	
Ambulance to Assessment Area Handover Time - TRUST						
30-59 minute breaches		12	14	14	↑	
60+ minute breaches		3	1	1	↓	

Performance - Key Performance Indicators cont.

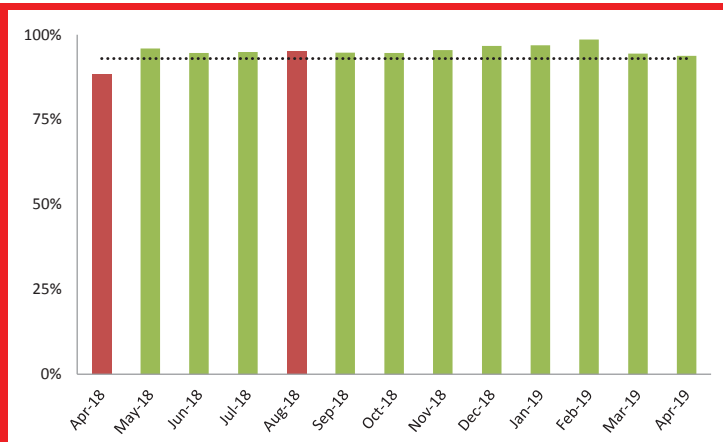
	Target	Mar-19	Apr-19	Actual YTD	Trend	Month Status
Cancelled Operations - TRUST						
% Cancelled Operations	1.0%	2.7%	1.7%	1.7%	↓	
Cancelled operations - breaches of 28 day rule	0	2	0	0	↓	
Urgent operations - cancelled twice	0	0	0	0	↔	
GP Discharge Letters						
GP Discharge Letters	90%	79.3%	84.3%	84.3%	↑	
Theatre Utilisation - TRUST						
Theatre Utilisation - Day Case (RHH & Corbett)		77.1%	77.6%	77.6%	↑	
Theatre Utilisation - Main		86.9%	87.4%	87.4%	↑	
Theatre Utilisation - Trauma		92.9%	92.8%	92.8%	↓	
GP Referrals						
GP Written Referrals - made		7215	7098	7098	↓	
GP Written Referrals - seen		6224	5538	5538	↓	
Other Referrals - Made		3668	3556	3556	↓	
Throughput						
Patients Discharged with a LoS >= 7 Days		6.4%	6.2%	6%	↓	
Patients Discharged with a LoS >= 14 Days		3.2%	3.1%	3%	↓	
7 Day Readmissions		4.8%	4.6%	5%	↓	
30 Day Readmissions - PbR		8.4%	8.3%	8%	↓	
Bed Occupancy - %		85%	92%	92%	↑	
Bed Occupancy - % Medicine & IC		84%	95%	95%	↑	
Bed Occupancy - % Surgery, W&C		87%	88%	88%	↑	
Bed Occupancy - Paediatric %		79%	82%	82%	↑	
Bed Occupancy - Orthopaedic Elective %		63%	78%	78%	↑	
Bed Occupancy - Trauma and Hip %		97%	96%	96%	↓	
Number of Patient Moves between 8pm and 8am		90	132	132	↑	
Discharged by Midday		13.1%	14.3%	14%	↑	
Outpatients						
New outpatient appointment DNA rate	8%	7.6%	7.6%	7.6%	↑	
Follow-up outpatient appointment DNA rate	8%	6.1%	8.4%	8.4%	↑	
Total outpatient appointment DNA rate	8%	6.7%	8.0%	8.0%	↑	
Clinic Utilisation		79.9%	78.9%	78.9%	↓	
Average Length of stay (Quality Strategy Goal 3)						
Average Length of Stay - Elective	2.4	2.37	2.77	2.5	↑	
Average Length of Stay - Non-Elective	3.4	5.3	5.0	5.3	↓	

The Dudley Group NHS Foundation Trust

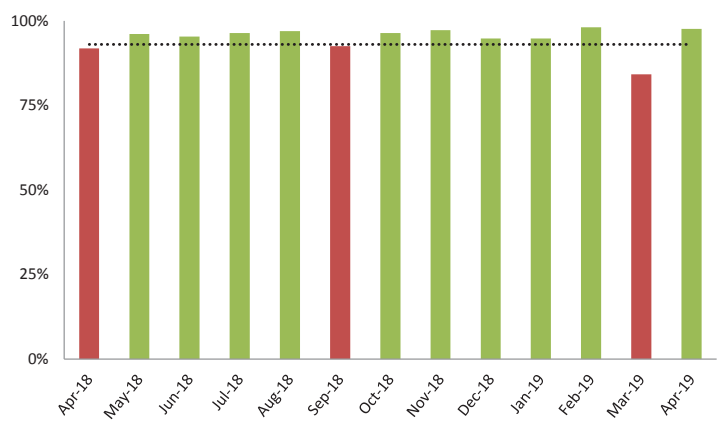
Performance Matters (KPIs)

Regulatory Performance - Cancer (Latest month is provisional)

All Cancer 2 Week Waits



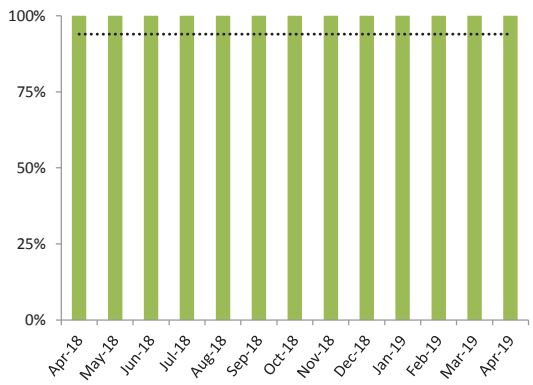
Breast Symptomatic



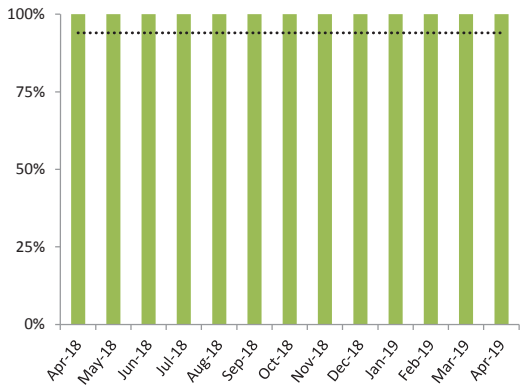
31 Day - Targets

31 Day Diagnostic to Treatment

31 Day Subsequent Treatment (Surgery)



31 Day Subsequent Treatment (Drugs)



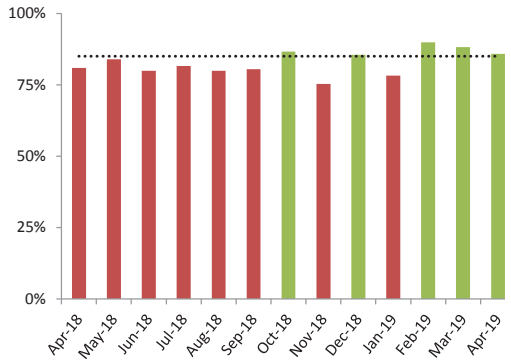
The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

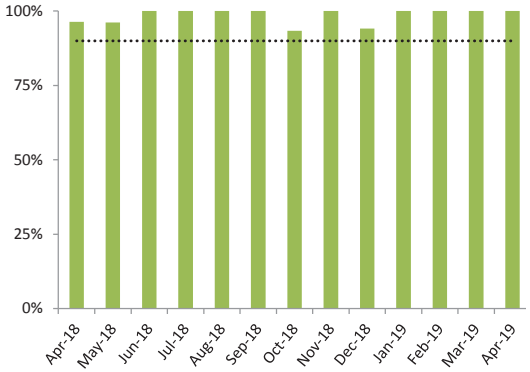
Regulatory Performance - Cancer (Latest month is provisional)

62 Day Cancer Targets

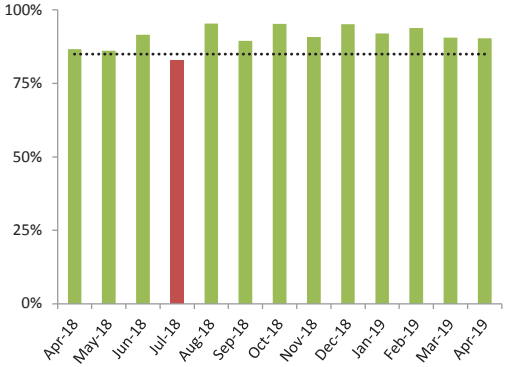
62 Day - Urgent GP Referral to Treatment



62 Day - Screening Programme



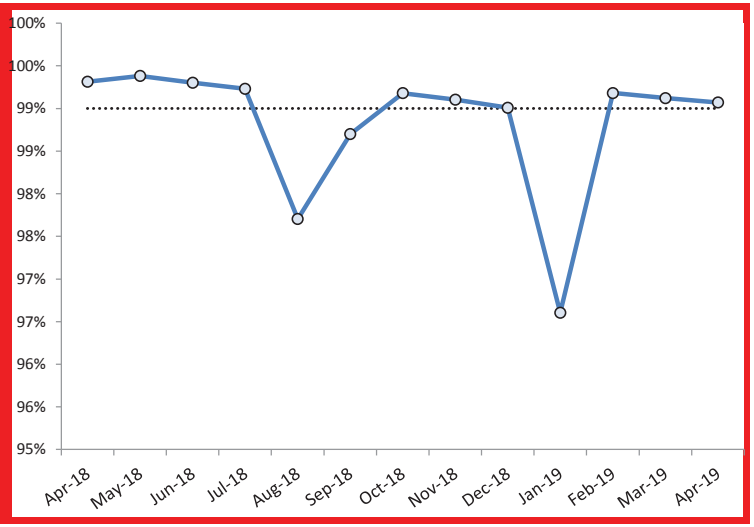
62 Day - Consultant Upgrades



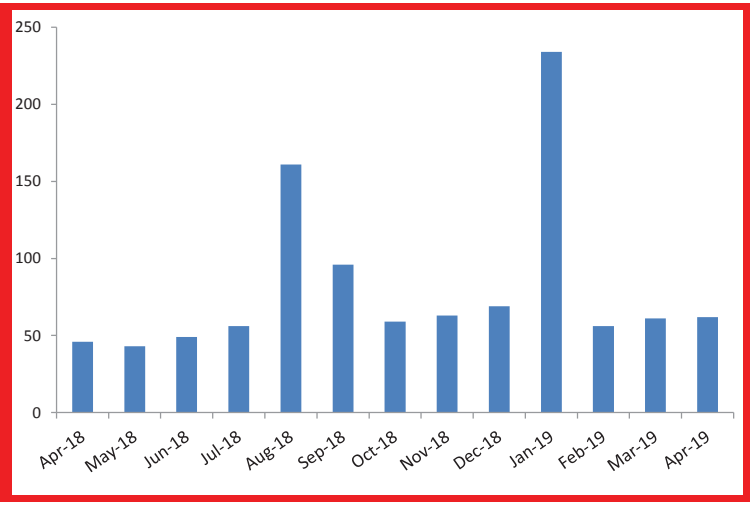
Performance Matters (KPIs)

Diagnostics

DM01 Performance



DM01 - Number of patients waiting over 6 weeks at month end (breaches)



DM01 Comments

The diagnostic standard (DM01) was achieved for April 2019 with a performance of 99.07% against the target of 99% patients seen in less than 6 weeks. As per previous months the greatest area of risk to the targets remains within MRI, with a total of 55 patients breaching the standard at the end of April, and these are a combination of GA MRI and Cardiac MRI tests. Plans are in place for additional lists throughout June and July 2019 to reduce this further and reduce the risk of failure of the standard.

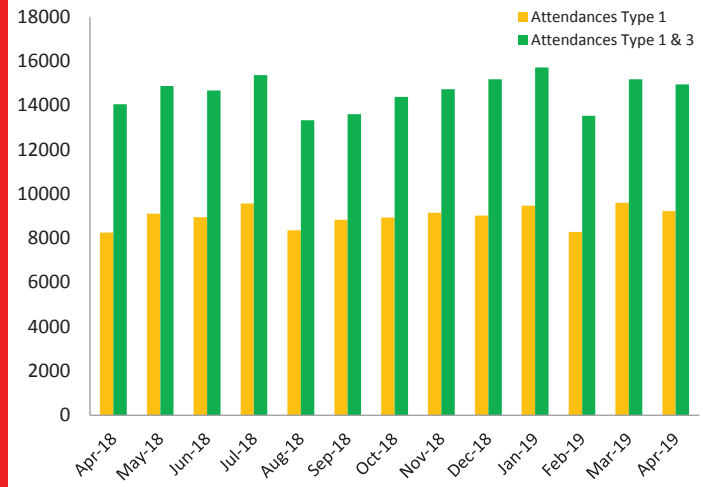
Looking forward the Imaging Department is set to commence the replacement of the two CT scanners at the Russells Hall Hospital site from 10th June 2019, a programme that is set to take approximately 3 months to complete. A key aspect of maintaining DM01 performance will be to ensure Cardiac CT lists are organised around Consultant Cardiologists' existing job plans and potential outsourcing of any activity that cannot be accommodated.

The Dudley Group NHS Foundation Trust

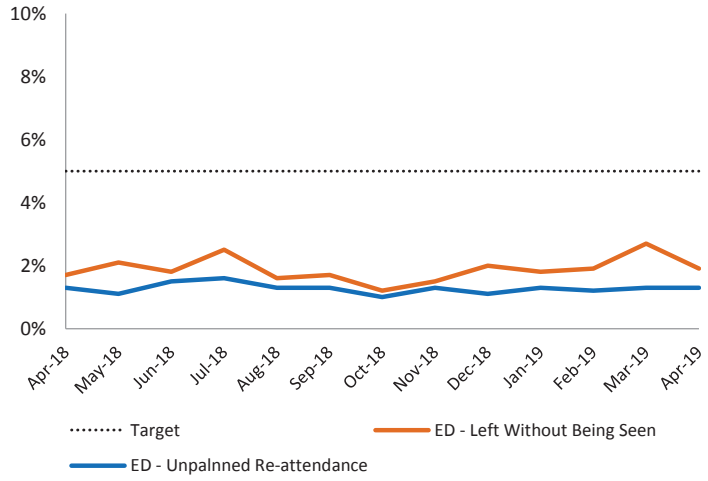
Performance Matters (KPIs)

Regulatory Performance - ED

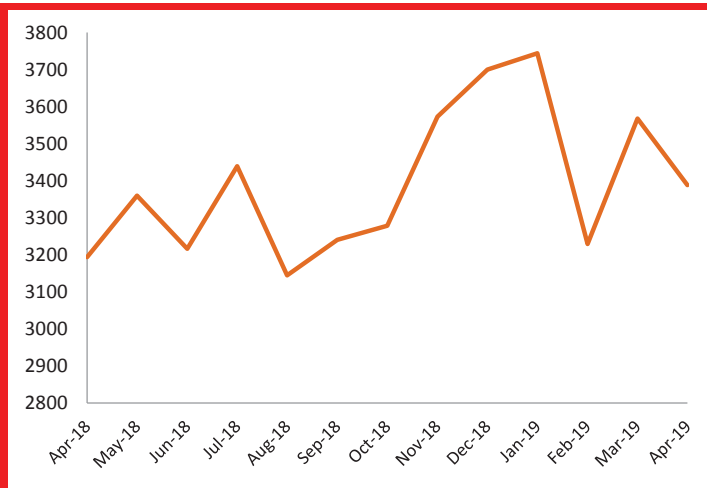
Number of Attendances



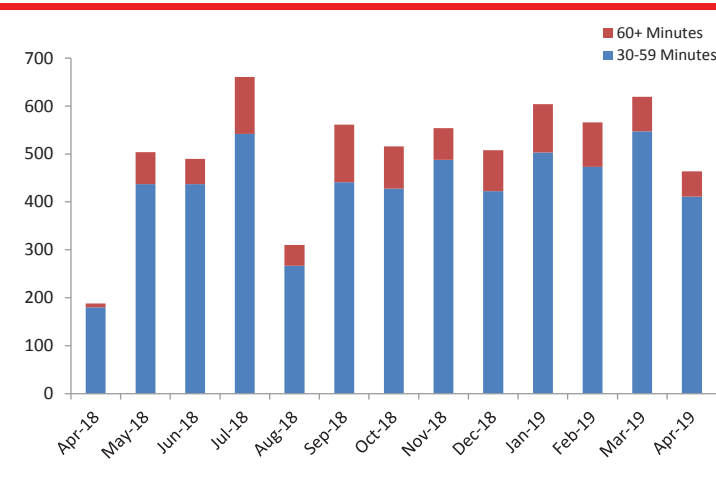
A&E Left without being seen & Unplanned Re-attendances Rates



No. of Ambulance Conveyances



Ambulance Handovers

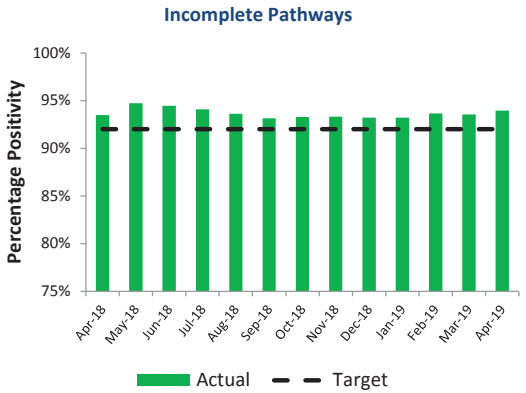


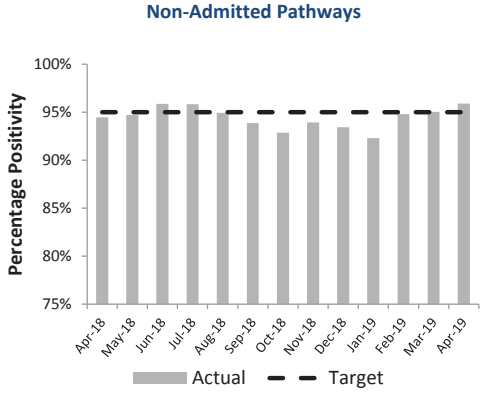
The Dudley Group NHS Foundation Trust

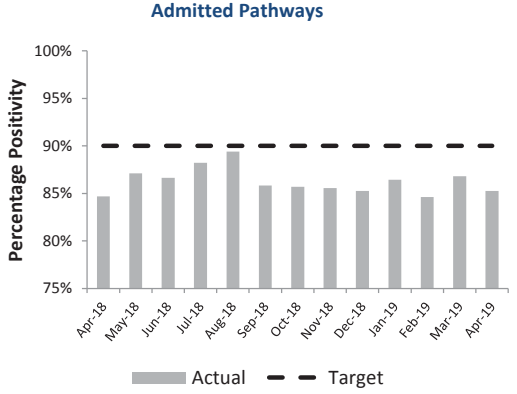
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment

Consultant 18 Week Referral to Treatment







RTT 18 Week Performance - April 2019

Validated Position

Specialty	Incompletes - Target 92%			
	<18	>18	Total	%
100 - General Surgery	828	101	929	89.1%
101 - Urology	1115	91	1206	92.5%
110 - Trauma & Orthopaedics	1710	152	1862	91.8%
120 - ENT	1245	17	1262	98.7%
130 - Ophthalmology	1876	289	2165	86.7%
140 - Oral Surgery	764	30	794	96.2%
160 - Plastic Surgery	738	72	810	91.1%
300 - General Medicine	1	0	1	100.0%
301 - Gastroenterology	1074	68	1142	94.0%
320 - Cardiology	506	21	527	96.0%
330 - Dermatology	865	23	888	97.4%
340 - Respiratory Medicine	368	1	369	99.7%
400 - Neurology	521	31	552	94.4%
410 - Rheumatology	524	5	529	99.1%
430 - Geriatric Medicine	119	1	120	99.2%
502 - Gynaecology	1101	60	1161	94.8%
Other	3945	152	4097	96.3%
Total	**17300**	**1114**	**18414**	**94.0%**

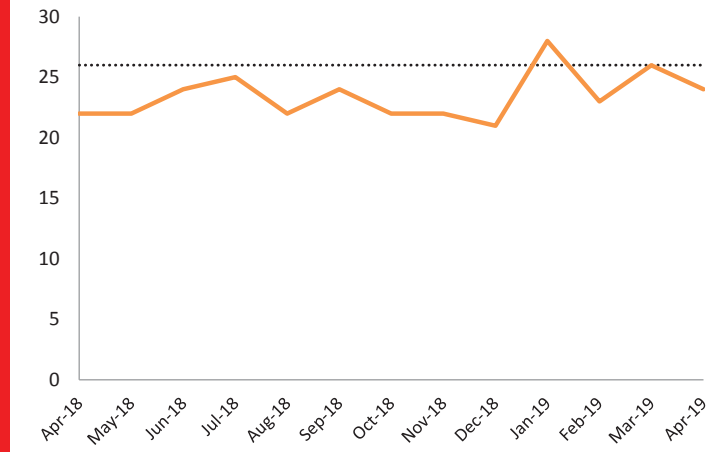
Comments

The Dudley Group NHS Foundation Trust

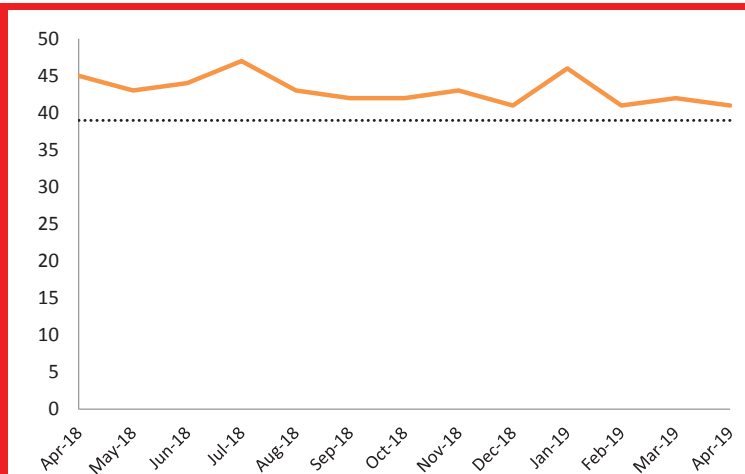
Performance Matters (KPIs)

Regulatory Performance - 18 Week Referral to Treatment

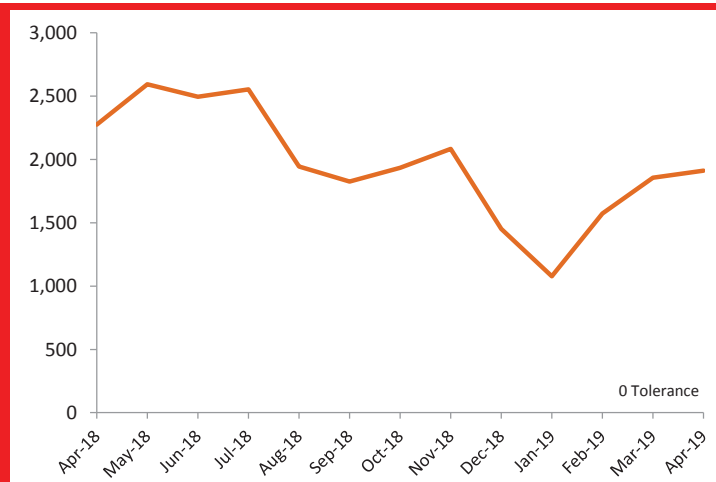
Wait in days from referral to 1st OPD



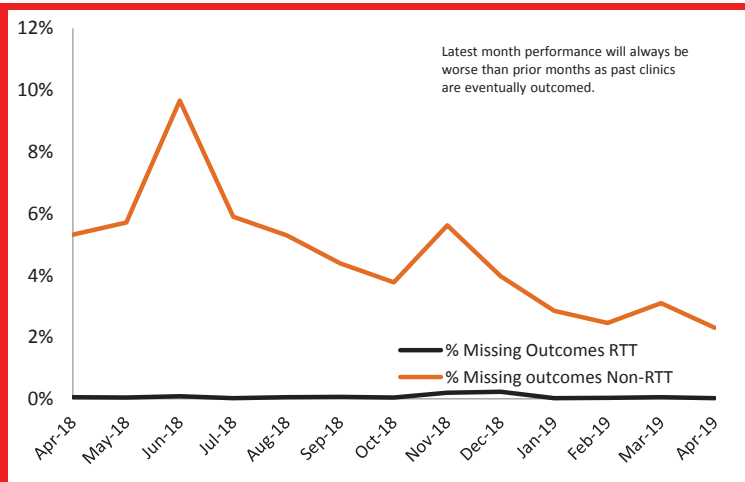
Wait in days from Add to Waiting List to Treatment or Removal



Number of unavailable slots at end of month (Appointment Slot Issues)



% Missing Outcomes

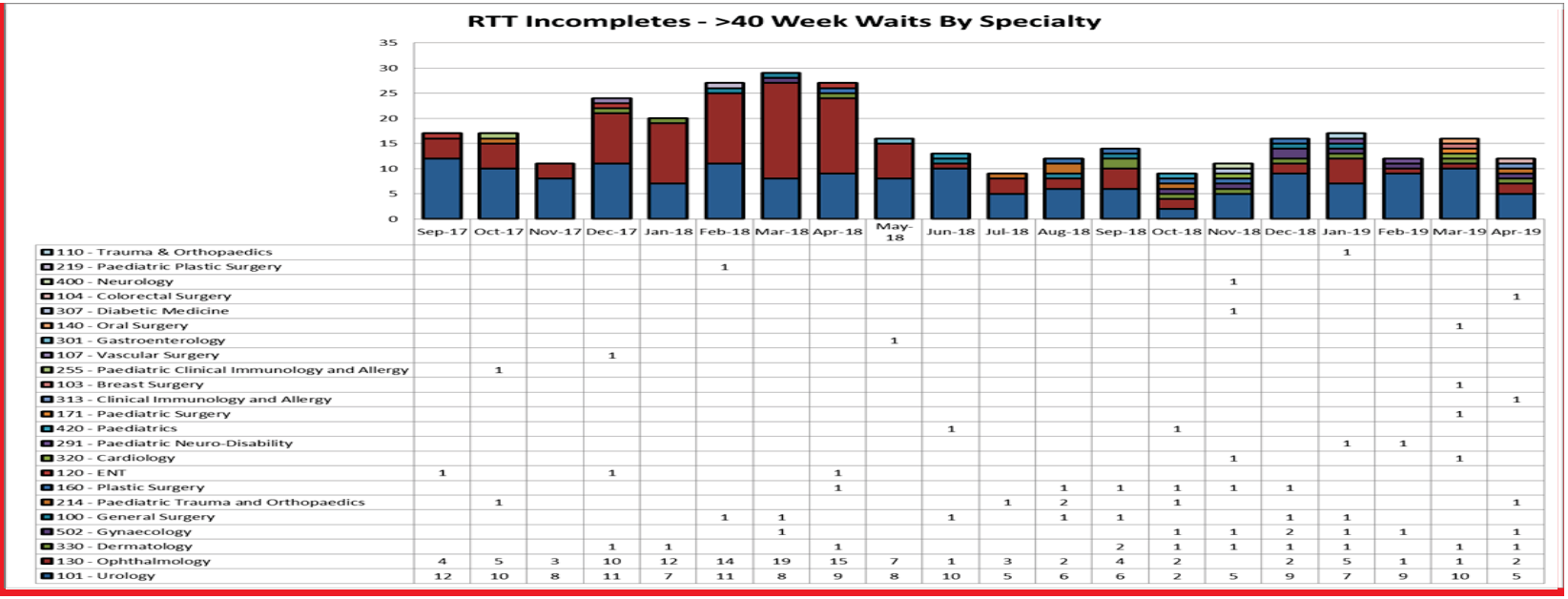


The Dudley Group NHS Foundation Trust

Performance Matters (KPIs)

Regulatory Performance - RTT Incompletes

RTT Incompletes by Specialty



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
110 - Trauma & Orthopaedics																	1			
219 - Paediatric Plastic Surgery						1														
400 - Neurology															1					
104 - Colorectal Surgery																				1
307 - Diabetic Medicine															1					
140 - Oral Surgery																			1	
301 - Gastroenterology									1											
107 - Vascular Surgery				1																
255 - Paediatric Clinical Immunology and Allergy		1																		
103 - Breast Surgery																			1	
313 - Clinical Immunology and Allergy																				1
171 - Paediatric Surgery																			1	
420 - Paediatrics										1				1						
291 - Paediatric Neuro-Disability																	1	1		
320 - Cardiology															1				1	
120 - ENT	1			1				1												
160 - Plastic Surgery								1				1	1	1	1	1				
214 - Paediatric Trauma and Orthopaedics		1									1	2		1						1
100 - General Surgery						1	1			1		1	1			1	1			
502 - Gynaecology							1							1	1	2	1	1		1
330 - Dermatology				1	1			1					2	1	1	1	1		1	1
130 - Ophthalmology	4	5	3	10	12	14	19	15	7	1	3	2	4	2		2	5	1	1	2
101 - Urology	12	10	8	11	7	11	8	9	8	10	5	6	6	2	5	9	7	9	10	5

Comments

There is 0 over 52 weeks

Financial Performance - "At a glance"

Executive Lead: Tom Jackson

The Dudley Group NHS Foundation Trust

Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	462	448	-3.0%	-15	1,469	1,378	-6.2%	-91
Day Cases	3,580	3,786	5.8%	611	12,158	13,838	13.8%	1,680
Non-elective inpatients	3,483	3,670	5.4%	-483	12,236	10,749	-12.2%	-1,487
Outpatients	40,276	42,189	4.7%	1,067	115,593	114,578	-0.9%	-1,015
A&E	8,134	9,220	13.4%	305	25,595	26,316	2.8%	721
Total activity	**55,935**	**59,313**	6.0%	**1,485**	**167,051**	**166,859**	-0.1%	**-192**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	124	148	19.4%	24	124	148	19.4%	24
Pay	276	246	-10.9%	-30	276	246	-10.9%	-30
Non-Pay	218	165	-24.4%	-53	218	165	-24.4%	-53
Total CIP	**618**	**559**	**-9.6%**	**-59**	**618**	**559**	**-9.6%**	**-59**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	28,123	28,794	2.4%	671	28,123	28,794	2.4%	671
Other Clinical	308	195	-36.8%	-113	308	195	-36.8%	-113
STF Funding	323	323	0.0%	0	323	323	0.0%	0
Other	1,863	1,903	2.1%	40	1,863	1,903	2.1%	40
Total income	**30,617**	**31,214**	**2.0%**	**597**	**30,617**	**31,214**	**2.0%**	**597**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-20,213	-20,029	-0.9%	184	-20,213	-20,029	-0.9%	184
Drugs	-2,884	-3,332	15.6%	-449	-2,884	-3,332	15.6%	-449
Non-Pay	-7,898	-7,596	-3.8%	302	-7,898	-7,596	-3.8%	302
Other	-1,876	-1,853	-1.2%	23	-1,876	-1,853	-1.2%	23
Total Costs	**-32,871**	**-32,811**	**-0.2%**	**60**	**-32,871**	**-32,811**	**-0.2%**	**60**

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	**-382**	**273**	**-171.5%**	**655**	**-382**	**273**	**-171.5%**	**655**
Depreciation	-743	-724	--2.6%	19	-743	-724	--2.6%	19
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,136	-1,132	--0.4%	4	-1,136	-1132	--0.4%	4
SURPLUS/(DEFICIT)	**-2,261**	**-1,583**	-30.0%	**678**	**-2,261**	**-1583**	-30.0%	**678**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	-953	-117	-87.7%	836	-953	-117	-87.7%	836
Inventory					3,287	3,606	9.7%	319
Receivables & Prepayments					11,217	18,401	64.0%	7,184
Payables					-34,419	-34,788	1.1%	-369
Accruals							n/a	0
Deferred Income					-3,316	-3,670	10.7%	-354
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					8,012	7,005	-12.6%	-1,007
Loan Funding							n/a	0
KPIs								
EBITDA %	-1.3%	0.9%	2.3%		-0.1%	0.1%	0.2%	
Deficit %	-7.8%	-5.5%	2.3%		-0.8%	-0.6%	0.2%	
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		

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

	People					
	Target			Actual		Month
	18/19	Mar-19	Apr-19	YTD	Trend	Status
Workforce						
Sickness Absence Rate	3.50%	4.44%	4.77%	4.77%	↑	
Staff Turnover	8.5%	8.48%	8.25%	8.25%	↓	
Mandatory Training	90.0%	88.8%	89.2%	89.2%	↑	
Appraisal Rates - Total	90.0%	95.6%	16.1%	16.1%	↓	

Quality Indicators

Heat Map - April 2019

Ward	Environmental Cleaning	Hand-hygiene	MRSA Screening - elective	MRSA Screening - emergency	HCAI CDIFF - due to lapses in care	Saving Lives - 02b peripheral lines	Saving Lives - 06b urinary catheter	Datix incidents reported	Falls, Injuries or Accidents	Avoidable Pressure Ulcers - Grade 3/4	Serious Incidents	Never Events	Nutrition Audit	Pain Score	Medicines Management Audit	% of Deaths with Priorities of Care	Deterioarating Patient Trolley Check (1 ~~month~~ ~~arrears~~)	Fluid Balance Management Audit	VTE Assessment Indicator (CQN01)	NQA - Skin Bundle	FFT - Response Rate	FFT - Recommended %	Complaints	Compliments	Appraisals	Mandatory Training	RN Average Fill Rate (day shifts)	RN Average Fill Rate (night shifts)	Sickness Rate	Ward RAG Trend		
	Patient Safety & Quality																Clinical Indicators				Patient Experience				Workforce & Safer Staffing					Ward RAG Trend		
AMU								102	14	1	1					No Data							5	0						2	1	-3
B1								14	1	1	1					No Deaths							0	14						0	-2	2
B2 Hip								15	6							NA							0	0						4	2	-6
B2 Trauma							Audit Not Done	9	2														2	0						1	0	-2
B3								25	6														2	0						1	1	-1
B4	Audit Not Done							32	7														1	11						0	-5	4
B5				NA				9	2														2	0						2	-1	-1
C1								19	4														0	0						1	-2	2
C2							NA	34	0							No Deaths				NA			2	1						2	-1	-2
C3								17	6														2	0						0	1	-1
C4								11	2														1	0						0	0	0
C5								25	8														1	2						1	-4	3
C6								11	0														1	1						0	-1	2
C7								23	4														0	0						-1	0	1
C8								32	13														1	0						0	-3	3
CCU & PCCU								12	3					Audit Not Done						Audit Not Done			0	0						1	-2	1
Critical Care								28	3												No Data	No Data	0	25						-2	2	-1
Maternity								87	0		1					No Deaths							1	25						2	0	-1
MHDU								20	0							Audit Not Done							0	10						-2	0	1
Neonatal				NA			NA	18	0				NA			No Deaths							0	13						1	-2	2
Trust Total	NA	99.6%			0	99%	98%	1435	102	2	6	1	95.4%	100%	98%	30.2%	78%	95%	95.0%	94.4%	35.30%	94.50%	50	424	16.1%	89.2%	85.4%	88.1%	4.8%			
RAG Rating	R: <85% A: 85%-95% G: ≥95%	R: <100% G: 100%	R: <95% G: ≥95%	R: <95% G: ≥95%	R: <0 G: 0	R: <75% A: 75%-95% G: ≥95%	R: <75% A: 75%-95% G: ≥95%	No RAG rating for this indicator	No RAG rating for this indicator	R: <0 G: 0	R: <0 G: 0	R: <0 G: 0	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: ≤30% A: 30%-60% G: ≥60%	R: <85% A: 85%-95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <95% G: ≥95%	R: <85% A: 85%-95% G: ≥95%	R: <26.18% A: 26.19%-32.74% G: ≥32.75%	R: <96.41% A: 96.42%-97.31% G: ≥97.32%	No RAG rating for this indicator	No RAG rating for this indicator	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: <80% A: 80%-90% G: ≥90%	R: >4% A: 3.5%-4% G: ≤3.5%			

Please note: MRSA Screening data is unavailable until the end of May 19

NHS
The Dudley Group
NHS Foundation Trust

Performance Dashboard

Performance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
A&E - 4 Hour A&E Dept Only % (Type 1)	74.15%	69.44%	-	-	-	-	-	-	-	-	-	-	-	69.44%	%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.69%	99.45%	-	-	-	-	-	-	-	-	-	-	-	99.45%	%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	83.96%	80.93%	-	-	-	-	-	-	-	-	-	-	-	80.93%	95%
A&E - Patients who Left Without Being Seen %	1.9%	1.9%	-	-	-	-	-	-	-	-	-	-	-	1.9%	5%
A&E - Time to Initial Assessment (95th Percentile)	6	4	-	-	-	-	-	-	-	-	-	-	-	4	15
A&E - Time to Treatment Median Wait (Minutes)	94	68	-	-	-	-	-	-	-	-	-	-	-	68	60
A&E - Total Time in A&E (95th Percentile)	732	743	-	-	-	-	-	-	-	-	-	-	-	743	240
A&E - Unplanned Re-Attendance Rate %	1.3%	1.3%	-	-	-	-	-	-	-	-	-	-	-	1.3%	5%
Activity - A&E Attendances	107,524	9,222	-	-	-	-	-	-	-	-	-	-	-	9,222	8,135
Activity - Cancer MDT	5,960	508	-	-	-	-	-	-	-	-	-	-	-	508	537
Activity - Community Attendances	426,917	35,199	-	-	-	-	-	-	-	-	-	-	-	35,199	33,715
Activity - Critical Care Bed Days	8,211	631	-	-	-	-	-	-	-	-	-	-	-	631	716
Activity - Diagnostic Imaging whilst Out-Patient	54,126	4,420	-	-	-	-	-	-	-	-	-	-	-	4,420	4,645
Activity - Direct Access Pathology	2,140,369	201,172	-	-	-	-	-	-	-	-	-	-	-	201,172	166,667
Activity - Direct Access Radiology	76,758	6,355	-	-	-	-	-	-	-	-	-	-	-	6,355	6,246
Activity - Elective Day Case Spells	49,959	3,786	-	-	-	-	-	-	-	-	-	-	-	3,786	3,581
Activity - Elective Inpatients Spells	5,469	448	-	-	-	-	-	-	-	-	-	-	-	448	462
Activity - Emergency Inpatient Spells	43,701	3,670	-	-	-	-	-	-	-	-	-	-	-	3,670	3,484
Activity - Excess Bed Days	8,242	728	-	-	-	-	-	-	-	-	-	-	-	728	960
Activity - Maternity Pathway	7,361	530	-	-	-	-	-	-	-	-	-	-	-	530	562
Activity - Neo Natal Bed Days	7,236	102	-	-	-	-	-	-	-	-	-	-	-	102	102
Activity - Outpatient First Attendances	171,763	15,904	-	-	-	-	-	-	-	-	-	-	-	15,904	13,970
Activity - Outpatient Follow Up Attendances	324,962	27,596	-	-	-	-	-	-	-	-	-	-	-	27,596	27,924
Activity - Outpatient Procedure Attendances	73,394	6,749	-	-	-	-	-	-	-	-	-	-	-	6,749	5,829
Activity - Rehab Bed Days	22,862	1,639	-	-	-	-	-	-	-	-	-	-	-	1,639	1,687
Activity - Renal Dialysis	49,399	4,105	-	-	-	-	-	-	-	-	-	-	-	4,105	4,144
Ambulance Handover - 30 min – breaches (DGH view)	5,165	411	-	-	-	-	-	-	-	-	-	-	-	411	0
Ambulance Handover - 30 min – breaches (WMAS view)	6,669	545	-	-	-	-	-	-	-	-	-	-	-	545	0
Ambulance Handover - 60 min – breaches (DGH view)	916	53	-	-	-	-	-	-	-	-	-	-	-	53	0
Ambulance Handover - 60 min – breaches (WMAS view)	1,071	65	-	-	-	-	-	-	-	-	-	-	-	65	0

The Dudley Group NHS Foundation Trust

Performance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	95.0%	93.7%	-	-	-	-	-	-	-	-	-	-	-	93.7%	93%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	94.5%	97.5%	-	-	-	-	-	-	-	-	-	-	-	97.5%	93%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.4%	98.1%	-	-	-	-	-	-	-	-	-	-	-	98.1%	96%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	-	-	-	-	-	-	-	-	-	-	-	100%	98%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	100.0%	100%	-	-	-	-	-	-	-	-	-	-	-	100%	94%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	100.0%	100%	-	-	-	-	-	-	-	-	-	-	-	100%	96%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	91.4%	91.4%	-	-	-	-	-	-	-	-	-	-	-	91.4%	85%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.1%	100.0%	-	-	-	-	-	-	-	-	-	-	-	100%	90%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	82.8%	86.0%	-	-	-	-	-	-	-	-	-	-	-	86%	85%
Maternity: Breastfeeding Data Coverage Rates	100%	100%	-	-	-	-	-	-	-	-	-	-	-	100%	0%
Number of Births Within the Trust	4,315	348	-	-	-	-	-	-	-	-	-	-	-	348	
RTT - Admitted Pathways within 18 weeks %	86.3%	85.2%	-	-	-	-	-	-	-	-	-	-	-	85.2%	90%
RTT - Incomplete Waits within 18 weeks %	94%	93.9%	-	-	-	-	-	-	-	-	-	-	-	93.9%	92%
RTT - Non-Admitted Pathways within 18 weeks %	94.5%	95.8%	-	-	-	-	-	-	-	-	-	-	-	95.8%	95%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	98.82%	99.06%	-	-	-	-	-	-	-	-	-	-	-	99.06%	99%

The Dudley Group NHS Foundation Trust

Staff/HR

Finance Dashboard

Finance															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Agency spend	£13,550k	£1,221k	-	-	-	-	-	-	-	-	-	-	-	£1,221k	k
Bank spend	£20,035k	£1,673k	-	-	-	-	-	-	-	-	-	-	-	£1,673k	k
Budgetary Performance	(£13,226)k	£657k	-	-	-	-	-	-	-	-	-	-	-	£657k	£0k
Capital v Forecast	88.1%	12.3%	-	-	-	-	-	-	-	-	-	-	-	12.3%	95%
Cash Balance	£8,928k	£7,005k	-	-	-	-	-	-	-	-	-	-	-	£7,005k	k
Cash v Forecast	64.9%	87.4%	-	-	-	-	-	-	-	-	-	-	-	87.4%	95%
Creditor Days	22.7	19.7	-	-	-	-	-	-	-	-	-	-	-	19.7	15
Debt Service Cover	0.8	0.08	-	-	-	-	-	-	-	-	-	-	-	0.08	2.5
Debtor Days	8.6	13.2	-	-	-	-	-	-	-	-	-	-	-	13.2	15
I&E (After Financing)	(£4,987)k	(£1,597)k	-	-	-	-	-	-	-	-	-	-	-	(£1,597)k	k
Liquidity	-15.65	12.66	-	-	-	-	-	-	-	-	-	-	-	12.66	0
SLA Performance	£3,277k	£45k	-	-	-	-	-	-	-	-	-	-	-	£45k	£0k

Staff/HR Dashboard

Staff/HR															
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
Appraisals	95.6%	16.1%	-	-	-	-	-	-	-	-	-	-	-	16.1%	90%
Mandatory Training	88.8%	89.2%	-	-	-	-	-	-	-	-	-	-	-	89.2%	90%
RN average fill rate (DAY shifts)	81.83%	85.42%	-	-	-	-	-	-	-	-	-	-	-	85.42%	95%
RN average fill rate (NIGHT shifts)	86.43%	88.14%	-	-	-	-	-	-	-	-	-	-	-	88.14%	95%
Sickness Rate	4.66%	4.77%	-	-	-	-	-	-	-	-	-	-	-	4.77%	3.50%
Staff In Post (Contracted WTE)	4,397.87	4,402.30	-	-	-	-	-	-	-	-	-	-	-	4,402.30	
Turnover Rate (Rolling 12 Months)	8.48%	8.25%	-	-	-	-	-	-	-	-	-	-	-	8.25%	%
Vacancy Rate	9.35%	13.81%	-	-	-	-	-	-	-	-	-	-	-	13.81%	%

Enclosure 20

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 6 June 2019

TITLE:	**Finance and Performance Committee Exception Report**		
AUTHOR:	Chris Walker Deputy Director of Finance	**PRESENTER:**	Jonathan Hodgkin F & P Committee Chair

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD / COMMITTEE / GROUP:

Decision	Approval	Discussion	Other
		Y	

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐	☐	☒	☐
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or action.

CORPORATE OBJECTIVE:

S05 Make the best use of what we have
S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary report from the Finance and Performance Committee meeting held on 30 May 2019.

IMPLICATIONS OF PAPER:

RISK	Y		**Risk Description:** BAF592
	Risk Register: Y		**Risk Score:** 20
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**Y**	**Details:** Achievement of Financial Plan
	Other	**N**	**Details:**

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**30 May 2019**	**Jonathan Hodgkin**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

Finance and Efficiency

- The financial performance as at 30th April 2019 was reported as £679k better than plan. The forecast position for the 2019-20 financial year remains in line with the 'base case' budgets approved at the Finance & Performance Committee in March 2019. At the end of April a shortfall of identified CIP of £3.479m means there remains a risk to the delivery of the 'base case' plan.
- The risk of the Trust needing to borrow cash remains high. The CIP risk to the financial plan provides a cash flow risk. The timing of the land receipt has moved to January 2020 which means the Trust will have to look for further cash flow smoothing to avoid the need to borrow from the Treasury.

Performance

- Excellent performance on RTT, Cancer and DM01 targets were noted for the reporting period. The Emergency Access Standard Target remains below the required level and below our trajectory. Increased activity and the implementation of the new E.P.R. system have contributed to the performance level.
- Medicine and Integrated Care provided a deep dive presentation. Recruitment issues were highlighted as the main risk to performance at this stage.

Workforce

- A Medical bank and agency report was discussed by the Committee. The Medical Director was asked to report back to the Committee in two months' time to provide assurance around how the consultant recruitment issues will be addressed.

Estates and Procurement

- The Q4 2018-19 Procurement Report highlighted good performance in the delivery of procurement savings in 2018-19 and an improvement in the Trusts procurement ratings. Concern was raised with the Committee around the Black Country Procurement Consortium's future direction and the lack of commitment from partner Trusts. The Trust will review its procurement plans in the coming months to ensure we are aligned to the best delivery model.

Oversight and Risk

- The Committee approved the costing process and the systems used in the production of reference costs.
- The Committee supported the business case for the Urgent Care redesign project resource and recommended approval of the case to the Trust Board.

Decisions Made / Items Approved

- Approved the costing process and the systems used in the production of reference costs.
- Supported the business case for the Urgent Care redesign project resource and recommended approval of the case to the Trust Board.

Actions to come back to Committee

- Medical Director was asked to report back to the Committee in two months' time to provide assurance around how the consultant recruitment issues will be addressed

Performance Issues to be referred into Executive Performance Management Process

None

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

None

Items referred to the Board for decision or action
• Approval of the business case for the Urgent Care redesign project resource

Enclosure 21

The Dudley Group
NHS Foundation Trust

Paper for submission to the Private Board of Directors on 6th June 2019

TITLE:	**Annual Audit Committee Report 2018/19**		
AUTHOR:	**Richard Miner, Committee Chair**	**PRESENTER**	**Richard Miner, 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.*

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

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

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

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

The Board are asked to note the Annual Report of the Audit Committee for the Year 2018/19.

The Dudley Group
NHS Foundation Trust

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

The Dudley Group NHS
NHS Foundation Trust

ANNUAL REPORT OF THE AUDIT COMMITTEE FOR THE YEAR 2018/19

1. Introduction

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

The purpose of this report is for the Audit Committee to account to the Trust Board of Directors on its activities relating to the financial year 2018/19. In practice this covers the period up to the approval and sign off of the Trust's Annual Report and Accounts, which is due to take place on 22 May 2019. The Board gives delegated powers to the Audit Committee to approve these documents.

After each of its meetings during the year, the Audit Committee provides a written report to the Trust Board that details the matters discussed, key issues identified and any items requiring referral to Trust Board. This annual report draws from the information contained in these regular reports.

The Committee's responsibilities are set out in detail below.

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

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

2. Audit Committee's Responsibilities

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

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

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

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

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

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

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

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

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

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

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

3. Audit Committee Membership

The Audit Committee is constituted as a sub-committee of the Trust Board with approved terms of reference that are aligned with the *Audit Committee Handbook 2018* published by the HFMA and Department of Health. The required quorum for meetings is two Non-Executive Directors.

It is recommended that the Chair of the committee is a suitably (CCAB) qualified accountant. Richard Miner is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA).

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

The table below records attendance at each meeting, including the last meeting of the 2017/18 cycle; the 2018/19 cycle of 5 meeting is due to complete at the forthcoming meeting on 22 May 2019:

Date of Meeting	Audit Chair	Other NEDs	Finance Director	External Auditors	Internal Auditors	LCFS
22 May 2018	Yes	2	Yes	Yes	Yes	Yes
20 August 2018	Yes	3	Yes	Yes	Yes	Yes
19 November 2018	Yes	2	Yes	Yes	Yes	Yes
21 January 2019	Yes	2	Yes	Yes	Yes	Yes
18 March 2019	Yes	2	Yes	Yes	Yes	Yes

Other individuals from the Trust are invited to attend meetings including the Chief Executive (who attended on 21 January) and the Director for Governance.

There have been some changes to the Committee during the year following the retirement from the Board of Jonathan Fellows and Ann Becke and I would like to record the Committees' thanks for the many years of valuable input from both of them. The Committee welcomed two new members – Julian Atkins and Richard Welford – although following Richard's retirement from the Board at the end of March, Jonathan Hodgkin is joining the Committee. All new appointments reflect an expansion of the Committee's skill set.

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

The Terms of Reference for the Audit Committee are reviewed annually and the most recent update was approved at the November meeting and presented to the Board at its December 2018 meeting. Whilst all Non-Executive Directors can attend meetings of the Audit Committee should they wish to do so, two specific Non- Executive Directors have been appointed to serve on the Audit Committee (and as noted above), in addition to the Chair of the Committee in order to provide the Committee with sufficient balance and experience.

4. Internal Audit

Internal Audit services for the 2018/19 year were provided by RSM. Internal Audit supports the work of the Audit Committee in two key areas:

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

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

As is normal, a risk- based approach was taken to establish the internal audit plan for 2018/19. This took account of the strategic and operational risks relating to quality and safety issues; service delivery standards and targets; workforce; finance and business, as identified by both management and the Committee, as well as the need to review key financial systems to ensure that External Audit could continue to place reliance on the work of Internal Audit. The plan is updated throughout the year.

The Committee noted, once again, that the risk from cyber crime is continuing to have a growing impact on the shape of the assurance the Committee is seeking. The Trust has maintained its ISO27001 accreditation.

Internal Audit has undertaken a number of advisory assignments as well as risk assurance assignments for which it issues a range of opinions between green (substantial assurance) and red (no assurance).

All issued reports have their agreed actions tracked and followed up, with Internal Audit providing a report on the progress made by management in implementing the agreed actions. During 2018/19 these included:

- Cost Improvement Programme - Quality Impact Assessment – reasonable assurance
- Cost Improvement Programme – Financial Delivery – partial assurance
- Payments to Staff – substantial assurance
- Clinical Audit – reasonable assurance
- Risk Management and Board Assurance Framework – partial assurance
- General Ledger and Financial Reporting – substantial assurance
- Data Security Review – Medical Devices – partial assurance
- Consultant Job Planning – partial assurance
- Division and Directorate Governance and Performance Reporting – advisory
- Learning from Deaths – reasonable assurance
- Senior Medical Leave – partial assurance
- Diagnostics – Red Dot Process – reasonable assurance
- Bank and agency (phase 2) – partial assurance
- Follow up of high and medium priority management actions (phase 1) – little progress (now followed up)
- Cash receipting and treasury management – substantial assurance
- Safeguarding children – partial assurance
- Creditor payments – substantial assurance

- Bank and Agency Staff – request approval process (medical and nursing) – no assurance (medical), partial (nursing)
- Safer Staffing – Data Quality – partial assurance
- Data Security Protection Toolkit – advisory
- CQUIN Sepsis – partial assurance
- Data Quality - Sepsis - partial assurance
- Quality Dashboard – Priorities of Care Indicator – no assurance

The above list shows a number of partial assurance conclusions as well as a "no assurance" around medical bank and agency costs. These have also been discussed in further detail at Board. All actions are, as noted above, followed through to completion and in some cases referred to the relevant committee for further action. As the Trust faced both clinical and financial challenges during the year, the work of Internal Audit was deliberately focused into these areas as well as around governance areas such as the BAF and the follow up of action points.

As a result of this work, the proposed opinion from the Head of Internal Audit is that:

"The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

Internal Audit also concluded, based on their work, that there were no significant internal control weaknesses that required reporting within the Trust's Annual Governance Statement.

The further enhancements relate to those framework areas (above) which provided less than substantial assurance but given Internal Audit is directed towards those more challenging or "uncomfortable" areas, this should not come as a complete surprise.

The Business Assurance Framework (BAF) is currently undergoing further development so that it more readily identifies the sources of assurance and risk mitigation actions particularly in respect of key corporate risks that threaten the Trust's strategic objectives. The BAF has now been the subject of a number of Board workshop sessions.

5. Clinical Governance

The core business of every NHS organisation is healthcare and consequently it is appropriate and necessary for the Audit Committee to consider the clinical objectives and risks in the Assurance Framework and report to the Trust Board on the controls and assurances relating to these. The Director of Governance reports to the Audit Committee on the progress of the Clinical Audit Plan and the Chief Nurse is also available to attend the Audit Committee as necessary.

A total of 258 clinical audits were on the plan for 2018/19 of which 159 had been completed, 35 were in progress and 55 had yet to commence at March 2019. 9 audits had been removed from the original plan. Clinical audits are now clinically led.

The categories of audits includes NICE guidance (8%), National Audit for Quality Account (20%),

Clinical Effectiveness (30%), Local Guidance (14%) and National Guidance (18%). While the Audit Committee monitors the system of control, the learning is dealt with at the Clinical Quality, Safety and Patient Experience (CQSPE) Committee.

The CQC visit at the start of the year (indeed during 2018 also) highlighted the importance of clinical lead audits and the Audit Committee will continue to work to provide greater assurance to CQSPE.

The work of Internal Audit in respect of workforce management is contributing to positive changes.

6. Counter Fraud Services

The Local Counter Fraud Services (LCFS) have continued to provide a combination of fraud awareness newsletters and training, hold meetings with key managers and engage in active investigations. The essence of their work is preventative.

The LCFS concluded based on their work that there were no significant fraud risks that required reporting within the Trust's Annual Governance Statement.

7. External Audit

This will be the fourth year that PriceWaterhouseCoopers (PwC) has acted as external auditor. Ali Breadon is Engagement Lead and Joanna Watson is Engagement Senior Manager.

The following audit risks were identified:

- Risk of management override controls
- Risk of fraud in revenue and expenditure recognition
- Valuation of land and buildings

Other areas that have been considered include:

- Going concern – particularly this year and last year
- The Trust Quality Report, which is reported on separately
- The accounts of the Charitable Funds Committee and those of Dudley Clinical Services Limited, both of which are consolidated into the Trust's annual financial statements.

The audit of the Financial Statements requires the setting of a materiality level in order to assess the impact of any adjustments that might be necessary.

The audit is planned on the basis that the Trust has an effective financial control environment and this is subsequently tested along with application of various substantive analytical procedures. They also take into account the work of the internal auditors. PwC issued an unqualified audit opinion which reflects that they had been able to satisfy themselves as to the truth and fairness of the financial accounts. We have again seen reference to the "going concern" situation in the Trust's accounting policies and PwC's reference to this "material uncertainty" in their report.

The Trust is required to demonstrate its Economy, Efficiency and Effectiveness in its Use of Resources which PwC reported as an "adverse modified value for money opinion" as a consequence of gaps in the Trust's application of the principles and values of sound governance due to the CQC enforcement notices as well as the Trust's financial performance.

As far as the Quality Account is concerned, this is a "limited assurance" style of report but

2018/19 highlights a disclaimer of opinion in respect of A&E 4 hour waits due to the lack of data availability from the UCC and also in respect of ambulance waiting times, a national measurement issue..

8. Review of Audit Committee Effectiveness and Other Matters

During the year the Committee carried out a (self) review of its effectiveness and reported positively notwithstanding some actions follow up action points arising.

Members of the Audit Committee have access to a number of training, development and networking opportunities through some of the larger private sector accounting firms as well as NHS Providers which, because of the technical and risk based work of the Audit Committee, they are encouraged to attend. In addition, given the changes in the Audit Committee (and also for the wider Board) this year, there have been a series of development sessions run by our Internal and External auditors to highlight their work as well as a fraud awareness session.

9. Conclusion and Audit Committee Opinion 2018/19

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

The Audit Committee considers it has obtained adequate assurance that the key controls and processes within the Trust, to ensure corporate and financial governance, continue to operate effectively and that this conclusion is supported by the reports of the Internal and External Auditors received by the Committee during the year. The recent CQC inspection has, however, highlighted areas in which the Audit Committee will be seeking further assurance in the future.

The Audit Committee is able to provide reasonable assurance to the Trust Board that there are no major weaknesses in the Trust's risk management, control and governance processes. The Trust Board should however recognise that assurance given can never be absolute and systems and the assurances around them must continue to improve.

[The Audit Committee reviewed the Trust's Annual Governance Statement and confirms, based on the information it has received, the statement is a balanced view of the Trust's systems of risk management, governance and internal control].

Richard Miner FCA
Chair of Audit Committee
May 2019

Enclosure 22

The Dudley Group
NHS Foundation Trust

Paper for submission to the Private Board of Directors on 6th June 2019

TITLE:	**Audit Committee Highlight Report**		
AUTHOR:	**Richard Miner, Committee Chair**	**PRESENTER**	**Richard Miner, 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.*

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

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

CORPORATE OBJECTIVE:

SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

The Board are asked to note the highlight report from the Audit Committee meeting held on 22nd May, 2019.

The Dudley Group
NHS Foundation Trust

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

Committee / Group highlights report to Board / Committee

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**22/05/2019**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

None

Assurances Received

Noted and accepted the Clinical Audit Q4 Report for 2018/19, including pressure from emphasis in ED, Acqua role and clinical lead and that of 258 audits, 159 have been completed, 35 are in progress and 55 have yet to commence and 9 were removed from the plan.

Noted the level of returns made for the Trust's register of interests, gifts, hospitality and sponsorship albeit some follow up actions for none responses.

Progress being made on the redesigned BAF in readiness for committee timetables and with presentation to the Board in July.

That PwC will issue and unqualified report on the financial statements for the year ended 31 March 2019 albeit with a material uncertainty note concerning going concern and referencing to the Trust's accounting policy. This follows a similar approach last year and is consistent with the reporting of other Trusts in similar situations.

That PwC will issue a modified adverse opinion in relation to Value for Money (VfM)/Economy, Efficiency, Effectiveness. This is driven by the CQC enforcement notices issued as well as financial performance. We are advised this is consistent with other Trusts in a similar position.

That of a limited assurance (this is the style of these reports) and unqualified report in respect of the content and consistency of the Quality Report and in respect of the 62 day cancer wait. However the report is qualified in respect of 2 mandated targets: time in A&E of 4 hours or less (information not available from the UCC) and continued issues with ambulance start clocks (a national issue).

The unqualified audit opinion in respect of the Financial Statements of Charitable Funds for 2018/19.

The Head of Internal Audit (HoIA) Opinion that "the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management……to ensure that it remains adequate and effective."

Noted the completed internal audit reports, with the following conclusions:

- CQUIN Sepsis – Partial Assurance
- Data Quality - Sepsis - Partial Assurance
- Quality Dashboard – Priorities of Care Indicator – No Assurance

The Fraud Risk Assessment self-review tool demonstrating an effective fraud risk management programme to identify and manage the risk of fraud.

Committee / Group highlights report to Board / Committee

Noted the contents of the Losses Report for Quarter 4 which showed £431,499 however £421,330 of this related to the write off of debtors – delayed discharge fines - already agreed by F&P.

189 out of 224 Internal Audit recommendations have been closed with 35 remaining open, of which 5 are now overdue. The Audit Committee has agreed the extensions on the 5 overdue actions. Internal Audit are also following up overdue actions including some closed ones that may be reopened.

Decisions made/Items approved

- Approved the Trust Annual Accounts for 2018/19.
- Noted the Trust Annual Report for 2018/19 which still requires some work on it and will be circulated for final approval including some agreed amends to the Annual Governance Statement.
- Approval of the Quality Report and Accounts (subject to some agreed amends) and Representation Letter
- Approval of the representation letter for the auditors in respect of the Trust Charitable Funds Accounts.
- Approved the LCFS 2018/19 Annual Report.
- Approved the Audit Committee Annual Report subject to the updates arising out of External and Internal Audit reports.

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

- Outstanding declaration of interests returns.
- Amendments to the Annual Report
- Approval of the representation letter for the auditors in respect of the Trust's Annual Accounts
- Continued monitoring of the BAF
- The status of overdue Internal Audit recommendations.

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

- Issues arising from Internal Audit reports
- The Committee's Annual Report

Enclosure 23

The Dudley Group
NHS Foundation Trust

Paper for Submission to Board on

TITLE:	No Deal EU Exit Planning		
AUTHOR:	**Christopher Leach**	**PRESENTER**	

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
		Y	

OVERALL ASSURANCE LEVEL (***Please insert x in one of the boxes***)

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE COMMITTEE

To note and approve the EPRR Group Terms of Reference

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and caring services
SO3: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

This document comprises of the high level indications of planning and preparedness by the Dudley Group NHS FT in preparation for the eventuality of a no deal EU exit scenario in October 2019

The Dudley Group
NHS Foundation Trust

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** A 'No Deal' EU exit may impact on the Trust's ability to deliver services adequately
	Risk Register: COR864		**Risk Score** Moderate
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**Y**	**Details: NHS England EPRR Core Standards Civil Contingencies Act 2004**

The Dudley Group NHS Foundation Trust

EU EXIT RESILIENCE STRATEGY		
	DOCUMENT TITLE:	EU EXIT Resilience Strategy
	Name of Originator/Author /Designation & Specialty:	Christopher Leach, Emergency Planning Manager
	Director Lead:	Chief Operating Officer (Accountable Emergency Officer)
	Target Audience:	All Staff
	Version:	4.0
	Date of Final Ratification at Committee/Board of Directors:	
	Review Date:	
	Registration Requirements Outcome Number(s) (CQC)	
	Relevant Documents /Legislation/Standards	Civil Contingencies Act 2004 ISO 22301:2012 Government Guidance EU Exit Dudley Group NHS FT No Deal EU Exit BIA Dudley Group NHS FT No Deal EU Exit Response Policy Dudley Group NHS FT Business Continuity Plan Dudley Group NHS FT Business Impact Analysis
	Contributors: ***Individuals involved in developing the document.***	**Designation:** Jane Elvidge, Deputy Chief Pharmacist & Medication Safety Officer Paul Mellor, Assistant Director of Procurement Dawn Woods, Head of HR Operations Dr Emma Suggett, Interim Chief Pharmacist Neal Shaw, Head of Medical Engineering Darren Lowe, Estates Compliance Manager Sarah Ellis, IT relationship manager Colin Plant, Estates Manager Interserve Phillip Stirling, Sandwell and West Birmingham NHS Trust Emergency Planning Officer Gregory Barber, Transfusion Laboratory Manager Claire Phillips, Research & Development Manager Chris Walker, Deputy Director of Finance – Financial Reporting Sharon Williams, Information Governance Manager/Data Protection Officer Danielle Stacey, Deputy Chief Pharmacist – Medicines Optimisation Rita Khan, Breast Imaging Manager
	The electronic version of this document is the definitive version	

Version	Date	Reason
1.0	October 2018	New Document
2.0	26th March 2019	Updated document for Board
3.0	April 2019	Updated document following new guidance
4.0	May 2019	Updated following updates from Radiology

THIS DOCUMENT IS SUBJECT TO CHANGE

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

EU EXIT RESILIENCE STRATEGY

1. INTRODUCTION

As part of the trusts resilience strategy it is necessary for us to prepare for incidents actual and perceived.

On the 29 March, 2017 the UK triggered Article 50 of the Lisbon Treaty as part of our preparations to leave the European Union

Currently the UK will leave the EU on the 1st June 2019 if a deal is not agreed by this point, if we decide to take part in EU elections this date could be changed to 31st October 2019

There is a potential risk of a `no deal` scenario, this generates a number of potential risks to:

- Supply chain
- Workforce
- Finances
- Reciprocal Healthcare

In the event of a deal being made there would be relatively little impact envisaged on NHS providers.

This strategy mainly considers a no deal scenario but the principles can be applied if required in a full or partial deal situation

This document identifies areas of potential risk and the assessment of these risks against the organisational aims and how the trust delivers care to its patients

This document will be supported by trust specific documentation:

- No Deal EU Exit Response Policy
- Business Continuity Policy
- Business Continuity Response and Recovery SOP
- Trust Business Impact Analysis
- Trust No Deal EU Exit Business Impact Analysis

2. STATEMENT OF INTENT/PURPOSE

This document is designed to assist the trust in responding to a no deal exit from the EU. Due to rapidly developing guidance from Department of Health and Social Care this document will be updated regularly

Aim

To define key impacts and strategy for the trust in relation to no deal EU exit planning

Objectives

- To identify areas that could potentially be impacted by EU exit
- To indicate potential impacts on trust provision of care
- To identify the anticipated work plan for the trust in relation to no deal EU exit
- To update on key national requirements and preparations in relation to no deal EU exit

3. DEFINITIONS

Acronym	Definition
DHSC	Department of Health and Social Care
EU Exit or Brexit	The UK process of exiting the EU
EU	European Union
ISO	International Standard
MHRA	Medicines and Healthcare products Regulatory Agency
IVDR	In Vitro Diagnostic Regulations
HMr	Human Medical Regulations
MDr	Medical Devices Regulations

4. NO DEAL EU EXIT TEAM

The no deal EU exit team is responsible for ensuring key areas are assessed and prepared for the eventuality of a no deal EU exit, they will meet bi-weekly and in the event of a no deal EU exit will form the subject matter expertise advising Strategic/Tactical Commanders in response to an incident generated by impacts from the exit, this group comprises of:

- SRO for the Trust (Chief Operating Officer)
- Emergency Planning Manager (Chair)
- Pharmacy lead
- EBME lead
- Trust IT/Terrafirma lead
- Trust Estates lead
- Procurement lead
- Staffing and workforce lead
- Clinical Support Services Lead
- Surgical Directorate lead
- Medicine Directorate lead
- Research and Development lead
- Finance lead
- Information Governance lead
- Summit/Interserve Representative
- Black Country Partnership (BCP) lead
- And others as are identified by Risk Assessment

5. NO DEAL EU EXIT HIGH LEVEL BUSINESS IMPACT ANALYSIS

Risk	Impact Definition	Service Delivery	Financial	Reputation	Wellbeing, Health & safety	Information Security	Statutory/ Regulatory	Business/ Work plan objectives
Reciprocal healthcare	Provision of care to EU nationals			X	X			X
Procurement	Supply of non-clinical and clinical consumables, goods and services	X	X		X			X
Pharmacy	Supply of medicines and vaccines	X	X	X	X		X	X
Medical devices	Supply and maintenance of medical devices	X	X	X	X		X	X
Interserve and support services	Estates and Soft FM	X	X	X	X		X	X
Blood Services	Blood, blood components, organs, tissues and cells	X	X	X	X			X
Workforce	Staffing	X	X	X	X		X	X
IT/Information Governance	Data sharing, processing and access	X	X	X	X	X	X	X
Fuel supplies	National supplies of fuel	X			X			X
Research and Clinical trials	Investigational medicine products and clinical research	X		X	X	X	X	X
Potential increases in demand	Capacity Increases	X		X	X		X	X

Note: All departments are expected to have in place individual Business Continuity and Impact Assessments that identify risks to their areas and a detailed specific Trust BIA for No Deal EU exit is available, this document is sensitive, a redacted version can be requested through FOI

6. AREA INDIVIDUAL IMPACTS AND RESILIENCE

6.1 Procurement

With regards to supplies and stocks purchased by the trust there are 2 methods that are utilised:

1. NHS Supply Chain
2. Trust directly procured

NHS Supply Chain- is being assessed nationally; the trust expects assurance to be fed in by this national structure as progression is made to ensure resilience; updates will be placed here as they are received.

Trust directly procured- The trust has undertaken an all-encompassing approach in relation to products that are directly procured by the trust and not through NHS supply chain, the procurement team have undertaken a `deep dive` into all of these areas ensuring that each supplier provides direct assurance as to their resilience in relation to a no deal EU exit scenario.

The trust BIA contains full details of these directly procured services, the companies identified as being based in the EU and that would be potentially be affected by a No Deal EU exit are indicated below:

Company	Category	Detail of supply	Departments affected	Assurance Provided?
Zimmer Biomet	Medical and Surgical equipment	Provision of Orthopaedic Trauma items, including Shoulder prosthesis	Surgical division (T&O)	Yes
Word 360	Staff & Patient Consulting / Services	Interpretation & Translation Service	All areas	Yes
HART Biologicals	Chemicals & reagents	Plasma & Other Haematology Products / Reagents	Black Country Partnetship	Partial
Bioventus	Diagnostic Imaging & Radiotherapy	Bone Growth Stimulator & Associated Products	Clinical Support Service (Imaging)	Yes
Genomic Healthcare	Purchased Healthcare	Provision of diagnostic testing services for early identification of breast cancer	Clinical Support Service (Breast Screening)	Yes

Once identified the areas within Dudley Group that require supplies from these companies have been contacted and in line with national guidance have been requested to ensure that they have a minimum of 3 days `buffer` stock in the event of a no deal EU exit, this will be maintained for the period of negotiation leading to the potential eventual exit of the UK from the EU

6.2 Pharmacy

One of the largest potentially impacted areas will be the provision of pharmaceuticals post no deal EU exit, this is currently being compounded by a national issue in the relation to medications shortages (not related to EU exit)

Dudley Groups pharmacy team has undertaken a risk assessment of hundreds of medications in use by the trust to ensure that any potential `at risk` medications are identified and raised to a national level to ensure resilience of supply chain, this includes “fragile lines” those that historically retained in small amounts or those requiring several days for delivery

The trust is also part of Regional discussions through bi-monthly meetings with the regional chief pharmacists and regional chair, with daily communication if necessary via email. The Chief Pharmacist will be fully briefed regarding any contingency and collaboration arrangements determined by the CPhO

Medications present a particularly complexity in that a number can only be procured from within the EU, and a number not produced within the EU do purchase raw materials from the EU. This supply chain tracing is being conducted at a national and local level, however it must be noted that whilst alternate suppliers are being explored there are not many that are available.

In addition to this in line with national request the trust has ensured that:

- Ensured we have a Senior Responsible Officer identified for no deal EU exit, this is being conducted by the chief pharmacist
- Medicines shortages has been raised on the trusts corporate risk register as a separate risk linked to the overarching no deal EU exit risk (COR 734)
- No stockpiling of medications takes place on site
- Medical staff within the trust have been instructed not to write longer prescriptions than what is required for patients
- All trust staff are communicated with to reassure patients and families, if asked, that preparations are being undertaken in relation to potential medications shortages and no deal EU exit preparations as a whole (see communications section)
- Pharmacy team monitors the supply of medications and maintains awareness for any potential stockpiling that may be occurring
- Trust has ensured it has a process in relation to “serious medications shortage” this will allow flexibility in relation to the dispensing of available medications
- Maintain Shortages Log with details of the shortage and interim advice for pharmacy staff
- Pharmacy Brexit steering group has been established and feeds directly into the trust No Deal EU Exit team

Pharmacy have also recently strengthened governance around drug shortages, and tabled a paper at CQSPE to detail formalisation of the process.

6.3 Drug Regulation

In the event of a no deal, UK participation in the European regulatory network would cease, the Medicines and Healthcare products Regulatory Agency (MHRA) would take on the functions currently undertaken by the EU for medicines on the UK market. This would require changes to UK law, via the Human Medicines Regulations 2012 (HMRs). The MHRA is planning a public consultation in early autumn on some of the key proposed legislative changes, this document will be updated as more information is received More information.

6.4 Black Country Pathology

Dudley Group NHS FT works closely with the Black Country Pathology (BCP) they are responsible for provision of:

- Biochemistry (inc. molecular genetics)
- Haematology (inc. blood transfusion)
- Histopathology (inc. histology, cytology and mortuary services)
- Immunology
- Microbiology

As such the Dudley Group has requested assurance from the Black Country Pathology service in relation to these areas in relation to no deal EU exit, this was provided to the trust on the 16/04/2019, they indicated that work has been undertaken to improve their resilience in relation to no deal EU exit and they have a in depth cross organisational strategy and plan that can be enacted if required

BCP have also investigated locally procured services in relation to their service assessment provided below:

Company	Category	Detail of supply	Departments affected	Assurance Provided?
Bio Rad	Automation principle/ technology	Supplier of automation / principle technology in use in the lab	Laboratory/Whole site	Verbal, further assurance being sought
Greiner	Blood Tubes	Suppliers of blood tubes manufactured outside of the UK	Whole site	Verbal, further assurance being sought
Other suppliers	Testing equipment	Range of items used by departments i.e. pipette tips	Biochemistry/ Haematology/ Histopathology/ Immunology/ Microbiology	Requested, alternative suppliers have been identifed

NHS Blood and Transplant have also provided the below assurance as the main provider of transfusion and transplant supplies as below:

NHS Blood and Transplant service provide key supplies to the trust in relation to transfusion and transplantation services, NHSBT have indicated that they are continuing to establish contingency arrangements to mitigate potential impacts on products and services arising from a no deal EU exit scenario, they have specifically indicated the below assurance:

- NHSBT collects blood from donors within the UK and does not routinely import from the EU for routine demand for red blood cells, platelets and plasma
- NHSBT have identified that they import and export very small numbers of rare red blood units for specific patients.
- NHSBT have identified that they import around 6.5% of plasma units from the EU (for patients born after 1996 at risk of vCJD)
- NHSBT have identified that the majority of organ donations come from the UK with only around 0.5% a year being imported from the EU
- NHSBT have considered the potential disruption to the road network around Kent and have put plans in place to ensure that stocks and samples are able to travel across the UK

Due to identification of the above resilience NHSBT have advised transfusion laboratories to continue to operate normally, ordering blood and blood components, and not to change our stock-holding of blood or blood components

The Blood Safety and Quality Regulations 2005 would be retained in UK law. The new regulation would maintain the current standard of blood quality and safety on exit day and enable updates to be made to the blood safety and quality standards to respond to emerging threats and changing safety, quality standards and technological advances.

MHRA (Medicines and Healthcare products Regulatory Agency) have indicated the following preparations for No Deal EU exit https://www.gov.uk/government/news/medicines-and-healthcare-products-regulatory-agency-statement-on-the-outcome-of-the-eu-referendum

The trust has in place an emergency blood and platelet management plan, describing how we ‘demand manage’ a RAG rated blood supply interruption.

6.5 Medical Devices

Dudley Group uses a variety of medical equipment devices from a range of suppliers, including Siemens, GE, Toshiba and Phillips.

The trust BIA contains full details of these equipment providers assurance, the companies identified as being based in the EU and that would be potentially be affected by a No Deal EU exit are indicated below:

Company	Detail of supply	Departments affected	Assurance Provided?

Siemens	Scanners and medical equipment	Cross Site impacts	Yes (via interserve)
Frost Optical Services Ltd	Optometrist equipment	Optometry	Yes
Seaward Group	PAT Testing equipment	Cross site impacts	Yes
Austin Medical Products	Alarm Systems	Multiple depts	Yes
Bien-Air UK ltd	Dental/Surgical Equipment	Dental/Surgical departments	Yes
Body Clock Healthcare	TENS machines	Maternity/ pain management	Yes
Evac Chair Int ltd	Evacuation Chairs and spares	Used cross site for emergency evacuation	Yes
Bioquell UK ltd	Bio decontamination equipment	Cleaning/capacity management	Yes
Bracco UK ltd	CT injectors and consumables	CT/Radiology	Yes, graded high risk as without these supplies we will not be able to provide CT on site, no alternative supplier
Critical Power Supplies ltd	Uninterrupted Power Supply system	Site Wide UPS systems	Yes, Alternative suppliers available
Goldenlite medical systems ltd	Dermatology PUVA cabinet	Dermatology	Partial, further assurance requested
Grazedean ltd	Diathermy foot pedals.	Diatheramy	Yes, Alternative suppliers available

Medical Equipment Regulation: In the event of a no deal exit the UK will still recognise medical devices approved for the EU market and those that are CE-marked, should this change in future adequate time will be provided for businesses to implement any changes to requirements. The UK will comply with all key elements of the Medical Devices Regulation (MDR) and the in vitro diagnostic Regulations (IVDR), which will apply in the EU from May 2020 and 2022 respectively.

6.6 Radiological Isotopes/ Starting agents

Dudley Group holds a contract with Sandwell and City to provide isotopes to the trust for radiological use.

Nationally companies responsible for the provision of items used in radiotherapy and radioactive processes have been asked to ensure resilience of the supply chain and as a result have stockpiled 6-months' supply of non-radioactive starting agents, this however still leaves a risk in relation the actual radioactive component, this cannot be stockpiled due to decay rate.

In the event of a no-deal EU exit, there is a risk of delayed delivery of radioactive generators which are key in manufacturing radiopharmaceuticals,

and other radioactive products which are usually provided as finished products,

- DaTSCAN (used in the diagnosis of Parkinsons Disease)
- I-123 MIBG (diagnosis of Tumors, adrenal medulla)
- Tl-201 (diagnostic agent)
- Ga-67 (radiopharmaceutical used to obtain images of a specific type of tissue, or disease state of tissue)

Sandwell has mitigated against this by amending their delivery schedule to ensure availability of generators for usual workload, there will be difficulties however if this new schedule of delivery cannot be met so a risk remains

Sandwell advise that this risk is being managed through there no deal EU exit preparations and remain in constant communication on progress of preparations with key partners, they have also advised that this is now included on their trusts risk register, rating it as an **Amber** risk.

6.7 Summit

Summit as the landlord for the Dudley Group PFI subcontract services to Interserve who provides services across the trust in relation to:

- Hard FM (Engineering, Electric provision, building maintenance)
- Soft FM (Porterting, Switchboard services, Food provision)
- Security (subcontracted to Olympian)

As such Summit have been requested by the trust to ensure that assurance is sought from these providers in relation to a no deal EU exit scenario

Interserve provided assurance to Summit on January 2019 and March 2019 which was then provided to the trust, this indicated that Interserve have established a national programme in relation to no deal EU exit preparations.

They identified that *"Interserve does not foresee any significant impacts on its ability to deliver services for the Hospitals in regard to Brexit. This is especially true given that import and export requirements are minimal to effective service delivery by Interserve"* (March 2019)

They further identified in January 2019 that they (Interserve) have put in place a *"Procurement and Supply Chain strategy includes identifying and mitigating potential risks to the supply of goods and services from key suppliers and subcontractors"*

In relation directly to service provision at the Dudley Group, Summit requested further assurances as detailed below:

Question	Response
Review of the assets and spares [particularly critical] to establish whether exiting the EU has an issue	A Request for Information (RFI) document has been issued to key suppliers within the health sector that are used across multiple hospitals. Clarification is being sought regarding how Brexit may impact the provision of spares; what suppliers are doing to

concerning timely fault repairs	ensure that stock is available and accessible etc.
Is the consumable supply chain robust	Based upon the responses received from suppliers, the Supply Chain Development (SCD) team will work with Procurement and Operations to assess suppliers based on their risk impact and develop risk mitigation plans as required. Given the criticality of certain service lines and vendors within the health sector – these will be prioritised.
Does Brexit affect the labour force here at Dudley?	A full review of the impact it may have has been initiated by the site team with the support of Interserve EU exit team. A meeting is planned for early January to review progress and we expect to have a full understanding soon after that.
Any subcontractors that we rely on from the EU [such as Siemens]	As outlined above, work is on-going with key suppliers to determine their plans in relation to Brexit and verifying their ability of being able to continue to provide the services required within the defined SLAs and having access to spares / stock to support this.

Further assurance has been requested by the trust to be included onto the trust BIA that will indicate any key suppliers that would be affected by a No Deal exit as well as full details of any staff that may be affected by a no deal EU exit.

6.8 NHS Property Services/ Community Health Partnerships/ Engie

Whilst the majority of Dudley Groups estate is through the PFI in place with Summit it is important to note other departments and services operate within buildings maintained by other companies, assurance was requested from these organisations and provided as below:

Organisation	Services affected	Assurance received
NHS Property Services	Hard and Soft Facilities Management of local healthcare community buildings where DGFT occupy rooms	Yes, anticipated minimal impacts
Community Health Partnerships	CHP are the SPC for the PFI	
Engie	As NHSPS, but specifically relates to Brierley Hill and Stourbridge Social Care Centres	Yes, anticipated minimal impacts

6.9 IT and Data Protection

The Trust completes the annual Toolkit; this year's Data Security and Protection Toolkit (DSPT) is due for sign off by **31st March 2019**

Trust IT 'Terrafirma' also completes the DSPT individually also for final sign off by **31st March 2019**

The Trust is certified to ISO27001 and Cyber Essentials indicating a good level of business continuity for disruptive events

The Trust has processing agreements in place with third party organisations within and without the EEA, during the process 4 have been identifed as being hosted within the EU and assurance has been requested:

Company	Assurance received
Medronic	No
Biotronik	No
Boston Scientific	Yes
Abbott (formerly St Jude Medical)	No

The Trust is currently receiving guidance on whether or not the National Framework Agreements cover the assurance required for the continued flow of data from EU to UK, or whether the Trust has to do this independently with the organisations themselves

6.10 Finance

In the event of a no deal EU exit costs will potentially rise impacting on the trust and/or additional costs may be incurred above normal expectations.

In line with national guidance the trust has ensured that we have a process in place to ensure additional costs are identified, logged and escalated to the Finance department. These will then be collated and NHS E EU exit team will be informed

6.11 Workforce and professional registration

Staffing and Workforce have been identified as an area that could be impacted by a no deal EU exit, the trust values its employees and will assist, where required, ensuring that staff originating from the EU, and requiring assistance, are able to stay within the UK, working as a member of the Dudley Group NHS FT

The Trust has identified 92 WTE staff potentially at risk from a no deal exit, below is a high level breakdown of staff, each department is aware of this and has conducted a risk assessment against staff reductions in their areas

Grade-Role	Number
Senior Manager	4
Matron	1
Consultant	14
Radiographer	3
Nursing	41
Health Care Support Workers	5
Practitioner	2
Medics	7
Registrar	8
Pharmacist	3

Occupational Therapist	2
Administration/Secretarial	4
Physiotherapist	3
Midwife	1

Should a situation arise whereby there are vacancies across the trust, workforce has robust recruitment plan/processes which can be enacted rapidly to refill vacant posts

The government has established an EU settlement scheme to allow persons originating from the EU to settle permanently in the UK, EU citizens who are resident in the UK before the UK leaves the EU will continue to be eligible to apply to the EU Settlement Scheme, until at least 31 December 2020, the trust has communicated this with our workforce and is readily able to assist staff if necessary in applying for the scheme

Professional Registration

The trust currently complies with the European Directive for Mutual Recognition of Professional Qualifications (MRPQ) for confirming professional registration of staff from EU based countries, in the event of a no-deal Brexit, the MRPQ would no longer apply

It has been designated that in the event of a no deal EU exit:

- Anyone registered using MRPQ before the date of exit would retain their registration
- Anyone who applies using MRPQ before the date of exit would be able to proceed with their application through that route which will include appeals
- Applications for registration after the date of exit would be considered depending on a number of factors set out in the statutory instrument

6.12 Surge and Escalation

In the event of a no deal EU exit the trust anticipates surge from patients who may not be able to access pharmaceuticals and care that they would usually access in the community, therefore the trust is prepared for surge in demand through its standing surge and escalation processes, with any surges as a result of no deal EU exit being escalated to the national NHS England EU exit team

6.13 Research and Clinical trials

As part of a potential impact to clinical trials and research across the NHS, we as a trust were requested to ensure exploration of impacts across:

- EU research and innovation funded schemes
- Clinical networks
- Clinical trial and investigations

Scheme	Response
EU research and	The trust does not currently have any EU, Horizon

innovation	2020 or Third Health programme grants
Clinical Networks	UK clinicians would be required to leave European Reference Networks (ERNs) However, we will seek to strengthen and build new relationships – including with the EU – ensuring clinical expertise is maintained through the UK DHSC and NHSE are in contact with the ERNs and no action is required at this stage. Further information will be communicated in due course
Clinical Trials and clinical investigations	The trust does not currently sponsor Investigational Medical Product (IMP) trials, all of our drug trials are sponsored commercially or through University or trial centre

Clinical Trial Regulation
EU Clinical Trial Regulation (CTR) will not be incorporated into UK law. However, the UK will align where possible with the CTR without delay
IF carrying out clinical trials the normal process for seeking regulatory approval will be followed

As a trust the Research Nurses and Clinical Trial pharmacists are liaising with sponsors regarding arrangements for future supplies, this will be fed into the trust BIA as the information is received.

6.14 Fuel Disruption

In the event of any fuel disruption the trust will follow its predetermined plan for fuel loss which is part of the trust Business Continuity Plan

Bunkered stocks- The trust does have 2 tanks on site that store fuel for the generators on site, the anticipated amounts stored are indicated in the below table, the quantities stored would be sufficient to fuel all four generators for approximately **12 days**

Tank Number	Tank Capacity (Litres)	Amount stored (litres)
1	180,000	0
2	83,600	68,000
3	90,000	69,200
Total Fuel	353,600	137,200

Note: Amount stored correct as of 01/2019
Tank 1: currently offline as not fit for purpose works ongoing to rectify/replace
Additionally there are 4 day tanks with 10 hours fuel provision with generators running at full load

If there is an anticipated fuel shortage tanks would be charged to take to full capacity amount of 353,600 litres

6.15 Local Health Economy Resilience

Dudley Group works closely with our commissioners in ensuring the Dudley Local Health Economy is prepared for a No Deal EU exit, the Dudley Group

also engages in a number of other key resilience working groups to ensure resilience:

- Local Health Resilience Partnership
- Local Health Resilience Forum
- Dudley Resilience Forum
- Dudley Health Protection Group
- West Midlands Local Resilience Forum (Trust represented by NHS England)

In working with Dudley CCG and NHS England, we have requested assurance that GPs and Community Pharmacists were being communicated with to ensure that they were also sending consistent messages re. No deal EU exit, and that they also had considered and have policies in place to ensure there is a limited risk of surge into the acute site in the event of a reduction in availability of key medications/supplies as highlighted in other sections of this document. The CCG and NHS England responded as below:

Dudley CCG
The biggest risk identified is prescribing during a restriction to drug supply, in the event of serious supply shortages, resulting in a Supply Disruption Alert (SDA) being issued; community pharmacies will supply alternative medicines

A panel will be convened consisting of a hospital and community pharmacist, GP and relevant specialists, to agree and distribute revised procedures and to monitor the impact. This panel will then determine frequency of meetings until normal stocks resume

NHS England
Indicate that they continue to work with all Social Care providers across a number of disciplines including medicines supply and that assurance is being gained across these areas, the work that NHS England has undertaken is outlined on their website.

6.16 Breast Cancer Screening

Breast Cancer Screening has been specifically reviewed by the trust at the request of NHS England, the key provider of services and equipment related to breast cancer screening are Hologic, they have indicated they have no anticipated risks related to no deal EU exit and continue to engage fully with the trust

A full assessment was also undertaken of key consumables, as with other departments, and where necessary a 3 day buffer stock has been maintained

Sandwell and West Birmingham have been identified as providing a Service Level Agreement with the trust in relation to breast MRI reporting, if SWBH decided not to provide this in the future it would pose a risk to patient safety, this is being looked at by the Radiology team

6.17 Reciprocal Healthcare

In the event of a no deal EU exit there is the potential that EU healthcare cards will no longer be valid for EU nationals within the UK.

Finance manages the arrangements in relation to Reciprocal Healthcare and will as such follow guidance from DHSC in relation to this, the trust already has established processes in place in relation to management of reciprocal healthcare in relation to other countries i.e. US and would be able to manage this eventuality if required:

Guidance provided from DHSC indicates that the most obvious consequence of these changes for the NHS is that visitors from the EEA or Switzerland, who come after the UK's withdrawal, may no longer be covered for healthcare in the same way they are now, there are exceptions to this which are covered in the DHSC letter dated 05 April 2019 *(EU Exit: Overseas Visitors and Migrants Cost Recovery)*

6.18 Communications

The trust has undertaken a wide ranging programme of work to ensure that communications are far reaching so the majority of trust staff are aware of the arrangements being undertaken in relation to a no deal EU exit scenario, this includes messaging to specific roles for example, medical staff have been contacted to prevent overprescribing. Other mechanisms include:

- Establishment of a No Deal EU exit portal on the trust communications page where key information is provided for staff to access, this includes FAQs as well as links to key documents and processes such as the EU registration scheme
- A poster has been produced by the trust indicating answers to key FAQs about the impacts of a no deal EU exit, it also indicates the process staff are expected to follow to escalate any identified issues and/or shortages to service provision
- A trust communications strategy is being developed separate to this document indicating how the public will be informed in the event of a no deal exit scenario occurring

6.19 Mammography

There are two mammography vans covering both Dudley and Staffordshire which are owned by Dudley Group they have been assessed to ensure they can continue to provide services in a no deal scenario and also have been assessed to ensure no external agencies would impact on their provision of services

A third van owned by Royal Wolverhampton and management by Dudley Group has been similarly assessed and no risks have been identified

7. EXERCISING

On the 1st February 2019 the trust undertook an exercise to test preparedness for a no deal EU exit this specifically identified key areas that required further development, the EU exit planning group has further developed its planning with focus on:

- Seeking potential alternate suppliers
- Stockpiling where guidance allows
- Issuing instruction to medics on the prevention of over prescribing
- Prioritization plans for services in the event of shortages ensuring care can be provided to critical areas
- Assurance from the Dudley local Health economy that they are prepared for a no deal EU exit to mitigate against surges into Dudley Group

8. TRAINING/SUPPORT

No training will be specifically provided for this document as business continuity response principles will apply if an incident was to be declared.

This document only contains overarching principles in relation to a no deal EU exit

9. PROCESS FOR MONITORING COMPLIANCE

Monitoring of Compliance Chart

Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Emergency Planning Manager	EPRR Group	Quarterly	Via EPRR Group	Emergency Planning Manager	Via EPRR Group

10. EQUALITY

Dudley Group is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

11. REFERENCES

Procurement Guidance	EU Exit - NHS Self Assessment Methodo; 3. EU Exit - Contract Data Consolidated Sp; 2. EU Exit - NHS Trust Triage Contract; 1. EU Exit - NHS Self Assessment Methodo; 1. EU Exit - NHS Self Assessment Methodo
Matthew Hancock Letter 7th December 2018	18.06.12 - Letter - Frontline Final (002).
Pharmacy Storage	Brexit Ministers launch tens of million; KR medicines-supply-upd
Interserve EU exit Statement	Brexit - Supply Chain Statement - Oct 2018

Matthew Hancock Letter 23rd August 2018	Brexit - Frontline letter final_.pdf
Government Guidance	HM Government. (2018) How to prepare if the UK leave the EU with a no deal. https://www.gov.uk/government/collections/how-to-prepare-if-the-uk-leaves-the-eu-with-no-deal#overview [accessed 5th October 2018]
EU Exit Operational Readiness Guidance	EU Exit Operational Readiness Guidance.p EU Exit operational readiness guidance cc

Annex A Procurement Suppliers Letter

The Dudley Group
NHS Foundation Trust

Procurement Department
Russells Hall Hospital
Dudley
West Midlands
DY1 2HQ

Dear Sir/Madam,

As your company is a key supplier to the Trust, we would welcome your input into the effect of a No-Deal EU Exit on the continued supply of goods and services, in order that we can collectively develop mitigation plans where appropriate.

To clarify, the definition of a No-Deal Brexit is defined at Annex A.

This request is intended to gather some outline information on the areas that may be affected. A detailed response is not required at this time and therefore I would appreciate your support in getting a response back by Friday **23rd November**.

Not all questions will be relevant to your organisation but please complete those that are.

Q1) Do you feel that a no-deal Brexit would have a significant impact on your organisations ability to deliver the current goods / services to the Trust? Please explain below.

Q2) What is the Country of Origin of the products or services delivered to the Trust?

Q3) Would the service offered by your company be affected by a change in customs arrangements for delivery through UK ports?

Q4) Notwithstanding existing pricing arrangements, could the pricing offered to the Trust be affected by a change in customs tariffs between the UK and EU countries?

Q5) Notwithstanding existing pricing arrangements, would the pricing offered to the Trust be affected by a fluctuation in the value of sterling?

Q6) Would your organisations service be affected by the inability to store data in the EU?

Q7) Would the service provided be affected by a more restrictive immigration regime with the EU?

Your support in identifying risks related to a No-Deal EU Exit would be greatly appreciated and I am happy to discuss these points further by request.

Yours sincerely

Paul Mellor
Assistant Director of Procurement

Annex A

‘No Deal’ EU Exit Scenario

This is a ‘scenario’ developed at a point in time. It does not represent the actual scenario which is unknown.

The UK leaves the EU on 29 March 2019 with no withdrawal and transition agreement, and no deal on the future relationship. This would have the following impacts:

Borders

• The EU would be likely to apply third country physical checks and border procedures to items entering the EU from the UK

• This would lead to delays at borders that could disrupt and reduce the normal flow of items in and out of the UK from the EU

Regulation

• It is anticipated that **regulatory changes** could ensue under the ‘No Deal’ scenario

• Some regulations are expected to be transferred into English law, thereby minimising the potential impacts as far as possible

Supplier preparedness

- Suppliers will face the impacts of additional customs requirements and potential broader economic factors under this scenario

• Supplier financial stability and resilience will depend upon their preparedness for new customs checks and their willingness to withstand short-term disruption

Smaller / SME providers may be most vulnerable to these impacts, and could withdraw from the market

Broader Economic environment

• Fluctuations may be seen in £ values, affecting pricing and affordability of products

• Additional financial factors may be seen in the application of customs tariffs and VAT implications

The Dudley Group NHS Foundation Trust

Strategy Consultation Form

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

During the development or review of the Strategy, consideration must be given to the actual or potential impact on equality. Due care is given to ensure that they do not contravene the article of the Human Rights Act or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, disability, sex, race, religion or belief, gender reassignment, marriage or civil partnership, pregnancy or maternity.

What is the title of the document:			
EU EXIT Resilience Strategy			
Date of Submission:		**Author**	**Christopher Leach**
Is there a similar/same document already in existence? Please state which document this will replace. If the document has a different title or has been merged with another document, please provide details of relevant documents.			
None			
Please detail under which folder on the Procedural Documents Hub Page that the document is to be stored. Procedural documents can only be stored on the central procedural documents page. If you require the document link to be stored on another page outside of this, please contact IT and ask them to put a link on.			
Emergency Planning hub page			
Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:			

Name	Designation	Date confirmed agreement (mm/yy)

Check List

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Prior to submission of the Strategy please ensure you can answer yes to all of the questions below.

	Yes/No
1. Title	
Is the title clear and unambiguous?	Y
2. Front Sheet Completion	
Is the colour banding strip purple?	Y
Is the Author identified (name and designation)?	Y
Is the Director Lead identified?	Y
Is the target audience identified?	Y
Is the document version controlled?	Y
Have the people contributing to the document been identified on the Front cover Sheet as per designation and not individual names?	Y
Have the CQC registration requirement outcomes been recorded?	Y
Have relevant documents/legislation standards been recorded if applicable?	Y
Have the identified contributors been documented?	Y
Has the change history been fully completed?	Y
3. Body of the document	
Has the contents page been fully completed and the numbering reflects the document content pages?	Y
Is there a footer on each page recording; document title, date of issue, version number, page number and total number of pages?	Y
Is the document written in Arial 12pt font?	Y
Does the document contain individual designations and NOT names?	Y
Does the numbering run in sequence?	Y
Does the document follow trust format of; Introduction, Statement of Intent/Purpose, Definitions, Process, Training/Support, Monitoring, Equality and References for the main body?	Y
The meaning for any definitions or abbreviations used is clearly stated?	Y
Is there identified training or support which includes the process for follow up of non-compliance clearly cited?	Y
Are procedural documents relating/supporting this document hyperlinked?	Y
Is the table for Monitoring Compliance fully completed?	Y
Are references cited in full and comply with the Harvard referencing?	Y
Does the document require changes to clinical documentation?	Y
If yes, has the digital Trust Clinical Approvals Group been informed?	Y
4. Consultation	
Is the consultation form completed?	Y
If the document includes prescribing or administering of medicines, has pharmacy been consulted?	Y
Has the Director Lead been consulted and accepted the document?	Y

Enclosure 24

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board on 6 June 2019

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

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

OVERALL ASSURANCE LEVEL:			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐ High level of confidence in delivery of existing mechanisms / objectives	☒ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD:

- Acknowledge the report
- Note the progress against our R &D strategy and the progression of integration with the EPR to reduce time to recruitment of first patient and absolute rates of recruitment.

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:

- NIHR study portfolio balance within the Trust
- Promotion of research to support clinical priorities and better patient outcomes
- Support Department Capacity Issues – pharmacy
- Research Data Archiving
- Training, development and retention of staff within department and across the Trust

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** reduction in annual funding from Clinical Research Network
	Risk Register: N		**Risk Score:** 12
	Y		**Risk Description:** lack of space for archiving study documents (up to 25 yrs)
	Risk Register: Y		**Risk Score:** 12
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** 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
	NHSI	**Y**	**Details:** R&D activity included in the Annual Report
	Other	**Y**	**Details:** Recruitment activity is monitored by CRN:WM, NIHR, DHSC

Research & Development Report

1. Strategic Direction

Our vision is: 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.
Our mission statement: *Research and Development: delivering the future to our patients today.*

We continue to make positive progress on the R&D strategy, with measurable success so far in increasing the numbers of principle investigators (PIs), increasing the PIs from non-medical backgrounds and sustainably increasing our recruitment figures (section 3).

We have continued to widely publicise our successes (section 2), regularly updating our Hub pages and circulating our quarterly newsletter . We are using existing structures to increase the profile of R&D, for example by including research in the Trust Induction Programme; representation at the CNS forum; Student Nurse Induction Programme and secondments in R&D, combining research and clinical practice for nurses (section 8), celebrating International Clinical Trials Day, May 2019 and well as a Research Showcase Event in Sept 2019, to promote research across the Trust.

The Royal College of Physicians released a policy statement, April 2019 stating: Every clinician working in the NHS should be supported to become research active. High-quality research in the NHS is everyone's responsibility and a core part of clinical care.
https://www.rcplondon.ac.uk/guidelines-policy/delivering-research-all-expectations-and-aspirations-nhs-england

2. Accolades for The Dudley Group

Congratulations to our Research Lab, who got full accreditation status following a GCLP inspection 9th May 2019 for another 2 years without a single minor finding. Our Research Lab is the only accredited research lab in the region.

Dr Adrian Jennings, Anaesthetics continues to be top recruiting site for FLO-ELA study (fluid optimisation in emergency laparotomy).

Dr Stephen Jenkins, Consultant Haematologist, has now commenced his 2 year Clinical Trials Scholar programme (funded by Clinical Research Network West Midlands).

Improving treatment for advanced prostate cancer - an NIHR supported prostate cancer trial called STAMPEDE, which TDG are involved in, with Dr Koh as PI, has made a global impact in how men presenting with advanced prostate cancer are treated. One particular arm of the trial has led to a change in NHS clinical practice for men with high risk, locally advanced metastatic prostate cancer who are starting first line hormone therapy.

The TRACE RA trial, developed by Professor George Kitas, Rheumatology, that Dudley has co-sponsored for over a decade, has been accepted for publication in the highly regarded A&R rheumatology journal with an international press release from the publishers (Wiley).

'Balancing the books – using EDGE' – a poster abstract, demonstrating the work we have done on our EDGE Finance Tool was presented at the R&D Forum conference in Brighton, May 2019.

3. National developments and performance management

High level objectives

Our end of year 2018/19 performance for HLO 1 patient recruitment was 85% (1605 patients recruited compared to target of 1884), with activity based funding (ABF) at 91%
Our performance against HLO2 'recruitment to time and target' was at 60% (compared to approx. 40% at previous year end).
HLO3; increasing the number of commercial studies we opened 10 new studies last year (previous year 11 studies)
HLO 4 (40 days of receiving an initial Health Research Authority assessment letter and full set of documents from the Sponsor), & HLO 5 'time taken to confirm site' were removed by NIHR Central Commissioning Facility in July 2018.

4. Capacity for research support departments

Pharmacy and R&D have worked extremely hard to provide additional clinical trial pharmacist cover to address the backlog of new studies that had previously built up, waiting for pharmacy set up whilst waiting for the new post to commence. A band 7 clinical trial pharmacist started 1st April 2019, capacity to open more trials is gradually improving.

5. Finance and Staffing

For 2019/20 there is a change in the CRN funding model with more emphasis on HLO 2 and other time and target measures. The CRN are still awaiting feedback from DHSC regarding the proposed funding model which is a 3 year model with stable funding 80%, 20% dependent upon achieving metrics (HL01 5%, HL02a 5%, HL02b 5%, specialty objectives 5%) with a cap and collar of 5%. The detail of how this will managed within the region has yet to be confirmed.

We have confirmation that our CRN funding for 2019/20 has been reduced by approx. £50,000 due to overall reductions in CRN WM funding – this has been added to the risk register. We plan to open more commercial studies this year, approximately 13, to minimise this risk. Hopefully with stable pharmacy staffing/capacity this will be achievable.

The EDGE finance tool has been rolled successfully providing us with the ability to manage income and expenditure more efficiently. We are now able to forecast future income using this database tool. We have successfully regained control of the department's finances to end on a positive year end position.
This has been promoted at external regional and national meetings/conferences. We have had huge interest in sharing this method from other Trusts, locally and nationally and so will look to promote this further.

6. Electronic Patient Record/IT/Archiving

R&D are represented at EPR meetings – pending roll-out of EPR within R&D.

Some external space at Foxes has been secured to store long term clinical trial data, however this is now full and so will be looking for some alternative storage arrangements within the Trust, if possible. Even with EPR, research continues to require paper copies of documents to be archived by site (Trust).

7. Education/Professional Development/Promotion/Service Improvement

The R&D department continue to support student nurses on their mentor programme with regular presentations at Student Nurse Inductions as well as R&D placements offered. Current activities are reported at CNS Forum meetings.

We continue to support MSc and PhD students from Birmingham University, Warwick University and Wolverhampton University, undertaking single centre or multi centre studies recruiting patients from the Trust, with three new students commencing in the next couple of months.
We are to pilot, later this year, a scheme for R&D to fund MSc's for members of staff to undertake a higher degree with an emphasis on how they will improve clinical care in their own area i.e. a research project looking at an area of need, or that the skills developed will change care for their patients in some way.

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 also available and accessible on the Hub. This is circulated to all clinical leads and Community Staff. The R&D pages on The Hub continue are updated on a regular basis.

We are in the process of finalising our programme for a Research Showcase Event, 17th September 2019, here at the Trust, to promote what we do, explain how staff can get involved and highlight training opportunities available.

Publications

73 publications January 2019 – May 2019. See appendix #1.

The Dudley Group NHS
NHS Foundation Trust

Appendix #1 - Published research - January to May 2019

1. Al Shakarchi, J. and N. Inston (2019). "Early cannulation grafts for haemodialysis: An updated systematic review." The journal of vascular access **20**(2): 123-127.

2. Arif, R., et al. (2019). "E012 Group education for patients prior to biologic and targeted synthetic disease modifying anti-rheumatic drugs: a quality improvement project at The Dudley Group NHSFT...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

3. Batten, R., et al. (2019). "240BSR multi-region audit on the management of adults with systemic lupus erythematosus 2018: compliance with audit standards...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

4. Berth-Jones, J., et al. (2019). "British Association of Dermatologists guidelines for the safe and effective prescribing of oral ciclosporin in dermatology 2018." The British journal of dermatology.

5. Cadoni, S., et al. (2019). "Impact of water exchange colonoscopy on endoscopy room efficiency: a systematic review and meta-analysis." Gastrointestinal Endoscopy **89**(1): 159.

6. Cadoni, S. and S. Ishaq (2019). "How to perform water exchange colonoscopy, with tips and tricks." VideoGIE.

7. Chapman, W., et al. (2019). "Acute upper gastrointestinal bleeding: a guide for nurses." British journal of nursing (Mark Allen Publishing) **28**(1): 53-59.

8. Claireaux, H. A., et al. (2019). "Critical care usage after major gastrointestinal and liver surgery: a prospective, multicentre observational study." British Journal of Anaesthesia **122**(1): 42-50.

9. Cuadrado-Godia, E., et al. (2019). "Ranking of stroke and cardiovascular risk factors for an optimal risk calculator design: Logistic regression approach." Computers in Biology and Medicine **108**: 182-195.

10. Deutsch, P. G., et al. (2019). "The management of chronic rhinosinusitis in primary care: An evidence-based guide." British Journal of General Practice **69**(678): 44-45.

11. Dimitroulas, T. and G. D. Kitas (2019). "Genetic regulation of dimethylarginines and endothelial dysfunction in rheumatoid arthritis." Amino Acids.

12. Gasparyan, A. Y., et al. (2019). "The Platelet-to-Lymphocyte Ratio as an Inflammatory Marker in Rheumatic Diseases." Annals of laboratory medicine **39**(4): 345-357.

13. Hensman, M., et al. (2019). "Comparison of sedentary behaviour questionnaires in people with multiple sclerosis." Disability and rehabilitation: 1-8.

14. Hope, H. F., et al. (2019). "Systematic review of the predictors of statin adherence for the primary prevention of cardiovascular disease." PLoS ONE **14**(1): e0201196.

15. Hsieh, Y. H., et al. (2019). "Total underwater colonoscopy: still murky." Gastrointestinal Endoscopy **89**(5): 1071.

16. Jamthikar, A., et al. (2019). "A Special Report on Changing Trends in Preventive Stroke/Cardiovascular Risk Assessment Via B-Mode Ultrasonography." Current Atherosclerosis Reports **21**(7): 25.

17. Jasim, M., et al. (2019). "128 Cytomegalovirus in the presence of anti-neutrophil cytoplasmic antibodies: beware!...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

18. Jasionowska, S., et al. (2019). "Development and Content Validation of the Urethroplasty Training and Assessment Tool (UTAT) for the Dorsal Onlay BMG Urethroplasty." BJU international.

19. Jung, C., et al. (2019). "A comparison of very old patients admitted to intensive care unit after acute versus elective surgery or intervention." Journal of Critical Care **52**: 141-148.

20. Khan, S. U., et al. (2019). "Emergency Laparoscopic Cholecystectomy: Is Dedicated Hot Gall Bladder List Cost Effective?" Journal of Ayub Medical College, Abbottabad : JAMC **31**(1): 3-7.

21. Khanna, N. N., et al. (2019). "Nonlinear model for the carotid artery disease 10-year risk prediction by fusing conventional cardiovascular factors to carotid ultrasound image phenotypes: A Japanese diabetes cohort study." Echocardiography **36**(2): 345-361.

22. Khanna, N. N., et al. (2019). "Effect of carotid image-based phenotypes on cardiovascular risk calculator: AECRS1.0." Medical and Biological Engineering and Computing.

23. Khanna, N. N., et al. (2019). "Performance evaluation of 10-year ultrasound image-based stroke/cardiovascular (CV) risk calculator by comparing against ten conventional CV risk calculators: A diabetic study." Computers in Biology and Medicine **105**: 125-143.

24. Khanna, N. N., et al. (2019). "Rheumatoid Arthritis: Atherosclerosis Imaging and Cardiovascular Risk Assessment Using Machine and Deep Learning-Based Tissue Characterization." Current Atherosclerosis Reports **21**(2).

25. Kitas, G. D. (2019). "I150 Implementation of physical activity enhancement interventions in routine practice: challenges and solutions." Rheumatology **58**.

26. Kitas, G. D. (2019). "Mediterranean journal of rheumatology March 2019 highlights." Mediterranean Journal of Rheumatology **30**(1): 1-2.

27. Kitas, G. D., et al. (2019). "Trial of atorvastatin for the primary prevention of cardiovascular events in patients with rheumatoid arthritis (TRACE RA): A multicenter, randomized, placebo controlled trial." Arthritis & rheumatology (Hoboken, N.J.).

28. Koutsianas, C., et al. (2019). "141 These spots on my shins...could it be something I've eaten? A rare case of cryoglobulinaemic vasculitis...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

29. Kuwai, T. and S. Ishaq (2019). "First two cases of Zenker's diverticulum treated with flexible endoscopic septum division in Japan." Digestive Endoscopy **31**(3).

30. Lee, T. J. W., et al. (2019). "Development of a national automated endoscopy database: The United Kingdom National Endoscopy Database (NED)." United European Gastroenterology Journal.

31. McClelland, L., et al. (2019). "A survey of fatigue amongst consultants in anaesthesia and paediatric intensive care medicine in the UK and Ireland." Anaesthesia **74**: 72.

32. Metsios, G. S. and G. D. Kitas (2019). "Physical activity, exercise and rheumatoid arthritis: Effectiveness, mechanisms and implementation." Best Practice and Research: Clinical Rheumatology.

33. Michael, A. and N. Gittoes (2019). "Hypophosphatasia, bilateral hip fractures and seizures." Calcified Tissue International **104**.

34. Michael, A. and C. Michael (2019). "Catatonia as a rare manifestation of gabapentin withdrawal." Journal of the American Geriatrics Society **67**.

35. Michael, A., et al. (2019). "Survival of patients following percutaneous endoscopic gastrostomy (peg)." Journal of the American Geriatrics Society **67**.

36. Michael, A. and N. Swingewood (2019). "Quantification of the impact of hip fracture and the operative procedure on patients' basic mobility in the early postoperative period." Age and Ageing **48**.

37. Miyasako, Y., et al. (2019). "Case of a small intestinal arteriovenous malformation diagnosed by double-balloon enteroscopy preoperatively." Digestive Endoscopy **31**(3).

38. Morgese, C., et al. (2019). "Patient-rated quality of recovery after major laparoscopic surgery: Is total intravenous anaesthesia better than inhalational anaesthesia?" Anaesthesia **74**: 72.

39. Nanus, D. E., et al. (2019). "Synovial fluid cytokines and adipokines as predictors of poor outcome in total HIP and knee joint replacement in patients with osteoarthritis." Osteoarthritis and Cartilage **27**.

40. Narayan, N., et al. (2019). "235Population demographics and clinical assessment from the BSR multi-region audit on the management of adults with SLE lend a unique insight into SLE in the UK...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

41. Nicolson, P. L., et al. (2019). "A haemstar-led, UK-wide "flash-mob" audit of intravenous immunoglobulin use in immune thrombocytopenia." British Journal of Haematology **185**: 9-10.

42. Pang, T., et al. (2019). "A multicentre, UK, retrospective, observational study to assess the effectiveness of insulin glargine 300 units/ml in treating people with Type 1 diabetes mellitus in routine clinical practice (SPARTA)." Diabetic Medicine **36**(1): 110-119.

43. Redgrove, J., et al. (2019). "Prescription infant formulas are contaminated with aluminium." International Journal of Environmental Research and Public Health **16**(5).

44. Saba, L., et al. (2019). "The present and future of deep learning in radiology." European Journal of Radiology **114**: 14-24.

45. Sandhu, R. (2019). "I032 Maximizing the clinical impact of BSR guidelines by assessing the baseline: results from the BSR multiregional audit of the management of SLE in adults...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

46. Shakarchi, J. A. and N. Inston (2019). "Early cannulation grafts for haemodialysis: An updated systematic review." Journal of Vascular Access **20**(2): 123-127.

47. Sharif, A., et al. (2019). "Effect of prophylactic ilioinguinal neurectomy on postoperative groin pain following Lichenstein hernioplasty." Journal of the College of Physicians and Surgeons Pakistan **29**(5): 406-409.

48. Sharp, C. A., et al. (2019). "233Enhancing quality improvement capacity through the British Society for Rheumatology's multi-region audit into the management of adults with systemic lupus erythematosus...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

49. Shirin, H., et al. (2019). "G-EYE colonoscopy is superior to standard colonoscopy for increasing adenoma detection rate: an international randomized controlled trial (with videos)." Gastrointestinal Endoscopy **89**(3): 545-553.

50. Siau, K., et al. (2019). "Certification of UK gastrointestinal endoscopists and variations between trainee specialties: results from the JETS e-portfolio." Endoscopy International Open **7**(4): E551-E560.

51. Siau, K. and I. Beintaris (2019). "My approach to water-assisted colonoscopy." Frontline Gastroenterology **10**(2): 194-197.

52. Siau, K., et al. (2019). "Training and assessment in flexible sigmoidoscopy: using a novel direct observation of procedural skills (DOPS) assessment tool." Journal of gastrointestinal and liver diseases : JGLD **28**(1): 33-40.

53. Siau, K., et al. (2019). "Performance indicators in colonoscopy after certification for independent practice: outcomes and predictors of competence." Gastrointestinal Endoscopy **89**(3): 482.

54. Siau, K., et al. (2019). "Training and assessment in flexible sigmoidoscopy: Using a novel direct observation of procedural skills (DOPS) assessment tool." Journal of Gastrointestinal and Liver Diseases **28**(1): 33-40.

55. Siau, K., et al. (2019). "Impact of the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) on endoscopy services in the UK and beyond." Frontline Gastroenterology **10**(2): 93-106.

56. Siau, K., et al. (2019). "Impact of fellowship training level on colonoscopy quality and efficiency metrics: a United Kingdom perspective." Gastrointestinal Endoscopy **89**(2): 441-442.

57. Siau, K., et al. (2019). "Performance indicators in colonoscopy after certification for independent practice: outcomes and predictors of competence." Gastrointestinal Endoscopy **89**(3): 482-482.

58. Siau, K. and A. J. Morris (2019). "A call to arms for change: The UK strategy to improve standards of care in acute upper gastrointestinal bleeding." United European Gastroenterology Journal **7**(3): 449-450.

59. Stavropoulos-Kalinoglou, A. and G. D. Kitas (2019). "Could IL-6 inhibition prevent exercise-induced fat loss in RA?" Nature Reviews Rheumatology **15**(4): 192-194.

60. Talbot, G., et al. (2019). "Ferroportin disease: One hospital's experience in diagnosis and management." British Journal of Haematology **185**: 63.

61. Tamaru, Y., et al. (2019). "Usefulness and safety of colorectal precutting EMR and hybrid endoscopic submucosal dissection for sessile serrated polyps with use of a novel multifunctional snare." VideoGIE.

62. Taylor, R. M., et al. (2019). "Description of the BRIGHTLIGHT cohort: The evaluation of teenage and young adult cancer services in England." BMJ Open **9**(4).

63. Twelves, S., et al. (2019). "Clinical and genetic differences between pustular psoriasis subtypes." Journal of Allergy and Clinical Immunology **143**(3): 1021-1026.

64. Veldhuijzen van Zanten, J., et al. (2019). "Comparison of the effects of exercise and anti-TNF treatment on cardiovascular health in rheumatoid arthritis: results from two controlled trials." Rheumatology International **39**(2): 219-225.

65. Walker, G. J., et al. (2019). "Association of Genetic Variants in NUDT15 with Thiopurine-Induced Myelosuppression in Patients with Inflammatory Bowel Disease." JAMA - Journal of the American Medical Association **321**(8): 753-761.

66. Whittaker, J. D., et al. (2019). "In Response to "Biomarkers in Peripheral Vascular Surgery"." Journal of Cardiothoracic and Vascular Anesthesia **33**(5): 1481.

67. Whittaker, J. D., et al. (2019). "Influence of Perioperative Serum Magnesium for Cardiac and Noncardiac Morbidity and Mortality Following Emergency Peripheral Vascular Surgery." Journal of Cardiothoracic and Vascular Anesthesia **33**(2): 474-479.

68. Whittaker, J. D., et al. (2019). "Short-term Mortality, Morbidity and Recovery Milestones after Major Lower Limb Amputation: a Prospective Evaluation of Outcomes in a Tertiary Center." Annals of Vascular Surgery **56**: 261-273.

69. Willetts, R. and E. Warriner (2019). "P103. Do our "Feel More Like Yourself" sessions have a lasting effect on breast cancer patients feelings of self-esteem and self-confidence." European Journal of Surgical Oncology **45**(5): 912.

70. Williamson, S. and S. Mahadevan-Bava (2019). "Case of knee swelling." Archives of Disease in Childhood: Education and Practice Edition.

71. Yu-Hsi, H., et al. (2019). "Total underwater colonoscopy: still murky...Anderson JC, Kahi CJ, Sullivan A, et al. Comparing adenoma and polyp miss rates for total underwater colonoscopy versus standard C02: a randomized controlled trial using a tandem colonoscopy approach. Gastrointest Endosc. 2019;89:591-8." Gastrointestinal Endoscopy **89**(5): 1071-1071.

72. Zaman, S., et al. (2019). "Impact of surgeonvolume and sub-speciality on cholecystectomy outcomes: Atenyear experience." Ambulatory Surgery **25**(1): 15-19.

73. Zanten, J. V. v., et al. (2019). "044 Temporal patterns in physical activity and sedentary behaviour: implications for cardiovascular disease risk in rheumatoid arthritis...British Society for Rheumatology Annual Conference 2019, April 30-May 02 2019, Birmingham, United Kingdom." Rheumatology **58**.

Enclosure 25

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 06/05/2019

TITLE:	**Seven Day Services (7DS) Report**		
AUTHOR:	**Dr. P. Hudson Interim DMD**	**PRESENTER**	**Dr. P. Hudson Interim DMD**

CLINICAL STRATEGIC AIMS

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
N	**N**	**N**	**To note**

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☒ High level of confidence in delivery of existing mechanisms / objectives	☐ General confidence in delivery of existing mechanisms / objectives	☐ Some confidence in delivery of existing mechanisms / objectives, some areas of concern	☐ No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

To note current compliance with 7DS standards and be aware of forthcoming business cases to drive changes in working models to allow delivery of 7DS

CORPORATE OBJECTIVE:

SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

- The Trust is currently compliant with the 2 of the 4 clinical standards identified in the 7DS
- Significant progress to meet the remaining two standards including making changes to job plans, the model of care and recruitment.
- Urgent action relating to access to MRI scanning is being taken and the risk register has been updated.
- The transformation of our clinical pathways will be completed in time to meet the delivery date of March 2020.

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Effective & Well Led**
	NHSI	**Y**	**Details: expected compliance by March 2020**
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

Update on Seven Day Service (7DS) Clinical Standards.

The Dudley Group NHS Foundation Trust

Trust Board 6th June 2019.

1.0 Introduction

The 7DS standards were initially introduced in 2013 by NHS Improvement to include 10 clinical standards. With the support of the Academy of Medical Royal Colleges, four of the ten standards were identified as clinical priorities on the basis of their potential to positively affect patient outcomes and it is against these which will the Trust will be assessed.

This paper will outline progress of the Trusts 7DS clinical strategy.

2.0 Objective

The 7DS programme's aim is to provide a standard of consultant led care to patients presenting urgently or as an emergency such that they have timely access to senior assessment, diagnostics and treatment such that their outcomes are not only optimized but there is equity of access nationwide but also outcomes are not dependant on the time of day patients present.

3.0 Outcomes

We already track and report the key outcomes related to 7DS and report these in our quarterly learning from deaths paper. In addition to mortality we monitor avoidable harm and also staff feedback related to patient safety through our GMC and local surveys.

4.0 The Four Priority Clinical Standards

- **Standard 2** - Time to first Consultant review- within 14 hours of admission for all non-elective patients
- **Standard 5** - Access to diagnostic tests - ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.
    - Within 1 hour for critical patients
    - Within 12 hours for urgent patients
    - Within 24 hours for non-urgent patients
- **Standard 6** - Access to consultant directed interventions - Critical Care, Interventional Radiology, Interventional Endoscopy, Emergency Surgery, Emergency Renal Replacement Therapy, Urgent Radiotherapy, Stroke Thrombolysis, Percutaneous Coronary Intervention and Stroke Thrombolysis
- **Standard 8** - Ongoing review by consultant twice daily if high dependency patients, daily for others

Progress against the six 7DS Standards for Continuous Improvement will not be measured through the collection of data or formal self-assessments, but the Trust will include summary progress information about their delivery in its report.

5.0 Reporting

It was previously mandatory for the Trust to complete a 7 day self-assessment survey annually where an audit was carried out on all patients admitted as an emergency for one seven day period. This has been discontinued from autumn 2018 and will be replaced by an assurance report to board.

6.0 Board reporting timeline

28/02/2019 - Trust submitted a Seven Day service Assessment Tool (7DSAT) based on audit data captured in the March 2018 7DS audits (appendix 1).

28/06/19 – Trust will submit further 7DSAT based on 2019 audit data

Autumn 2019 - Trust will submit further 7DSAT from repeat audit data

Spring 2020 - Trust will submit further 7DSAT with the expectation that we will be compliant with the 4 priority standards.

7.0 Summary of March 2019 position

Standard 2 (target 90%) – achieved 67 % not met.
Standard 5 **– met**
Standard 6 **– met** (with exception of urgent radiotherapy)
Standard 8 (target 90%) – achieved 77% (once daily) and 71% (twice daily) - **not met**

Key points:

- Trust behind national and regional position for standards 2 & 8
- Most marked in patients who require second daily review on high dependency areas due to unique set up of 3 independent areas (ITU, SHDU and MHDU.)
- Divisional discrepancy with medicine outperforming surgery due to most medical specialities adopting a Consultant of the week model
- Deterioration in performance from weekday to weekend

More detailed analysis and regional comparison data can be found in Appendix 2.

8.0 Audit process for June 2019.

No clear guidance form NHSI/E on what constitutes a representative sample. DGFT have adopted a devolved approach where all specialities have been asked to audit a sample proportional to the numbers of patient's they admit e.g. acute medicine 30 patients stroke medicine 5. Approach well

received by NHSI/E and shared at regional events and webinars and subsequently adopted by other trusts.

9.0 Progress since March 2018

9.1 Acute Medicine:
Greatly enhanced Consultant presence in evening which now includes one Consultant resident in ED in addition to 2 twilight ward rounds on AMU, 7 days per week. Acute Medicine is the largest single admitting speciality, accounting for 37% of total patients in 2018 audit. Previously 82% weekday and 56% weekend compliance with standard 2 in March 2018 but previous internal audits after change demonstrated full compliance with standard 2.

9.2 Paediatrics:
Implementation of Consultant of the week model with daily ward rounds and resident Consultant cover until 20:00 to improve compliance with standard 2 (previously 55% weekday and 20% weekend accounting for 8% of admissions). Ongoing risk of single consultant covering C2 and neonatal unit at the weekend so dependent on activity levels there is a risk to compliance with standards 2 & 8, including neonatal unit patients who require twice daily review.

Actions: business case in development to expand Consultant workforce to allow separation of paediatric and neonatal duties and include resident Consultant cover overnight.

9.3 Speciality Medicine:
All specialities now operate Consultant of the week model with daily review of inpatients on weekdays. Variable presence at weekends and evenings.

Actions: Clinical Directors and Service Leads all attended 7DS delivery board and actions agreed to meet compliance by 2020.

9.4 Trauma & Orthopaedics:
Business case agreed to expand Consultant workforce to implement consultant of the week model and free on call Consultant from operating theatre duties. Expected compliance with standards 2 & 8 by October 2019.

9.5 Cardiology: Opening of cardiac assessment unit and implementation of Consultant of week model with Consultant resident until 20:00 weekdays and 16:00 weekends.

10.0 Current issues:

10.1 General Surgery:
Second largest admitting speciality with 26% of patients in 2018 audit return. 58% weekday and 67% weekend compliance with standard 2 and no weekend presence of Consultant for ward rounds of

inpatients. Previously no timetabled weekday Consultant ward rounds in job plans. Included in 2018 job planning round.
Actions: Business case developed to expand Consultant workforce from 8 to 12 to allow reduction of on call periods (currently 1 Consultant working 48-72 hours per on call), resident Consultant until 20:00 7 days a week and weekend ward rounds of in-patients, thus ensuring compliance with standards 2 & 8. Presented at Directors May 2019 and further clarification sought over metrics that will be used to measure performance outcomes.

10.2 Critical Care:
All patients in level 2 facilities require twice daily Consultant review. Inconsistent Consultant presence across 3 units ITU, SHDU and MHDU, especially at weekends.
Actions.
All 3 units now under remit of one directorate. Enhanced handover of higher acuity true level 2 SHDU and MHDU to on call ITU Consultant out of hours. Expansion of ITU Consultant workforce agreed but shortage speciality with 20% vacancy rates nationally, (shortlisting completed) plus Anaesthetists offered chance to undertake weekend ward rounds of MHDU, SHDU.
In long term general surgery expansion will allow second daily review of SHDU patients. Process underway to explore feasibility of combining units into one area.

10.3 Radiology: MRI scanning:
Previously reported compliant with standard 5. Currently MRI available 7 days a week up to 20:00, with a network arrangement with UHB to undertake urgent or emergency scans outside these times. However NHSI Spinal Services GIRFT report highlighted that this is not meeting national standards for investigation of spinal cord compression.
Actions: to be added to divisional risk register. Chief of Division exploring regional solution with neighbouring trusts. To report by June 19.

11.0 Next steps

1. 7DS audit to be completed and submitted by 28/06/2019
2. Risk of non-compliance to be added to corporate risk register
3. Directory of services to be published June 19

12.0 Summary and recommendation.

In the first report to Board we highlighted the static position that that had existed over the previous three years in the delivery of 7DS and the critical steps to delivering compliance with the standards. These included timetabled ward rounds, new models of care and additional recruitment.

The board is asked to note the report, and recognise the significant process made in all three areas to meet the target date for compliance of March 2020.

Enclosure 26

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on
6th June 2019

TITLE:	**Trust Constitution**		
AUTHOR:	Gilbert George – Interim Director of Governance	**PRESENTER**	Gilbert George – Interim Director of Governance

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.*

ACTION REQUIRED OF BOARD			
Decision	**Approval**	**Discussion**	**Other (Assurance)**
	Y		

OVERALL ASSURANCE LEVEL			
Significant Assurance	**Acceptable Assurance**	**Partial Assurance**	**No Assurance**
☐	☑	☐	☐
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery

RECOMMENDATIONS FOR THE EXECUTIVE TEAM

The Board are asked to note:

- the updates to the Trust Constitution [this follows comments from the Board and solicitors]
- the Constitution will be on the Council of Governors June agenda for approving

CORPORATE OBJECTIVES:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

No major issues to note.

The constitution has been reviewed and updated following board discussion in March 2019 and comments from our legal advisers.

The updates reflect current best practise in the following sections:

- Conflicts of interest
- Council of Governors duties
- Annex 11 Reservation of powers and scheme of delegation
- Annex 12 Annual Members meeting

(All edits and updates are highlighted in RED for ease of navigating, board members are also asked to note that section numbering will be further reviewed and edited).

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** covers many risks, nut key are those related to the Trust quality priorities, deteriorating patient and patient experience
	Risk Register: Y		**Risk Score:** numerous across the BAF, CRR and divisional risk registers
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** links all domains
	NHSI	**Y**	**Details:** links to good governance
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

FOUNDATION TRUST CONSTITUTION

~~December~~ June ~~March~~ 2019~~2017~~

The Dudley Group NHS Foundation Trust Constitution

TABLE OF CONTENTS

Comment [BH(DGNFT1]: Page numbers to be checked once all draft amendments are approved

1. 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.

Board of Directors The role of the Board of Directors, comprising of Non-Executive and Executive Directors is led by the Chairman. The Board provides effective and proactive leadership of the Trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided as well as ensuring that the Trust is well-governed in every aspect of its activities.

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.

Annual Members Meeting has the meaning given in paragraph 10 of the constitution

Care Quality Commission - CQC

Constitution means this constitution and all annexes in it

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.~~

2. Name

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

3. Principal purpose

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

3.2 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.

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

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

3.3.2 the promotion and protection of public health.

3.4 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.

4. Powers

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

4.2 All powers of the Trust shall be exercised by the Board of Directors on behalf of the Ttrust.

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

5. Membership and constituencies

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

5.1 a public constituency or

5.2 the staff constituency

6. Application for membership

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

7. Public Constituency

7.1 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.

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

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

8. Staff Constituency

8.1 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:

8.1.1 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

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

8.2 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.

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

8.4 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.

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

Automatic membership by default – staff

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

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

8.6.2 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.

9. Restriction on membership

9.1 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.

9.2 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.

9.3 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.

10. Annual Members Meeting

10.1 The Trust shall hold an annual meeting of its members ('annual Members' Meeting'). The annual Members Meeting shall be open to members of the public.

10.2 Further provision about the Annual Members Meeting are set out in Annex 12 Annual Members Meeting.

11. Council of Governors – composition

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

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

11.3 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.

12. Council of Governors – election of Governors

12.1 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.

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

12.3 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.

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

12.5 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 on Annex 9

13. Council of Governors - tenure

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

13.2 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.

13.3 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.

13.4 An appointed Governor may hold office for a period of up to 3 years.

13.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

13.6 An appointed governor shall be eligible for a re-appointment at the end of his or her term (subject to a maximum period of office of 6 years).

Comment [BH(DGNFT2]: 9 years?

14. Council of Governors – disqualification and removal

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

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

14.1.2 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;

14.1.3 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.

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

14.3 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.

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

15. Council of Governors – meetings of Governors

15.1 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.

15.2 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.

16. Council of Governors – duties

The general duties of the Council of Governors is:

16.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
16.2 to represent the interests of the members of the Trust as a whole and the interests of the public
16.3 To appoint, and if required, to remove the Trust Chair.

The Trust must take steps to ensure that the governors are equipped with the skills and the knowledge they require in their capacity as such.

17. Council of Governors – standing orders

17.1 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.

18. Council of Governors – referral to the Panel

18.1. In this paragraph, the Panel means a panel of persons appointed by NHS Improvement to which a governor of an NHS foundation trust may refer a question as to whether the Trust has failed or is failing –

18.1.1. to act in accordance with its constitution, or

18.1.2. to act in accordance with provision made by or under Chapter 5 of the 2006 Act

18.2. A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

19. Council of Governors - conflicts of interest of governors

19.1 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.

20. Council of Governors – expenses

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

21. Council of Governors – further provisions

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

22. Board of Directors – composition

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

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

22.2.1 a Non-executive chairman

22.2.2 Not less than 5 and no greater than 8 other ~~6 other~~ Non-executive directors; and

22.2.3 a Chief Executive and not less than 4 and no more than 7 executive directors

22.2.3 ~~6 executive directors~~at least half of the Board of Directors, excluding the Chair, will comprise of non-executive directors determined to be independent .

22.3 One of the executive directors shall be the Chief Executive.

22.4 The Chief Executive shall be the Accounting Officer.

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

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

22.7 One of the executive directors is to be a registered nurse or a registered midwife.

22.8 The Board may determine that other Trust officers may attend meeting of the Board of Directors as and when required to provide operational advice and support to the Board to assist the Board in the discharge of their responsibilities. For the avoidance of doubt, such an officer attending will not be a Director of the purpose of the 2006 Act. Nor will they be able to vote and will bear no responsibility or liability for an action of decision of the Board of Directors

23. Board of Directors – general duties

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

24. 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 –

24.1 he or she is a member of the Public Constituency,

24.2 he or she is not disqualified by virtue of paragraph 25 below.

25. Annual Report

25.1 the Board will publish in its annual report, each non-executive director it considers to be independent. At least half the Board, excluding the Chair, will comprise non-executive directors determined by the Board to be independent.

26. Board of Directors – appointment and removal of chairman, deputy chairman and other non-executive directors

26.1 A nominations committee shall be established to make recommendations to the Council of Governors in respect of the appointment made of chairman, deputy chairman and other non-executive directors; only at a ~~The Council of Governors only at a~~ general meeting of the Council of Governors can ~~they~~ appointment or ~~remove~~removal of the chair ~~of the trust~~, deputy chairman of the trust and the other voting Non-executive directors be undertaken.

26.2 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.

26.3 The chairman and the voting non-executive directors are to be appointed in accordance with paragraph 27 below.

27. Board of Directors – appointment of chairman, senior independent director and deputy chair and other voting Non-executive directors

27.1 The Council of Governors has the power to appoint the other voting non-executive directors of the Trust.

27.2 ~~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.~~

27.3 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).

27.4 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.

27.5 The Council of Governors will appoint an independent non-executive director to be the senior independent director and one other non-executive director to the position of Deputy Chair in consultation with the Trust Chair.

28. Board of Directors - appointment and removal of the Chief Executive and other executive directors

28.1 The voting Non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

28.4 A person deemed to be fit and proper as set out in the CQC Fit and Proper Persons test requirements except with the approval in writing of NHS Improvement. Removal is ~~may be~~ triggered "if" a person fails to meet the fit and proper requirements, - which includes the competence, experience and qualifications to perform the role.

~~the competence, experience and qualifications to perform the role.~~

29. Board of Directors – disqualification

An individual cannot become or continue to be a director or a member of the Board of Directors if the individual is disqualified or otherwise prevented from being a director under the Directors Disqualification Act 1986". The following may not become or continue as a member of the Board of Directors:

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

29.2 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.

29.3 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.

29.4 person who is, or is the spouse or partner of, a member of a clinical commissioning group (for the purposes of the Health and Social Care Act 2012 established to commission NHS funded services) that commissions services from the Trust

29.5 Removal may be triggered by a person who fails the meet the FPPR (see 27.4).

30. Board of Directors Meetings

30.1 Meetings of the Board of Directors shall be open to Members of the public. Members of the public may be excluded from a meeting for special reasons". As per the provision laid out in the Act.

30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. Board of Directors – standing orders

31.1 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.

32. Board of Directors - conflicts of interest of directors

~~32.1~~ ~~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~~.

32.1. The duties that a director of the Trust has by virtue of being a director include in particular –

31.1.1. a duty to avoid a situation in which the director has (or can have) a direct or indirect, interest that conflicts (or possibly may conflict) with the interests of the trust;

31.1.2. a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

32.2. The duty referred to in sub paragraph 31.1.1 is not infringed if –

31.2.1. the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

31.2.2. the matter has been authorised in accordance with the constitution

32.3. The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4. In sub-paragraph 31.1.2 “third party” means a person other than –

31.4.1. the Trust, or

31.4.2. a person acting on its behalf

32.5. If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made

32.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement

32.8. This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9. A director needs not declare an interest –

32.9.1. if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2. if, or to the extent that, the directors are already aware of it;

32.9.3. if, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered

32.9.3.1. by a meeting of the Board of Directors, or

32.9.3.2. by a committee of the directors appointed for the purpose under the constitution

32.10 A matter shall be ‘authorised’ for the purposes of paragraph 32.2.2

32.10.1 the Board of Directors by majority disapplies the provision of the constitution which would, otherwise prevent a director from being counted as participating in the decision making process

32.10.2 the director’s interest cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.10.3 the director’s conflict of interest arises from a permitted cause (as determined by the ‘Board of Directors’) from time to time.

33. Board of Directors – remuneration and terms of office

33.1 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 Council of Governors Appointments and Remuneration Committee.

33.2 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.

33.3 The terms of office shall be reflective of any guidance issued by NHS Improvement.

34. Registers

The Trust shall maintain:

34.1 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;

34.2 a register of members of the Council of Governors;

34.3 a register of interests of Governors;

34.4 a register of board members~~directors~~; and

34.5 a register of interests of board members~~the directors~~.

35. Admission to and removal from the registers

35.1 Any person entitled to be a Member who, as appropriate, applies or is invited to become a Member, shall have their name added to the register of Members. Such person's membership of the Trust shall commence from the date of their name being added to the register of Members.

35.2. The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member and if:

35.2.1. the Member is no longer eligible under the provisions of this constitution or is disqualified

35.2.2. the Member is deceased.

35.3. The register of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted (which may be the Secretary).

35.4. The register of interests of Governors shall contain the names of each Governor, whether he has declared any interests and, if so, the interests declared in accordance with this constitution or the standing orders for Governors.

35.5. The register of Directors shall list the names of Directors, their capacity on the Board of Directors and an address through which they may be contacted (which may be the Secretary).

35.6. The register of interests of Directors shall contain the names of each Director, whether he has declared any interests and, if so, the interests declared in accordance with this constitution on the standing orders for Directors.

36. Registers – inspection and copies

36.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Trust shall not make any part of its register of member available for inspection by members of the public, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 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.

37. Documents available for public inspection

37.1 The Trust shall make the following documents available at the Trust Headquarters for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current constitution;
37.1.2 a copy of the current authorisation;
37.1.3 a copy of the latest annual accounts and of any report of the auditor on them;
37.1.4 a copy of the latest annual report and quality accounts;
37.1.5 a copy of the latest information as to its forward planning; and
37.1.6 a copy of any notice given under section 52 of the 2006 Act.

37.2 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

37.3 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.

38. External Auditor

38.1 The Trust shall have an external auditor.

38.2 The Council of Governors shall appoint or remove the external auditor at a general meeting of the Council of Governors.

39. Audit committee

39.1 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.

40. Accounts

40.1 The Trust must keep proper accounts and records in relation to the accounts.

40.2 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.

40.3 The accounts are to be audited by the trust's auditor.

40.4 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.

40.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

41. Annual report and forward plans and non-NHS work

41.1 The Trust shall prepare an Annual Report and send it to NHS Improvement.

41.2 The trust shall give information as to its forward planning in respect of each financial year to NHS Improvement.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

41.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

41.5 Each forward plan must include information about –

41.5.1 the activities other than the provision of goods and services for the purposes of health service in England that the Trust proposes to carry on, and

41.5.2 the income it expects to receive from doing so.

41.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub paragraph ~~34.1~~41.1, the Council of Governors must –

41.6.1 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 its principal purpose or the performance of its other functions, and

41.6.2 notify the directors of the Trust of its determination.

41.7 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.

41.8 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

42. Meeting of Council of Governors to consider annual accounts and reports

42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

i. the annual accounts

ii. any report of the auditor on them

42.2 the annual report and quality account

42.2.1 The documents shall also be presented to the members of the Trust at the Annual Members Meeting by at least one member of the Board of Directors in attendance

43. Instruments

43.1 The trust shall have a seal

43.2 The seal shall not be affixed except under the authority of the Board of Directors.

44. Amendment of the Constitution

44.1. The Trust may make amendments of its constitution only if –

44.1.1. more than three quarters of the Council of Governors of the Trust voting to approve the amendments; and

44.1.2. more than half of the members of the Board of Directors of the Trust voting to approve the amendments.

44.2. Amendments made under paragraph 43.1 take effect as soon as the conditions in that paragraph are satisfied but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3. Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)

44.3.1. at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and,

44.3.2. the Trust must give the members an opportunity to vote on whether they approve the amendment; and

44.3.3 if more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.3 An amendment initially made pursuant to paragraph 44.1 but which later fails to achieve the approval of more than half of the members voting pursuant to paragraph 44.3.3, and any actions taken pursuant to that amendment, shall be valid from the approvals pursuant to paragraph 44.1 until the time of the vote at which the approval of more than half of the members voting was not achieved pursuant to paragraph 44.3.3 (the time of the vote at which the approval of more than half of the members voting was not achieved pursuant to paragraph 44.3.3 being the "**Rescission Date**"). As from the Rescission Date, the relevant amendment shall cease to have effect and the constitution shall revert to its pre-amendment state. The constitution ~~is~~shall be amended accordingly and notified to NHS Improvement.

45. Indemnity

45.1. Members of the Board of Directors and Council of Governors 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 of their functions, any costs arising in this way will be met by the Trust. This does not apply when the relevant person has acted recklessly.

45.2. The Trust may purchase and maintain for members of the Council of Governors and Board of Directors insurance in respect of directors' and officers' liability, including, without limitation, liability arising by reason of the Trust acting as a corporate trustee of an NHS charity.

46. Procedures and Protocols

The Board of Directors shall adopt such procedures and protocols as it shall deem to be appropriate for the good governance of the Trust from time to time.

47. Mergers etc. and Significant Transactions

47.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction

47.3 "Significant transaction" means a transaction which meets any one of the below criteria:

47.3.1 the total of the fixed assets and current assets subject to the transaction represents more than 25% of the value of the total fixed assets and current assets of the Trust;

47.3.2 the increase or decrease in income attributable to:

47.3.2.1 the assets; or

47.3.2.2 the contract associated with the transaction represents more than 25% of the value of the Trust's income; or

47.3.2.3 the gross capital of the company or business being acquired/divested represents more than 25% of the total capital of the Trust following completion (where gross capital is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets).

47.4 "Significant Transaction" excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 6.1 and 6.3)

Eligibility to become a member of the Public Constitution is open to people living within the defined catchment area of the Trust. This will include residents from the following Local Authority electoral areas (as defined for the purpose of Local authority elections).The Public Constituency may also include volunteers providing support to the Trust who will be a member of the constituency in which they ordinarily reside. An individual is only eligible for membership of the public constituency if he/she lives in an area specified in the constitution for a public constituency.

Constituency	**Minimum Number of Members**	**Number of Governors to be elected from that area**
Dudley		
Brierley Hill	50	2
Central Dudley	50	2
North Dudley	50	2
Stourbridge	50	2
Halesowen	50	2
Others		
Tipton and Rowley Regis	24	1
South Staffordshire and Wyre Forest	24	1
Rest of the West Midlands	12	1

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 7.1 and 7.2)

Eligibility to become a member of the Staff Constituency is defined in paragraph 8 of the Constitution. The table below details the minimum number of staff within each class.

The staff constituency will include all staff employed by the Trust who have a contract of employment which does not have a fixed term or if does have a fixed term is at least 12 months duration, or they have been employed continuously for 12 months subject to any member of staff deciding to opt out. The constituency will also include independent contractors working at DGFT Only individuals who fulfill these criteria will be eligible to be staff members, see paragraph 8.2. Staff membership will be on an opt-out basis.

Class	Minimum Number of Members	Number of Staff Governors
Medical and Dental	44	1
Nursing and Midwifery	157	3
Allied Health Professionals and Healthcare Scientists	79	2
Non-Clinical Staff	58	1
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	1

Medical:
The members of the Medical staff class shall include individuals who are eligible as members of the Staff Constituency and who are persons who are included in the register of medical practitioners maintained in accordance with Section 2 of the Medical Act 1983 and who hold a licence to practice if and when this is required by legislation to enable such a person to practice.

For the avoidance of doubt, the Medical staff class shall include junior doctors who have been registered provisionally in the register of medical practitioners.

Nursing and Midwifery:
The members of the Nursing and Midwifery staff class shall include individuals who are eligible as members of the Staff Constituency who do not fall within the Medical staff class but whose regulatory

body is the Nursing and Midwifery Council. For the avoidance of doubt, the Nursing and Midwifery staff class shall also include nursing auxiliaries and health care assistants.

Allied Health Professionals and Clinical Support Staff:
The members of the Allied Health Professionals and Clinical Support Staff class shall include individuals who are eligible as members of the Staff Constituency who do not fall within the Medical and Dental Practitioners staff class or the Nursing and Midwifery staff class but whose regulatory body is within the remit of the Council for Healthcare Regulatory Excellence or who are otherwise designated by the trust from time to time as eligible to be members of this class.

Management, Administrative and Support Staff (including eligible contractors):

The members of the Management, Administrative and Support Staff class shall include individuals who are eligible as members of the Staff Constituency but do not fall within any of the other staff classes mentioned above. The Management, Administrative and Support Staff class shall include individuals who are not employed by the Trust but carry out the functions of the Trust through an independent contractor.

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)

The composition of the Council of Governors is as set out below, provided always that the number of Public Governors shall be more than half the total membership of the Council of Governors.

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

Model Rules for Elections

Reviewed ~~October 2017~~ April 2019

CONTENTS

Comment [BH(DGNFT3]: Check page numbers once amendments are final

PART 1 - INTERPRETATION

1.1 Interpretation

1.1 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.
"*council of governors*"	means the council of governors of the Trust;
"*declaration of identity*"	has the meaning set out in rule 21.1;
"*e-voting*"	means voting using either the internet, telephone or text message;
"*e-voting information*"	has the meaning set out in rule 24.2;
"*ID declaration form*"	has the meaning set out in Rule 21.1;
"internet voting record"	has the meaning set out in rule 26.4(d);
"*internet voting system*"	means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;
"*lead governor*"	means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code. "*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;
"*method of polling*"	means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;
"*numerical voting code*"	has the meaning set out in rule 64.2(b)
"*polling website*"	has the meaning set out in rule 26.1;
"*postal voting information*"	has the meaning set out in rule 24.1;
"*telephone short code"*	means a short telephone number used for the purposes of submitting a vote by text message;
"*voter ID number*"	means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,
"*voting information*"	means postal voting information and/or e-voting information

1.2 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

2.1 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

3.1 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.

3.2 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

4.1 Subject to rule 64, the returning officer for an election is to be appointed by the Trust.

4.4 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

9.1 Each candidate must nominate themselves on a single nomination paper.

9.2 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

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).

(c) Constituency or class within a constituency of which the candidate is a member.

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

13.1 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.

13.2 Where the return of nominations forms is an electronic format is permitted, the returning officer

shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 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,

(b) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 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.

14.3 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.

14.4 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.

14.5 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. If an email address has been given in the candidates nomination form (in addition to the candidates postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of nominated candidates –

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 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.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 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

16.1 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.

16.2 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

18.1 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.

18.2 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.

18.3 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

19.1 The votes at the poll must be given by secret ballot.

19.2 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

20.1 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.

20.2 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.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity public constituency

21.1 In respect of an election for a public constituency a declaration of identity must be issued with each ballot paper.

21.2 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.

21.3 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.

21.4 The voter must be required to return the declaration of identity together with the ballot paper.

21.5 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

22.1 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.

22.2 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,
(h) the date and time of the close of the poll, and
(i) the contact details of the returning officer.

24. Issue of voting documents by returning officer

24.1 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.

24.2 The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:
(a) the address for return of the ballot paper printed on it, and
(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer:
(a) the completed ID declaration form if required, and
(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1.1 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").

26.1.2 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”).

26.1.3 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”).

26.1.4 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.

26.1.5 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.

26.1.6 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

27. 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.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 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.

29. Spoilt ballot papers

29.1 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.

29.2 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.

29.3 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.

29.4 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.

30. Lost voting information

30.1 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.

30.2 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.

30.3 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.

31. Issue of replacement ballot paper

31.1 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.

31.2 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.

32. Declaration of identity for replacement ballot papers public constituency

32.1 In respect of an election for a public constituency a declaration of identity must be issued with each replacement ballot paper.

32.2 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.

32.3 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.

32.4 The voter must be required to return the declaration of identity together with the ballot paper.

32.5 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

33. Receipt of voting documents

33.1 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.

33.2 The returning officer may open any ballot paper envelope, 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.

33.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

34. Validity of ballot

34.1 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.

34.2 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.

34.3 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.

34.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

34.5 Where the returning officer is satisfied that rule 34.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

34.6 Where the returning officer is not satisfied that rule 34.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

35. 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.

36. 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.

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 - COUNTING THE VOTES

37. 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.

38. Arrangements for counting of the votes

38.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38.3 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

39. The count

39.1 The returning officer is to –

(a) count and record the number of ballot papers that have been returned;
(b) the number of internet voting records, telephone voting records and/or text voting records that have been created; and
(c) count the votes according to the provisions in this Part of the rules.

39.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records 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 or the voter ID number on an internet voting record, telephone voting record or text voting record.

39.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

40. Rejected ballot papers

40.1 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.

40.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

40.3 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).

40.4 Any text voting record:
(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate, or
(b) on which anything is written or marked by which the voter can be identified except the unique identifier
.

40.5 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

40.6 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 (b) of rule STV 40.4.

41. First stage

41.1 The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

41.2 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.

41.3 The returning officer is to also ascertain and record the number of valid ballot papers.

42. The quota

42.1 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.

42.2 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").

42.3 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.

43. 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 44 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 44 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.

44. 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 43 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 43 or 45 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 43 or 45 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.

45. Exclusion of candidates

(1) If—

(a) all transferable papers which under the provisions of rule 43 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 46 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 44 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 46 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 43 and rule 44.

(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.

46. 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.

47. 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 43 (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

48. 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 available on request:

(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 40 (1),

49. 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

50. 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.

51. Delivery of documents

Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 50, the returning officer is to forward them to the chair of the Trust.

52. 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.

53. 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 54 (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.

54. 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

55. 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 50 (1) (a).

Part 10 – Election expenses and publicity Election expenses

56. 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.

57. 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.

58. 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 59 and 60.

Publicity

59. 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 60, 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.

60. 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.

61. 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

62. 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 62(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

63. 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.

64. 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.

65. 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.

66. 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.

67. 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

March 2019

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Comment [BH(DGNFT4]: Page numbers to be checked after final amendments

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 Outpatients Centre, Vicarage Road, Stourbridge, West Midlands, DY8 4JB
- Guest Outpatients Centre, Tipton Road, Dudley, West Midlands, DY1 4SE

NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 and 2012 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
- 1 Local 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 working 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 Leadership Academy~~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

March 2019

FOREWORD

NHS foundation trusts are obliged by NHS Improvement (NHSI) 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 NHSI 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.

CONTENTS

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 Outpatients Centre, Guest Outpatients Centre and the Community of Dudley.

NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 and 2012 Health Acts, 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 and 2012 Acts 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
between 5 and 7 non-executive directors excluding the Chairperson
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, so as to be available to him or her at least three clear working 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-executive 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** (Annex 11) 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.

7.5 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.

7.6 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 ~~T~~tendering or ~~Q~~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 ~~C~~chief ~~E~~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 in line with the Trust's retention documents policy.

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 cannot 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.

7.1 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.

7.2. 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.

7.3. The acting director will vacate office as soon as the Absent Director returns to office.

7.4. 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.

8. 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.

9. 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.

RESERVATION OF POWERS AND SCHEME OF DELEGATION

March 2019

CONTENTS

Reservation of powers and scheme of delegation

1. Introduction

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. Notwithstanding any specific delegation, the Board of Directors remains accountable for all of its functions, including those which have been delegated. Therefore the Board of Directors expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role. It is consistent with the Scheme of Delegation with the NHS Code of Conduct and Accountability.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive or other Executive Directors. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

2. Purpose

The purpose of this document is to clearly identify the control framework set by the Board and identifies the powers and functions and who will perform these as in the

- Decisions Reserved for the Board
- Decisions and duties delegated by the Board to committees
- Standing Financial instructions
- Standing Orders

To be put in on completion

ANNEX 12 – ANNUAL MEMBERS' MEETING

1. ANNUAL MEMBERS' MEETINGS

1.1. The Trust shall hold a members' meeting for all members (called the "Annual Members' Meeting") within six months of the end of each financial year of the Trust.

1.2. Annual Members' Meetings shall be open to all members of the Trust, members of the Council of Governors and members of the Board of Directors, together with representatives of the Trust's auditors, and open to members of the public. The Trust may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend any such meeting.

1.3. The Board of Directors (or at least one member thereof) shall present to the members at the Annual Members' Meeting:

1.3.1 the annual accounts;
1.3.2 any report of the auditor on them;
1.3.3 the annual report:
1.3.4 the results of any election and appointments to the Council Governors, and any other reports or documentation it considers necessary.
1.3.5 If there has been an amendment to the Trusts Constitution which relates to the powers, duties or roles of the Council of Governors, at least one Governors must attend the next Annual Members Meeting and present the amendment/s to member. Members have the right to vote on and veto these types of constitutional amendments.

1.4. The Chair of Governors shall give notice to all members' of the scheduled meeting:

1.4.1 by giving not less than 21 ~~days~~ day's notice
1.4.2. by notice prominently displayed at the Trust's headquarters and at all sites operated by the Trust
1.4.3 by notice on the Trust's website; and to the Council of Governors, the Board of Directors, and to the Trust's auditors, stating the meeting is an Annual Members Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least at least 21 working days before the date of the relevant meeting).
1.4.5 meeting papers and any associated documentation to be made available on the Trust website not less than three working days before the meeting

1.5. An accidental omission to give notice of a members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.

1.6. The Chair, or in his or her absence, the Deputy Chair shall preside at all members' meetings of the Trust. If neither the Chair nor the Deputy Chair is present, the governors present shall elect one of their members to act as Chair.

1.7. The quorum for a members' meeting shall be 8 (eight) Council members present and entitled to vote. If a quorum is not present within thirty minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven days until such time as the Council of Governors determine.

1.8. The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time-to-time and from place to place or for an indefinite period.

1.9. A resolution put to the vote of a members' meeting shall be decided on a show of hands.

1.10. No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.

1.11. If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date and/or place.

1.12. In the case that a members' meeting is adjourned or postponed for 14 days or more, at least seven working days' notice shall be given specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted.

1.13. The Board of Directors may make any arrangement and impose any restrictions it considers appropriate to ensure the security of a members' meeting.

1.14. Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. Unless in the opinion of the Chair it would not be appropriate or desirable to time limit speeches on any topic to be discussed having regard to its nature, complexity or importance, no proposal, speech or any reply may exceed three minutes. In the interests of time, the Chair may, in his or her absolute discretion, and where that discretion is exercised reasonably, limit the number of replies, questions or speeches which are heard at any one members' meeting.

1.15. A person who has already spoken on a matter at a members' meeting may not speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply, or (ii) on a point of order.

1.16. The Board of Directors shall cause minutes to be made and kept, in writing, of all proceedings at the Annual Members' Meeting.

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
March 2019	Review	To reflect current best practise on conflicts of interest and the addition of new Annex 11 & 12	March 2019	

Enclosure 27

The Dudley Group
NHS Foundation Trust

Paper for Public Board - 6 June 2019

TITLE:	**NHS Provider Licence Self-Certification**		
AUTHOR:	Gilbert George Interim Director of Governance	**PRESENTER**	Gilbert George Interim Director of Governance

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.*

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other (Assurance)
	Y		

OVERALL ASSURANCE LEVEL

Significant Assurance	Acceptable Assurance	Partial Assurance	No Assurance
☐	☐	☒	☐
High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	No confidence in delivery

RECOMMENDATIONS FOR THE BOARD

The Trust operates under an NHS Provider Licence, and is required to self-certify on an annual basis whether or not they have complied in full with its condition of licence G6 and FT4.

Recommendations:

(1) (a) **G6** - Systems for compliance with licence conditions and related obligations
Recommendation 1: The Trust was '**Not Confirmed'** compliant with condition G6

Basis for recommendation:
Failure to meet all the conditions of its licence as demonstrated with the issuing of four section 31 breaches (*see appendix 5).*

(b) **CoS7** (FTs designated CRS only) – Availability of resources
Recommendation 2: The Trust was '**Confirmed'** compliant with condition CoS7 (*see appendix 6).*

Basis for recommendation
The Trust Board has approved the Trust's financial operational plans for the financial year 2019/20 that demonstrates that the Trust may require working capital to deliver sustainable services. A letter received from the Department of Health), indicates that if the

Trust were to require working capital this would be made available to the Trust.

(2) **FT4** - governance compliance
Recommendation 3: The Trust was **'Not Confirmed'** compliant with condition FT4

Background
The Trust was compliant with all elements of FT4 conditions with the exception of section 5c and therefore cannot record compliance in full with the condition (*see appendix 7*).

Extract from NHSI FT4 (5c) - governance conditions:

5. The Licensee shall establish and effectively implement systems and/or processes:

(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions

Basis for recommendation:
Breaches (4, s31s) of the licence, demonstrate a lack of effective governance.

(3) NHSI also requires the Trust to certify that during the financial year most recently ended the licensee has provided the necessary training to its Governors, as required in section 151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role (this must be certified by the Board, having regard to the views of the governors.

Recommendation 4: The Trust was **'Confirmed'** compliant with this requirement.

Basis for recommendation:

The results of the Council of Governors survey (April 2019):

- 94.7% of governors said they had received an effective induction on the role of the Council of Governors and its statutory powers
- 88.9% of governors reported that training was provided on an on-going and timely basis
- 89.5% said that briefings were provided in relation to key topics when required

Foundation Trust self-certification for Condition G6 must be published on Trust website on 7 June 2019 2019 and FT4 governance compliance by 30 June 2019.

CORPORATE OBJECTIVES:

SO1 Deliver a great patient experience

SO2 Safe and Caring services

SO3 Drive Service improvements, innovation and transformation

SO4 Be the place people choose to work

SO5 Make the best use of what we have

SO6 Deliver a viable future

SUMMARY OF KEY ISSUES:

The Trust failure to comply with its licence conditions due to its *s31s*, has resulted in the Trust having to record that it is 'not compliant' with its licence on the stated conditions below on its self-certification:

G6	Systems for compliance with licence conditions. DGFT – **'Not Confirmed'** (not compliant)
CoS7	Availability of resources DGFT – **'Confirmed'** (compliant)
FT4	Governance compliance DGFT – **'Not Confirmed'** (not compliant)
Statement required	Has the Trust provided the necessary training to its Governors DGFT – **'Confirmed'** (compliant)

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** covers many risks, nut key are those related to the Trust quality priorities, deteriorating patient and patient experience
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** links all domains
	NHSI	**Y**	**Details:** links to good governance
	Other	**N**	**Details:**

The Dudley Group
NHS Foundation Trust

Provider Licence Self-Certification Report

Content

The Dudley Group
NHS Foundation Trust

Provider Licence Self-Certification Report

1 Background

On 1st April 2013, Monitor's healthcare licensing regime was implemented for all NHS Foundation Trusts (The Health and Social Care Act 2012). It replaced the Terms of Authorisation for Foundation Trusts and is the main tool NHS Improvement (NHSI - previously Monitor) uses for regulating providers of NHS services.

All NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, and, have complied with governance requirements.

Providers should review whether their governance systems meet the standards and objectives in this licence condition. There is no set standard or model to follow; instead in determining whether the Trust is compliant, the Trust should assess effective board and committee structures, reporting lines and performance and risk management systems

NHSI guidance, most recently updated in March 2018, requires NHS Providers to self-certify the following three Licence Conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - Condition G6;
- The provider has complied with required availability of resources arrangements - Condition CoS7;
- The provider has complied with required governance arrangements - Condition FT4;
- In addition, whilst not a condition of licence the Trust must, review and self-certify whether Governors have received enough training and guidance to carry out their roles.

2 What is required?

Overall the aim of self-certification is for providers to carry out the necessary due diligence to assure that they are in compliance with the conditions, and any internal process must ensure that the Board understand clearly whether the Trust is able to confirm compliance.

NHS Improvement has found the Trust to be in breach of specific licence conditions (G6 - during 2018/19 and the Trust has accepted this finding, the Board is unable to certify that it had effective governance arrangements as necessary in order to comply with the conditions of the licence in full during 2018/19).

3 Recommendations

G6	Systems for compliance with licence conditions. DGFT – **'Not Confirmed'** (not compliant)
CoS7	Availability of resources DGFT – **'Confirmed'** (compliant)
FT4	Governance compliance DGFT – **'Not Confirmed'** (not compliant)
Statement required	Has the Trust provided the necessary training to its Governors? DGFT – **'Confirmed'** (compliant)

Appendix 1

Condition G6 – Systems for compliance with licence conditions and related obligations

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) the Conditions of this Licence,

(b) any requirements imposed on it under the NHS Acts, and

(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHSI a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHSI in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Appendix 2

Condition CoS7 – Availability of resources

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS Improvement a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

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

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

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

4. The Licensee shall submit to NHS Improvement with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to NHS Improvement in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS Improvement immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

Appendix 3

Condition FT4 – NHS foundation trust governance arrangements

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

   (a) have regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time; and

   (b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

   (a) effective board and committee structures;

   (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

   (c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

   (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

   (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

   (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to NHS Improvement within three months of the end of each financial year:

(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

(b) if required in writing by NHS Improvement, a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Appendix 4

Statement of Compliance / Non Compliance G6, CoS7, FT4 & Training Governors

1 Condition G6 – Systems for compliance with licence conditions and related obligations

Not confirmed (non-compliance)

- *Non-compliance as evidenced by the issuing of four s31s during 2018/19.*

2 Condition CoS7 – Availability of resources

Confirmed (compliant)

- *Trust's financial operational plans for 2019/20, demonstrates that the Trust may require working capital to deliver sustainable services.*
- *Extract from Dept of Health letter - indicates working capital would be made available if the Trust were to require it.*

3 Condition FT4 - Governance compliance

Not confirmed (non-compliance)

- *Breaches (four, s31s) of the licence demonstrate a lack of effective governance arrangements.*

Background
The Trust was compliant with all elements of FT4 conditions with the exception of section 5c and therefore cannot record compliance in full with the condition (*see appendix 7*).

Extract from NHSI FT4 (5c) - governance conditions:

5. The Licensee shall establish and effectively implement systems and/or processes:

(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions

4 Statement on training governors

Confirmed (compliant)

- *The Trust has surveyed the views of Governors (April 2019) on whether Governors have received effective training and guidance to carry out their roles. The view of governors was 89%, in the affirmative.*

Condition G6 – Systems for compliance with licence conditions and related Obligations – Evidence on elements of compliance

Lead Exec	Compliant	Comment	Evidence (supporting information)
Overall: **Not Compliant** with Condition G6 – Systems for compliance with licence conditions			
Part 1			
COO	**N**	The DGFT was registered with CQC throughout the financial year. DGFT are currently registered with four conditions. The Executive Lead for the CQC is the Chief operating Officer. Breaches (s31s) of the licence demonstrate a failure of effective governance arrangements.	Non-Compliant ED: Action being taken in the following areas: 1 – Triage Activity 2– Triage Audit 3 – Sepsis 4 – ED staffing 5 – e-Observations 6 – Safeguarding 7 – Specialist Clinical Expertise
DoG	Y	**Comments:** (A) Controls relating to this are described in the whole of this appendix (B) The Trust is registered with the CQC and the HTA as per the NHS Acts. (C) The Board is not aware of any other significant requirements under the NHS Acts.	**Evidence - to support elements of compliance in comments section:**
		The NHS constitution establishes the principles and values of the NHS in England. The constitution can be broken down into 6 key areas, 4 of which apply to requirements for the organisation: guiding principles, NHS values, rights of patients & public and rights for staff. The Trust's two year strategy echoes the **guiding principles** in the NHS constitution including putting the patient at the heart of everything the organisation does, working across organisational boundaries and aspiring to achieve the highest standards of excellence & professionalism. The strategy also provides a set of **values** that are consistent with those in the NHS constitution including promoting respect & dignity, commitment to quality of care and being compassionate. The measurement of the outcomes of these indicators is through consideration of a suite of reports received by the Board and its Committees and at an Executive level by reports to the weekly Executive meeting.	• Two year forward strategy and strategy refresh • Integrated Performance Report • Quality Account • Dudley Improvement Plan • Clinical Quality, Safety and Patient Experience papers • Finance & Performance Committee meeting papers • Use of Resources • Quality & Patient Safety report • Executive complaints reports • National Staff Survey results

Lead Exec	Compliant	Comment	Evidence (supporting information)
		The Trust has also established a number of arrangements to monitor quality governance and improvements in quality. These include the use of performance dashboards, a clinical audit programme, the review and monitoring of Nursing Care Indicators and the robust monitoring against local and national targets for quality measures including healthcare associated infections (HCAI), pressure ulcers and falls, all of these linking to the Trust's own Quality Priorities. The Trust has further developed its integrated performance report during 2018/19 which sees a consistent base set of data being used to report to each of the Committees of the Board - Finance and Performance and Clinical Quality, Safety and Patient Experience as well as operationally to the divisions and the executive. Complementing this reporting has been the enhancement of the quality dashboards for each ward providing visual feedback on quality metric delivery for staff and patients. Nursing Care Indicator audits, along with the undertaking of Matrons' observation audits, measure the quality of care given to patients and the monthly audits of key nursing interventions and associated documentation, are published, monitored and reported to the Board of Directors by the chief nurse. This is supported by the implementation of real-time surveys, capturing the views of patients and using these to make improvements. The Trust continues to monitor the hospital standardised mortality ratio (HSMR) to ensure it is consistent with national levels. In terms of compliance with the constitutional requirements relating to the **rights of the public and patients**, compliance is demonstrated through performance against the range of nationally commissioned targets set out in the Quality Account & Annual Report. The specifics relating to confidentiality & consent are monitored respectively by the Caldicott and information Governance Group (the DPO, SIRO, CIO and Caldicott Guardian. In terms of complaints and redress, the Trust has made improvements to its processes for complaints handling during the year and	• Quality Account 2018/19 • Annual Report 2018/19 • Data security toolkit toolkit submission • Minutes of Clinical Quality, Safety and Patient Experience • Annual complaints reports to Clinical Quality, Safety and Patient Experience Committee • Duty of Candour updates to Clinical Quality, Safety and Patient Experience Committee • CQC report and CQC action plan • Screenshot of joint formulary • NICE guidance internal audit and action plan • Performance against access targets included in the Integrated and Performance report

Lead Exec	Compliant	Comment	Evidence (supporting information)
		acknowledge complaints within 3 working days of receipt. The right to drugs and treatments can be demonstrated by the Joint Formulary available on the internet and by the work undertaken during the year to address a shortcoming in the handling of new NICE guidance issued. Regarding the **rights of staff**, the Trust has policies and procedures in place to support staff and ensure that their needs are met appropriately. The Trust has a Workforce Strategy which identifies the Trust's workforce priorities over the next 5 years with alignment directly with the Trust Strategy 2019-2021 (Care Better Every Day) as well as consideration of the NHS 10 year plan. The Strategy supports our staff to achieve the 6 strategic objectives within our Trust Strategy underpinned by our values of Care, Respect and Responsibility. The Workforce Strategy provides four strategic workforce priorities that are underpinned by Strategic aims as well as initiatives to support these aims and measures of success. The strategic workforce aims are: Diversity & Inclusion; Improvement and Learning Culture; Staff Well-Being; and Workforce Capacity. The aims to support each of the strategic priority areas will be overseen by the Workforce and Staff Engagement Group that reports to the Finance and Performance Committee of the Board to provide assurance that priorities are being met. The Trust has a raising concerns speak up safety (whistleblowing) policy in place The Trust has in place a Freedom to Speak Up Guardian who reports to the Chief Nurse. The Trust Board is supported by the Finance & Performance Committee underpinned by the work of the Workforce and Staff Engagement Woking Group. The Finance Committee seeks assurance on the Trust's adherence to staff-related policies, workforce matters and organisational development.	• Workforce policies, including Freedom to Speak Up • Establishment of the Equality & Diversity network • Schwartz Round information • EDS2 assessment to Trust Board and Staff Experience & OD Committee • WRES assessment to Staff Experience & OD Committee • Freedom to Speak Up presentation to Trust Board • Freedom to Speak Up Guardian role description • Staff Experience & OD Committee terms of reference • National staff survey results

Lead Exec	Compliant	Comment	Evidence (supporting information)
Part 2			
DoG	Y	**Comments:** The Director of Governance / Trust Board Secretary has Board level responsibility for the oversight of the Trust's risk management policies and processes. Board Committees have oversight and assurance reporting of BAF and Corporate Risks assigned to them. Bard Committees meet monthly; each Committee is in place to challenge the levels of assurance throughout the organisation and to ensure the effective management and mitigation of risks. Additionally, each division of the Trust, through their divisional governance framework, reports to the Clinical Quality, Safety and Patient Experience Committee on operational risks. The Trust has a comprehensive induction and training programme, supplemented by e-learning training packages and additional learning opportunities for staff. Collectively, these cover a wide range of governance and risk management topics for both clinical and non-clinical staff in all disciplines and at all levels in the organisation. The Head of Internal Audit Opinion for 2018/19 confirms that the Trust has adequate internal control mechanisms, however there is further work to do.	**Evidence - to support elements of compliance in comments section:** • Annual Governance Statement • Board Assurance Framework • Corporate Risk Register • Risk Management Strategy • HOIA 2018/19

Appendix 6

Condition CoS7 – Availability of resources

Evidence on elements of compliance

Lead Exec	Compliant	Comment	Evidence (supporting information)
Overall: Compliant with Condition CoS7 – Availability of resources			
DoF	Y	**Comments:** After making enquiries the Directors of Finance of the Trust has a reasonable expectation, subject to what is explained below, that the Trust will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factor which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. The Trust Board has approved the Trust's financial operational plans for 2019/20 that demonstrates that the Trust may require working capital to deliver sustainable services	**Evidence - to support elements of compliance in comments section:** Financial operational plans, CiP programme (2019/20) and working capital considered by the Finance & Performance Committee in March and April, 2019. *Extract from Dept of Health letter 21 May 2019:* 'In advance of wider reforms, the Department recently agreed extensions to loans due during the 2018-19 financial year to November 2019. The Department will continue to take refinancing decisions on loans due in the coming year. Such options, as well as the ongoing availability of interim support, are available to ensure that NHS providers remain operationally viable'.

Condition FT4 - governance compliance

Lead Exec	Compliant	Comment	Evidence (supporting information)
Overall: Not Compliant with Condition FT4 - governance compliance			
DoG	N	The DGFT was registered with CQC throughout the financial year. DGFT are currently registered with four conditions. The Executive Lead for the CQC is the Chief operating Officer. Breaches (s31s) of the licence demonstrate a failure of the governance arrangements in particular but not limited to a failure by the Licensee to ensure appropriate systems and standards of governance, adequate oversight by the Board and establishment.	**Non-Compliant ED (S31s):** Weekly reporting - 'ED' covering: • Report 1 – Triage Activity • Report 2– Triage Audit • Report 3 – Sepsis • Report 4 – ED staffing • Report 5 – e-Observations • Report 6 – Safeguarding • Report 7 – Specialist Clinical Expertise
DoG	Y	**Comments:** **The Trust was compliant with all elements of FT4 conditions with the exception of section 5c and therefore cannot record compliance in full with the condition.** The Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Trust has also been rated as "good" by the CQC within the domain of well led This is reflected in the Trust's Annual Governance Statement. 2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time. 3) The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation. 4)The Board is satisfied that these processes were referred to and their effectiveness was considered by the	**Evidence (to support statement in comment section:** • The Board of Directors has a Strategic Framework for Risk Management which is reviewed and updated bi annually • The Trust's Internal Auditors conducted a review of the Trust's risk management processes, and has provided assurance that there were no significant control issues • The Board of Directors receives quarterly reports on the Trust's new top risks • The Board Assurance Framework (BAF) is in place as the framework for identification and management of strategic risks, and will be reviewed regularly by Executive Directors and the Board's assurance committees • Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up-to-date guidance from HM Treasury. This statement includes a description of the Trust's risk management and assurance frameworks. It is reviewed by the Trust's external auditors and presented to the Board's Audit Committee as part of the Trust annual accounts before receiving sign off by the Board of Directors • Annual Head of Internal Audit Opinion does not identify any significant control gaps • The Board of Directors has established Assurance Committees each chaired by a Non-executive Director together with other Non-executive Director members that

Lead Exec	Compliant	Comment	Evidence (supporting information)
		Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair. 5)The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements. The Board is satisfied directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen	ensure that there is effective monitoring and assurance arrangements in place to support the system of internal control • Audit Committee provides assurance to the Board of Directors about the soundness of the overall systems of governance and internal control. It reviews risk management Systems and Processes, Financial Risk Management and seeks assurance on the overall management of strategic risk on the Board Assurance Framework • The Head of Internal Audit opinion stated that "The organisation has an adequate and effective framework for risk management, governance and internal control" and identified "further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

Lead Exec	Compliant	Comment	Evidence (supporting information)
		during the year, for example in respect of operational performance, timely actions have been implement to improve these areas. Assurance is routinely and regularly obtained as to the quality of the data supporting the Trust's performance reporting and decisions being taken. The Board has approved the Trust's longer term strategy and annual plan. Key risks and associated assurance has been reported to the Audit Committee and Board during the year and the process has been subject to Internal Audit review which concluded positively over the Trust corporate risk and assurance processes.	

KEY	Lead
COO	Chief Operating Officer
DoF	Director of Finance
DoG	Director of Governance