The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 6th February 2014 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 9th January 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 9th January 2014	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Video	D McMahon	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D McMahon	To Note & Discuss	10.00
	7.2 Keogh Review Progress Update	Enclosure 5	P Clark	To Note & Discuss	10.10
	7.3 Francis Report	Enclosure 6	P Clark	To Note & Discuss	10.20
	7.4 Audit Committee Exception Report	Enclosure 7	J Fellows	To Note	10.30
	7.5 Staffing Capacity and Capability (How to Ensure the Right People, with the Right Skills are in the Right Place at the Right Time)	Enclosure 8	D McMahon	To Note	10.40
	7.6 Board Assurance Framework	Enclosure 9	J Cotterill	To Note	10.50
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 10	D Badger	To Note & Discuss	11.00
9.	**Date of Next Board of Directors Meeting** 9.30am 6th March, 2014, Clinical Education Centre		J Edwards		11.10

10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		11.10

Enclosure 1

The Dudley
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 9th January, 2013 at 9:30am in the Clinical Education Centre.

Present:
John Edwards, Chairman
David Bland, Non Executive Director
Ann Becke, Non Executive Director
Richard Miner, Non Executive Director
David Badger, Non Executive Director
Jonathan Fellows, Non Executive Director,
Richard Beeken, Director of Strategy, Performance and Transformation
Paula Clark, Chief Executive
Denise McMahon, Nursing Director
Paul Assinder, Director of Finance and Information

In Attendance:
Helen Forrester, PA
Elena Peris - Cross, Administrative Assistant
Liz Abbiss, Head of Communications and Patient Experience
Annette Reeves, Associate Director for Human Resources
Richard Cattell, Director of Operations
Julie Cotterill, Associate Director of Governance/Board Secretary
Julian Sonksen, Clinical Director, Surgery and Anaesthetics (Organ Donation Report)
Rebecca Timmins, Clinical Nurse Specialist (Organ Donation Report)

14/001 Note of Apologies and Welcome

Apologies were received from Paul Harrison, Medical Director. The Board welcomed Julie Cotterill who has joined the Board as the Director of Governance/ Board Secretary.

14/002 Declarations of Interest

There were no declarations of interest received.

14/003 Announcements

The Chairman explained that agenda item 9 will be discussed first to enable Julian Sonksen, Clinical Director of Surgery and Anaesthetics to present and get back to clinical duties as soon as possible.

14/004 Minutes of the previous meeting on 5th December, 2013 (Enclosure 1)

Richard Beeken, Director of Strategy, Performance and Transformation asked for his title to be corrected at the bottom of page 8.

With these amendments the Board approved the minutes of the previous meeting.

14/005 Action Sheet, 5th December, 2013 (Enclosure 2)

14/005.1 Finance and Performance Report – C.Diff

This action has been completed.

14/005.2 Information Governance Report – On Hub

This action has been completed.

14/005.3 How to ensure the right people with the right skills are in the right place at the right time.

This action has been completed.

14/006 Patient Story

Denise McMahon, Director of Nursing explained to the Board that this patient story is a comment a patient had left on the NHS Choices website on the 29th December. The Board heard the comments left by the patient following care provided by a student nurse that works at the Trust.

The Chief Executive asked if the University could also be given this feedback for the student's portfolio

The Chairman asked if we had responded to this comment

Liz Abbiss, Head of Customer Relations and Communications confirmed that a policy is in place to respond to the NHS choices comments within 5 days however sometimes there is a delay between the comment being written and NHS Choices website posting them on the site. If the comments are positive this feedback is given to the appropriate area and if the comment is negative the area is also made aware and an investigation into the concerns takes place.

David Badger, Non Executive Director asked if the comments are time limited and do they eventually drop off the site.

Liz Abbiss confirmed that they were not and they always remain on the website.

The Board were notified that the Dudley Group get the most NHS Choices comments out of our local peers.

Ann Becke, Non Executive Director asked if we give an opportunity for patients to contact us when leaving a negative comment on NHS Choices.

Liz Abbiss confirmed that we did.

The Chairman asked how many comments we receive on NHS Choices and do we see peaks and troughs in the amount we receive.

Liz Abbiss informed the Board that there is usually a steady amount however recently there is a slow increase of comments being left, we receive around 100-150 comments per year.

The Board noted the positive patient story and the information given around NHS Choices

14/007 Chief Executive's Report (Enclosure 4)

The Chief Executive presented her report including:

- **95% 4hr ED target and winter funds:** The Board noted that the Trust had failed to hit the 4hr ED target for quarter 3 achieving 93.31%. The Chief Executive commented that in her whole time working for the acute sector this is the busiest she had seen, the health service is under extreme service pressures across the Black Country and the national average for this target in quarter 3 was 93%. The Trust is currently on 86% for the first week of quarter 4 making the target very tight for the remaining time left. The Chief Executive informed the Board that there was a weekly call with Monitor to discuss the issues around this target and Trust capacity.

- **Winter Incentive Scheme:** Board members noted that we are the only CCG area to have this scheme put into place. We have estimated to earn £400k against the first £1m; currently changes to the scheme are being discussed with the CCG however this has not yet been agreed.

The Chief Executive informed the Board that the emergency care system issues were discussed at the LAT meeting the previous Tuesday.

- **Friends and Family Test:** The results can be seen in the back of the report for information

- **MARS scheme:** Information can be seen in the report for information

- **Cancer Survey:** Information can be seen in the report for information

The Chief Executive pointed out that all trusts are in a very difficult place going into the New Year.

The Chief Executive informed the Board that at the LAT meeting the CCG had offered to increase the incentive scheme for weekend discharges, however that offer was never confirmed.

David Badger, Non Executive Director expressed his disappointment over the incentive scheme adding that we are not getting a coherent health economy approach and suggested we called for this. We cannot achieve this double incentive when access to care home beds at weekends is difficult.

Richard Beeken, Director of Strategy Performance and Transformation added that incentive schemes can work when the target is influenced by the provider. To apply this to an ED target is inappropriate, there is national evidence this is not working.

The Chairman agreed that although an incentive has been offered around weekend discharges it is largely out of our control to achieve this.

Ann Becke asked if a Board to Board meeting could be held between the Trust and the CCG

The Chief Executive confirmed that Paul Maubach, Accountable Officer of the CCG has asked for a Board to Board meeting and this will be held on the 20th February.

The Board noted that the Finance and Performance Committee will discuss options going forward for the 4 hr wait target and the recommendations will be brought back to Board. The Board also noted that the monies will be lost to the local economy at the yearend if the CCG is in surplus and monies do not come to the Trust.

- **Sunday Telegraph Article:** The Chief Executive explained that this article was prompted by an ex employee of Interserve, The Trust stands by the statement that we empathetically refute these allegations. It is not clear why this has been raised now. The Trust has been acting legally in line with the restraints policy. Unfortunately a 14 year old patient's confidentiality has been compromised as a result of this article.

David Badger, Non Executive Director asked if the cost of works for the Georgina pod could be reported to the Finance and Performance Committee. The Chairman agreed this.

14/008 Quality

14/008.1 Clinical Quality, Safety and Patient Experience Committee Exception Report including Mortality Report (Enclosure 5)

David Bland, Non Executive Director explained that there are two month's worth of report included and the Committee are now back in line with the Board schedule.

- **WHO checklist:** Positive news for this as we have high compliance. The Chairman asked if the WHO benchmarking information could be included in the report.
- **Trust Quality Priorities:** There are currently 5 priorities for the Trust and we will be adding diabetes and mortality to these.
- **Falls Champion:** Matron Bree, Falls Champion for the Trust has been pleased to report that the numbers of falls are gradually decreasing.

The Chairman asked if a fall is recorded if the patient falls from the lower rise beds to the floor.

Denise McMahon confirmed that this is not classed as a fall as the patient will roll from the low rise bed to a crash mat; it is pleasing to note the work being done is having a decreasing effect on the figures despite the issues and complications of maintaining patient's dignity whilst protecting them from falls.

- **Staff Survey:** David Bland was pleased to announce the participation rate of the staff survey has increased by 13%.

- **C.Diff:** The Board were informed that the Committee spent time going through the C.Diff exception report and received assurance from the Director of Nursing and her Team.

Denise McMahon, Director of Nursing added that we had looked at a recovery plan which is agreed by CCG partners, the Board noted that this would be put on the Shared drive for viewing.

Jonathan Fellows, Non Executive Director asked for clarification around the meaning of the comment on the 2nd Page of the November report with regards to the Allocate system that reads, '1000 unused hours'

Julie Cotterill, Associate Director of Governance/ Board Secretary assured the Board that the team were awaiting feedback on this and clarification would be reported back to the committee.

14/008.2 Infection Prevention and Control Exception Report (Enclosure 6)

Denise McMahon, Director of Nursing, presented the Infection Prevention and Control Exception Report given as Enclosure 6.

- **C.Diff:** The Trust has reached the target number of 38 C.Diff cases allowed for the year. With 1 case so far in January and 2 in December we must have less than 6 cases per month to have a lower level of C.Diff this year compared to 2012/2013.

- **Trust HCAI performance dashboard, Q2:** this appendix shows the bed day rate for Q2.

The Nursing Director commented that the wide variation between West Midlands trusts of the rate per 1,000 bed days is concerning. The position for Q3 has worsened along with the other trusts' results. This issue has been raised with the LAT; it is suspected there is a variation of reporting methods.

The Chief Executive asked that the LAT confirms that every trust is collecting data in the same way.

The Nursing Director explained that it has been difficult to move forward with this as there is currently no one to lead quality at the CCG.

The Chief Executive pointed out that it would be interesting to know what the C.Diff community burden was for Warwickshire.

Paul Assinder, Director of Finance informed the Board that there is a £50k fine per C.Diff case over the target. It is important we work on a case for the CCG which categorsises C.Diff cases as either avoidable or unavoidable.

The Boards attention was drawn to appendix 2 & 3 which shows this year's performance against last.

14/008.3 Keogh Review Progress Update (Enclosure 7)

The Chief Executive presented the progress update given as enclosure 7.

Capacity issues: The Board was informed that there are still issues to deal with and work through and therefore this will remain in amber.

Patient Experience Strategy: the actions have been completed and this is now to be reported as delivered.

AUKUH: The Trust is now working to this and therefore this will be reported as delivered.

The Chief Executive pointed out that we must push on and ensure the whole plan is completed. Monitor has asked us to look at outcome measures as a result of delivering the plan.

The Chairman asked the Board to note the plan and that item 4 would be marked as amber due to capacity issues. Progress of the AUKUH tool will be brought back to a future Board.

14/008.4 Charitable Funds Committee Report (Enclosure 8)

Richard Miner, Chair of the Charitable Funds Committee explained to the Board that a position meeting was held and the total expenditure for charitable funds is now over £½ m for the year.

The Board were informed that the investments had been removed from Coop and the money is now deposited in Santander.

Richard Miner explained that the Committee are looking at opening a charity shop.

The Board were informed that the fundraiser for Trust's charitable funds is ahead of the target.

It was agreed that the organ donation sculpture was an excellent way of spending charitable funds monies in terms of remembering these patient and their families who had consented and given the gift of life.

Richard Miner informed the Board that he is now attending the Georgina charity Annual General Members meeting.

The Chairman thanked Richard Miner for the report and the positive progress and asked the Board to note the contents.

14/008.5 Organ Donation Recognition Project (Enclosure 9)

David Badger, Non Executive Director welcomed Julian Sonksen, Clinical Director of Surgery and Anaesthetics and Rebecca Timmins, Clinical Nurse Specialist to the meeting.

Julian Sonksen, Clinical Director of Surgery and Anaesthetics explained to the Board that the budget to fund this project has been formed from a £5k grant from NHS Blood and Transplant and £15k from the Charitable Funds.

The Board were informed that the Trust received an excellent response to the request of an artist for the project and had 29 excellent ideas put forward. The project team shortlisted these down to 6 and then 3 and held an open viewing of these ideas for Board members in December.

The Project Team have decided to recommend a local artist called Paul Margetts from Stourbridge to be commissioned to make his steel sculpture idea called 'The Gift of Life.' This is subject to planning permission for placement by Russell's Hall Hospital main entrance if required and also clearance from the world health organisation whose log shared

similarities with the proposed sculpture. Julian presented a prototype of this sculpture explaining the idea behind it.

Julian Sonksen explained that a further report will be brought to the Board on the placement of the sculpture and an unveiling of the sculpture once it is in place will also be organised. Richard Miner, Non Executive Director asked how large the full size sculpture is

Rebecca Timmins, Clinical Nurse Specialist clarified that it is 5 metres high mounted on a 0.5 meter plinth.

Ann Becke, Non Executive Director pointed out it was important to note that this is also a good way of raising awareness of organ donation.

The Board endorsed the recommendations of the report and the Chairman thanks Julian Sonksen and Rebecca for their work.

14/009 Finance

14/009.1 Finance and Performance Report (Enclosure 10)

David Badger, Non Executive Director presented the overview of the December meeting given as enclosure 10.

The Board were informed that there has been significant deterioration of the Trusts financial position and the Finance and Performance Committee are looking at how to reduce spending.

There has been a trading deficit in 4 of the last 5 months which has adversely affected our end of year forecast and has created a significant risk to the sustainability of the Trust. This is a disappointment when compared against the generally excellent performance against other targets.

David Badger, Non Executive Director explained that there are worries around the identification of CIP for 2014/2015 and there is a need for a very early start to schemes to produce savings. It is also important we talk to our PFI partners to make greater contributions to CIP in the year ahead.

Paul Assinder, Director of Finance and Information pointed out that the Trust is £1.3m in deficit. We are spending £300k per month over budget and the gap is rising and is unsustainable. We will exhaust our available cash if we continue at the same run rate and therefore the current trend must be urgently reversed. Mr Assinder reminded the Board that its role was to provide the best quality services possible within the resourses the Government makes available to us. Currently we are spending resources we do not have and are effectively trading insolvently. It is the collective responsibility of the Board to live within our means on a monthly basis and not to preside over unaffordable spending.

The Chairman pointed out that although we have increased our numbers of permanent staff we are still spending at the same rate on temporary agency cover.

Paul Assinder also mentioned that next year the Trust will be paid 4% less for the same volume and mix of work and the Trust will need to identify further recurrent savings of £21m, as well as arresting current overspending trends.
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The Board noted the contents of the report including points around A&E, the Never Event, the good target performance of the trust and finally the extremely concerning cash position.

14/010 Any Other Business

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

13/086 Date of Next Meeting

The next Board meeting will be held on Thursday, 6th February, 2014, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

PublicBoardMins9thJanuary2014

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 9 January 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/008.1	Clinical Quality, Safety, Patient Experience Committee – C.Diff	Recovery plan available on the Directors shared drive.	DM	9/1/14	Done
14/007	Chief Executives Report – ED	Finance and Performance Committee to discuss missing ED target against impact on financial position and report recommendations back to the February Board.	DB/PA	30/1/14 6/2/14	F&P Report on Agenda
14/007	Chief Executives Report – Georgina Pod	Outcome of costing challenge to be reported to the Finance and Performance Committee.	RB	30/1/14	On F&P Agenda
13/083.10	How to ensure the right people, with the right skills are in the right place at the right time	Staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.	DM	6/2/14	On Agenda
13/081	Patient Story	An exercise to be undertaken on demand versus availability of value cards.	RB	6/2/14	Done
13/083.4	Francis Report	Update on the response from Monitor on the Role of the Governor Report to be included in the Chief Executives Report.	JC	6/2/14	Awaiting response from Monitor
14/008.1	Clinical Quality, Safety, Patient Experience Committee – Allocate System	Update on trial to the Clinical Quality, Safety, Patient Experience Committee.	DM	13/2/14	Done
13/083.9	Emergency Plans Assurance	Update on red areas in the report to be included in the Quarterly Estates Report to the Finance and Performance Committee.	RB	27/2/14	

13/083.8	Stroke Service Review Strategy	Executive Team to enter into discussions with other local providers regarding the Stroke Strategic Review and feedback to the Board in March.	RB	6/3/14	
14/008.1	Clinical Quality, Safety, Patient Experience Committee – WHO Checklist	Benchmarking information for WHO checklist to be included in the March Chief Executives Report.	CE	6/3/14	
14/008.3	Keogh Action Plan	Update on AUKUH Tool to future Board.	DM	6/3/14	

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 9th January 2014 - PUBLIC

TITLE:	Infection Control Report		
AUTHOR:	Denise McMahon Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:
SG01: Quality, Safety & Service Transformation Reputation – To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

GLOSSARY OF INFECTIONS

MSSA

What is Meticillin Sensitive Staphylococcus aureus (MSSA)?

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

What illnesses are caused by Staphylococcus aureus?

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

MRSA

What is Meticillin Resistant Staphylococcus Aureus (MRSA)?

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

Who is at risk of MRSA infection?

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

E Coli

What is *Escherichia coli*?

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

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

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

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

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

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

C difficile

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

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

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

SUMMARY OF WARDS AND SPECIALTIES

Area	Speciality
A1	Rheumatology & Pain
A2	
A3	Stroke Rehabilitation
A4	Acute Stroke
B1	Orthopaedics
B2	Hip & Trauma Orthopaedics
B3	General Surgery
B4	Mixed Colorectal & General Surgery
B5	Female Surgery
B6	Ear, Nose and Throat, Maxillo-Facial & Urology
C1	Renal
C3	Elderly Care
C4	Georgina Unit/Oncology
C5	Respiratory
C6	Respiratory/ Gastro Intestinal Medicine (GI Medicine) Overflow
C7	Gastro Intestinal Medicine (GI Medicine)
C8	Acute Medical Unit/Short Stay Unit
CCU/PCCU	Coronary Care Unit/Post Coronary Care Unit
Critical Care Unit	Critical Care
EAU	Emergency Assessment Unit
ED	Emergency Department
GI Unit	Gastro Intestinal Unit
MHDU	Medical High Dependency Unit
OPD	Out Patients Department
SHDU	Surgical High Dependency Unit

Report to: Board of Directors

Subject: Infection Prevention & Control Report

Summary:

Clostridium Difficile - The target for 2013/2014 is 38 cases; at the time of writing the report 41 cases have been recorded.

C. Difficile Cases Post 48 hours – Ward breakdown:

Ward	April '13	May '13	June '13	July '13	August '13	September '13	October '13	November '13	December '13	As of 28th January '14	Totals so far 13/14
A2	0	1	0	1	1	1	1	0	1	0	6
A3	0	0	0	0	0	1	1	0	0	0	2
A4	0	0	0	0	0	1	0	0	0	1	2
B2	0	1	0	0	0	0	0	2	0	0	3
B3	0	0	0	0	0	1	0	0	0	0	1
B4	0	0	0	0	0	1	0	0	0	0	1
B5	0	0	0	0	0	0	0	0	0	1	1
B6	0	0	0	0	0	0	0	0	1	1	2
C1	1	1	0	0	0	0	0	2	0	0	4
C3	0	1	1	1	0	1	1	0	1	0	6
C4	0	0	0	0	0	0	0	0	0	1	1
C5	0	0	2	0	0	0	1	2	0	0	5
C7	0	0	0	0	0	0	0	1	0	0	1
C8	0	0	0	0	1	0	1	0	0	0	2
MHDU	0	0	1	1	0	0	0	0	0	0	2
CCU/PCCU	0	0	1	0	0	0	0	1	0	0	2
Total	**1**	**4**	**5**	**3**	**2**	**6**	**5**	**8**	**3**	**4**	**41**

See Appendix 1 – Board Report (2013/2014)

A series of 72 hour meetings have taken place over the last 3 months, the last being on the 16th January 2014. Work towards developing a recovery plan with the CCG, CSU and PHE has been undertaken and returned to Monitor with the quarter 3 report. At the end of quarter three last year, we had reported 43 cases, to improve on the 2012/2013 outturn, which is our revised trajectory, we require less than six cases per month in quarter four.

MRSA – Annual Target 2 (Post 48 hrs) - There have been no post 48 hour cases in the last month and no cases so far this financial year. The last reported case was November 2012. Following a Post Infection Review (PIR) of a pre 48 hour MRSA bacteraemia case reported in December 2013, there is an ongoing review of where this case should be apportioned, with a conclusion expected by the middle of February 2014.

Norovirus – There have been no confirmed cases of Norovirus in the Trust.

(N13) Clostridium difficile infections

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	Cumulative % Over/Under Target	Trust Total	Health Economy
Apr-13	1	3	-66.7%	1	3	-66.7%	4	6
May-13	4	3	33.3%	5	6	-16.7%	10	11
Jun-13	5	3	66.7%	10	9	11.1%	6	6
Jul-13	3	3	0.0%	13	12	8.3%	9	11
Aug-13	2	3	-33.3%	15	15	0.0%	8	11
Sep-13	6	3	100.0%	21	18	16.7%	12	17
Oct-13	5	4	25.0%	26	22	18.2%	9	17
Nov-13	8	3	166.7%	34	25	36.0%	15	16
Dec-13	3	4	-25.0%	37	29	27.6%	5	6
Jan-14	4	3	33.3%	41	32	28.1%	5	7
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	41	38	7.9%				83	108

Monthly number of C.diff cases

The CCG target for Cdiff is 38 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.
The Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.
The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-13	-	0	0.0%	-	0	0.0%	-
May-13	-	0	0.0%	-	0	0.0%	-
Jun-13	-	0	0.0%	-	0	0.0%	-
Jul-13	-	0	0.0%	-	0	0.0%	-
Aug-13	-	0	0.0%	-	0	0.0%	-
Sep-13	-	0	0.0%	-	0	0.0%	-
Oct-13	-	0	0.0%	-	0	0.0%	-
Nov-13	-	0	0.0%	-	0	0.0%	-
Dec-13	-	0	0.0%	-	0	0.0%	1
Jan-14	-	0	0.0%	-	0	0.0%	-
Feb-14		0			0		
Mar-14		0			0		
FY 2013-14	-	0	-				1

Monthly number of MRSA cases

As a Foundation Trust the regulator, Monitor, measures compliance against the contract with our commissioners Dudley CCG. NHS England (previously the NHS Commissioning Board) has established a national zero tolerance approach regarding MRSA bacteraemia for 2013/14 onwards.

Monthly number of MSSA cases	MSSA infections		
	Month / Year	**Total**	**Cumulative**
	Apr-13	6	6
	May-13	6	12
	Jun-13	-	12
	Jul-13	6	18
	Aug-13	7	25
	Sep-13	4	29
	Oct-13	9	38
	Nov-13	2	40
	Dec-13	6	46
	Jan-14	4	50
	Feb-14		
	Mar-14		
	FY 2013-14	50	

Monthly number of E.coli cases	E.coli infections		
	Month / Year	**Total**	**Cumulative**
	Apr-13	25	25
	May-13	13	38
	Jun-13	14	52
	Jul-13	22	74
	Aug-13	32	106
	Sep-13	17	123
	Oct-13	22	145
	Nov-13	15	160
	Dec-13	17	177
	Jan-14	13	190
	Feb-14		
	Mar-14		
	FY 2013-14	190	

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 6th February 2014

TITLE:	**Keogh Improvement Plan and Progress Update – January 2014**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Paula Clark** **Chief Executive**

CORPORATE OBJECTIVE: SGO1: Quality, safety & service transformation, reputation, SGO2: Patient Experience, SGO5: Staff commitment

SUMMARY OF KEY ISSUES:

The Board met with Monitor representatives on 15th August to discuss the Keogh Review and Action Plan and to agree how the Trust would track progress against this. It was agreed that the Monitor template would be used to confirm the Trust position monthly.

The attached report focuses on the urgent actions discussed at the Risk Summit. The "Improvement Plan & our Progress" describes the issues identified by Keogh, the actions we are taking and how we will keep the public updated on progress. Progress is monitored in accordance with a colour coded key on the front cover where "blue" denotes "delivered".

"How we are checking that the Improvement Plan is working" summarises how the Trust is checking that the actions we are taking are being delivered and how the Board is assured that actions have been implemented and quality of service has improved.

The Trust has continued to progress the identified actions. Progress since the last meeting is shown in red on the attached.

IMPLICATIONS OF PAPER:

RISK	**R**		**Risk Description:**
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people Outcome 4 – Care & welfare of people Outcome 7 - Safeguarding Outcome 12 – Requirements relating to workers Outcome 16 – Assessing & monitoring quality of service provision
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance requirements
	Equality Assured	**Y**	**Details:** Better health outcomes for all Improved patient access and experience
	Other	**Y**	Details: Confirmation of action to DoH

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

The Board is requested to receive the report, note the progress against urgent actions and identify any further actions required.

The Dudley Group NHS Foundation Trust

Keogh Action Plan and Progress as at January 2014

KEY
Delivered
On Track to deliver
Some issues
Narrative - Disclose delays/risks/plan to recover
Not on track to deliver

The Dudley Group NHS Foundation Trust - Our Improvement Plan & our Progress

What are we doing?

- The Keogh review made 39recommendations, of which 9 were urgent. A Risk Summit , chaired by Paul Watson(Regional Director – Midlands and East, NHS England) was held on 6th June 2013 and focussed on supporting the Trust in addressing the urgent actions identified to improve the quality of care and treatment. The Trust recognised all of the recommendations and has ensured that related actions are being addressed by the Trust to improve the quality of services provided to patients.
- Specifically, the Keogh review said that the Trust needed to:
    - Review current nursing and staffing levels using a nationally recognised tool and action any changes required for improving both the quality and safety of care.
    - Review the staffing levels on two large (72 bedded) wards and take action to split these into separate wards
    - Further embed a culture of learning from incidents, complaints and mortality reviews, including reviewing data more systematically to target improvements.
    - Review the complaints process and the way we respond to patients needs.
    - Fully embed patient safety and quality processes at ward level.
    - Review and simplify the Quality Governance processes and arrangements and communicate these to staff
    - Review the performance information required to obtain complete assurance on quality improvement

The Trust has responded positively to the review process with some urgent issues already addressed and many other actions in progress. The Trust accepted the findings and welcomed the support of risk summit members to increase the pace and focus of improvement. Further support was offered to develop clinical leadership with input from NHS England and the NHS Leadership Academy to embed accountability and ownership for quality improvement in the organisation.

- This "Plan and Progress" document shows our plan for making these improvements and demonstrates how we are progressing. It builds on the "key findings and action plan following risk summit" document which we agreed immediately after the review was published http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx.

Who is responsible?

- Our actions to address the Keogh recommendations have been agreed by the Trust Board.
- Our Chief Executive , Paula Clark, is ultimately responsible for implementing actions in this document together with the Executive Directors who provide the executive leadership for quality, patient safety and patient experience .
- Ultimately, our success in implementing the recommendations of the Keogh plan will be assessed by the Chief Inspector of Hospitals who will re-inspect our Trust during 2014.
- If you have any questions about how we're doing, please contact Paula Clark (01384 321012 or at communications@dgh.nhs.uk

How we will communicate our progress to you

- We will update this progress report monthly and will continue to hold a monthly Board meeting in public where we will update our local community on the progress we are making.
- We will share our progress with our Governors and stakeholders by providing regular updates and briefings
- We will update our staff by providing regular briefings, through our Trust magazine and via our intranet .

Signed by the Chief Executive of The Trust (on behalf of the Board)

Paula Clark

The Dudley Group NHS Foundation Trust - Our Improvement Plan – January 2014

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
1. The Trust's quality governance arrangements are complex and were not embedded consistently below Board level	• The Trust should review its quality governance arrangements to develop and consider how it can embed these further at directorate and ward level	November 2013	Deloittes	The Trust commissioned Deloittes to undertake an independent review of the Quality Governance arrangements and advise on best practice. The review found areas of good practice and noted some areas where improvements could be made in relation to the effective governance of quality , many of which the Board are already addressing. The Board has considered the report and is progressing the actions.	
2. Systematic learning from incidents, reviews and complaints was not clearly evidenced by the Trust.	• The Trust should review how it can embed a culture of learning from incidents, RCAs, complaints and mortality reviews, including reviewing data more systematically to target improvements. • The Trust should also review its complaints process to ensure that it is fully addressing the Ombudsman's requirements and there is adequate resource to support this.	September 2013 October 2013	West Midlands Quality Network Clinical Commissioning Group Central Support Unit	A review has been undertaken and actions have been agreed. Revised procedures have been introduced. A review has been undertaken. The Trust complies with statutory requirements. An action plan is in place.	
3. The Trust's mortality review process is currently not identifying opportunities for systematic improvement	• The Trust needs to consider how it will review mortality data more systematically and use this alongside its learning from directorate reviews to target improvement actions more effectively.	October 2013		The Trust has revised the mortality review process and board report. Reporting is now comprised of mortality data, feedback from Directorate performance reviews and speciality mortality meetings. Local Speciality and Directorate level actions reflect a trust level log of ongoing actions in response to the data ,which is reviewed monthly.	

The Dudley Group NHS Foundation Trust - Our Improvement Plan – January 2014

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
4. The Trust has capacity challenges which its operational management procedures are not addressing fully	• The Trust's system for bed management, patient flows and discharge need to be urgently reviewed and improved to address operational effectiveness issues and improve patient experience	October 2013 **Ongoing monitoring**	Emergency Care Intensive Support Team (ECIST) to review processes NHS England	• ECIST follow up review team response agreed. Action plan being delivered •AEC unit saw 451 patients in first month **•Agreed winter pressure schemes in operation** **•Frail elderly assessment unit is operational and showing early LOS benefits** **•Dudley health and social care daily teleconferences are engaging external partners in the management of complex discharges**	
5. The Board's patient experience strategy needs further development and embedding at ward level.	The Trust Board has more work to do to agree a Patient Experience Strategy with clear performance metrics, embed this and demonstrate that it is effectively monitoring performance.	• Mid July 2013 **Revised Timescale Dec 2013**	Healthwatch Clinical Commissioning Group Stakeholder Event	Information gathered at event fed back to participants. Meeting arranged with CCG and Healthwatch to discuss strategy development and metrics Patient Experience Strategy received at Board	
6. The Trust's nurse staffing levels/skill mix need urgent review along with some other staffing issues identified.	•The Trust should review its current staffing levels for nursing and medical staff using a nationally recognised tool; it should then action any changes required for improving both the quality and safety of care. •There is an urgent action identified to make sure that nurse staffing levels are assessed using an evidence based methodology. This should be reviewed in conjunction with the clinical teams to ensure each ward has appropriate nurse staffing levels and the appropriate ratio of registered to unregistered nurses on all wards. •The Trust should review how it can improve engagement in the national staff survey. •It should further review staff engagement in theatres, following up the external review undertaken in 2012.	• Sept 2013 **Revised Timescale TBA**	No additional support was required.	• AUKUH (Tool to measure staffing levels) Data collected. • National Database not yet available. • Use of bank and agency staff continues to cover absence and sickness. • Daily Nurse to Patient Ratio published on wards as per RCN Best practice. •The Trust runs staff focus groups relating to the national survey and has implemented changes over the past two years as a result. Staff are also given time to complete the survey. •A full review of theatres has been undertaken. *(refer also to item 9)*	

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
7. A number of the Trust's processes relating to patient safety and quality were not being consistently applied at ward level.	The Trust should review its processes to ensure all equipment and safety checks are undertaken appropriately.	• July 2013	No additional support was required.	• Delivered. • In Place. • Audit now embedded.	
8. Consistency of pressure ulcer care including prioritisation of patients and access to equipment	The Trust should review its processes to provide appropriate care and equipment for patients that are high priority for pressure ulcer prevention. The Trust should also audit compliance with its pressure ulcer care bundles	• July 2013 • July 2013	No additional support was required.	The Trust has reviewed pressure ulcer care bundles and implemented bundle usage and compliance as part of a monthly audit review. Audits are now part of the Forward Audit programme.	
9. Theatre Staff engagement.	The Trust has agreed to undertake a follow up review of theatres, specifically around staffing levels and response to an earlier whistle-blowing issue.	Sept 2013	No additional support was required.	•The Theatre investigation is complete. • External advisor contacted for a scoping exercise. • Initial safety checks implemented.	

The Dudley Group NHS Foundation Trust - How we are checking that our improvement plan is working

Oversight and improvement action	Timescale	Action owner	Progress
Independent External Review of Quality Governance arrangements by External Auditors.	Delivery November 2013	Director of Finance	
Monthly progress update report on Keogh actions by Lead Directors to Board.	Monthly	Executive Directors	
Mortality & Morbidity Reports to Clinical Quality Safety and Patient Experience Committee	Monthly	Medical	
Governors holding Board to account on all aspects of quality	November 2013	Governors	
Working with a range of partners, who are providing support on a variety of areas, including mortality levels and service quality. These partners include the Emergency Care Intensive Support Team, AQuA (Advancing Quality Alliance).	From July 2013 onwards	Executive Directors	
Monthly scrutiny by the Clinical Commissioning Group through Clinical Quality Review meetings.	Monthly	Director of Nursing / Medical Director	
Local economy level consideration of whether the trust is delivering its action plan and improvements in quality of services by a Quality Surveillance Group (QSG)	Monthly	Chief Executive	
Update reports to the Dudley Health Scrutiny Committee confirming progress against the Action Plan.	When requested	Director of Nursing	
Trust Reports to the public about how our trust is improving via briefings to local media and monthly public board meetings.	Monthly	Chief Executive	

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 6th February 2014

TITLE:	**Francis Inquiry Table of Recommendations requiring Local Action (*exception report*)**		
AUTHOR:	**All Directors**	**PRESENTER**	**Paula Clark Chief Executive**

CORPORATE OBJECTIVE: SGO1: Quality, safety & service transformation, reputation, SGO2: Patient Experience, SGO5: Staff commitment

SUMMARY OF KEY ISSUES:

The Board has received regular progress reports against the Francis recommendations requiring local actions. Many of these have now been closed. The progress against the remainder is shown in the attached extract where updates provided are shaded in yellow. Completed and closed actions are shown in yellow and bold.

A number of actions have been linked to the Keogh Action Plan and will be progressed through that. The remainder will be progressed as shown.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people Outcome 4 – Care & welfare of people Outcome 7 - Safeguarding Outcome 12 – Requirements relating to workers Outcome 16 – Assessing & monitoring quality of service provision
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance requirements
	Equality Assured	**Y**	**Details:** Better health outcomes for all Improved patient access and experience
	Other	**Y**	Details: Confirmation of action to DoH

ACTION REQUIRED OF BOARD:

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

RECOMMENDATIONS FOR THE BOARD
The Board is requested to receive the report and note and approve the local action taken to date by Lead Directors against the outstanding recommendations contained in the Francis Report.

Report to Board February 2014 - Francis Inquiry Table of Recommendations requiring Local Action

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.					
4	Clarity of values and principles	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21	Board	Whilst the NHS Constitution underpins the core values and principles of the Trust, these will be re-visited and re-considered in light of the report and recommendations made.	**Open**
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings					
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance	The Health and Safety Manager role is currently vacant and is being recruited to as part of a restructuring of the F&E function within the Trust. Whilst arrangements for reporting RIDDOR incidents remain sound, the review of this recommendation will have to be deferred until the appointment of a new Health and Safety Manager for the Trust.	**Open**
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing	We will work with the HSE to meet any new requirements.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
	Nursing					
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the:	23	Director of Nursing and Human Resources		
		– Possession of the appropriate values, attitudes and behaviours;			An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation. New system should be available nationally by 3rd Feb. Local value question agreed ready for implementation by 31st March 2014	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		– Drive to maintain, develop and improve their own standards and abilities;			All nursing staff/CSW have appropriate competencies and training programme, required to achieve before promotion to next grade – shortlisted for National Award 2013.	**Closed**
					The new Healthcare Support Workers Code of Conduct is now integrated into all care support workers programmes.	
					Clinical Supervision re-launched during August/September 2013 Trust wide by posters sent to Lead Nurses for display in ward areas and Launch on the Hub. Training dates in September 2013 organised for staff wanting to become supervisors	
		• Leadership which constantly reinforces values and standards of compassionate care;			Developing Appraisal questions based on "The Way We Care" and Codes of Conduct. Changes to the Appraisal Policy are going through the development and ratification process.	**Closed**
					The Trust runs 3 Leadership programmes • Clinical leadership in conjunction with the Hay Group aimed at CDs, MSHs and aspirant Clinical leaders. • A Trust Leadership programme which links to the NHS Leadership competency framework • A Trust Leaders Tool kit, aimed at people who are new to leading and are looking to again basis level technical skills in people management.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		– Regular, comprehensive feedback on performance and concerns; Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	 23	 Associate Director of Human Resources	Nurses referred to NMC report to be taken to the Board. An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation. *As above on NHS Jobs*	**Open** **Open**
	Caring for the elderly - Approaches applicable to all patients but requiring special attention for the elderly					
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:	25			
		• All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.		Director of Nursing	Matron and Lead Nurse availability will be posted on ward boards. This is being trialled in Paediatrics and will then be rolled out across the Trust.	**Open**
		• Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients		Director of Ops /Director of Nursing	Every ward has an area that is confidential to converse with patients and visitors.	
		• The NHS should develop a greater willingness to communicate by email with relatives		Director of Ops/Medical Director /Director of Finance & Information	All e-mails from patients relatives and nurses are responded to by the Executive team. Ward level will require more process.	
		• The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered			The trust plans to move to an Electronic Patient Record system in the future and will include this requirement in the system specification In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved discharge letter functionality specified by Francis in Autumn 2014.	
		• Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.		Director of Ops/Medical Director	Care plans available at the bedside. Communication with relatives/visitors sheet being trialled on C7.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations	i) Late night discharge reports to be provided to clinical teams routinely to enable peer review and challenge ii) Review of the criteria for and protocol supporting patient moves at night as a requirement of managing bed capacity during periods of high escalation levels Discharge lounge is now appropriately staffed and furnished to provide care for patients awaiting discharge. Further work is being undertaken to improve the uptake of the service provided by the discharge lounge	**Open**
242 243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director/ Director of Finance & Information	Not currently possible to record electronically. This functionality is specified in a replacement EPR solution being procured by the Trust In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014.	**Open**
					Paper charts are at each bedside.	
					Compliance with charts is audited via Nursing Care Indicators.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Information					
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	26	Director of Finance & Information	The requirements outlined here will be considered when reviewing the electronic Patient Information Systems. In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014. Information is currently shared and available via the manual systems in place across the Trust.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.				
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26	Director of Nursing	The Friends and Family Test follows patients up on discharge/shortly after. The new website will host more online surveys – awareness will be raised via the ward leaflets Web pages with an online option for feedback are complete. Patients will be advised of this option via the ward leaflets by Jan 2014	**Closed**

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 6th February 2014

TITLE:	**Audit Committee Exception Report**		
AUTHOR:	**Jonathan Fellows**	**PRESENTER**	**Jonathan Fellows**
CORPORATE OBJECTIVE: Quality			

SUMMARY OF KEY ISSUES:

The Trust Audit Committee met on 21st January 2014 and considered:

- Progress reports from Internal Audit, Local Counter Fraud Specialist (LCFS), External Audit and Clinical Audit;

- Proposed changes to Accounting Policies to reflect new accounting standards, together with proposed changes to the segmental analysis to be included in the 2013/14 accounts.

In addition, the Committee met in private with the external and internal auditors, to establish if there were any concerns that either auditor wished to raise.

A summary of the key issues discussed and items referred to the Trust Board is shown below.

Progress report from Internal Audit

Since the last Committee meeting a further 11 Internal Audit reports had been finalised, with 7 reviews in progress or scheduled to be undertaken. Of the 11 completed reports, 7 received **GREEN** ratings, 1 was rated **AMBER** and 1 rated **RED**, with two reports advisory only:

- Doctor Revalidation : Advisory only
- Data Quality – 62 Day Cancer Wait : **GREEN** opinion
- Cost Improvement Programme : **AMBER** opinion
- Data Centre Review : **GREEN** opinion
- General Ledger : **GREEN** opinion
- Safety Thermometer : **RED** opinion
- Financial Reporting : **GREEN** opinion
- Adherence to Policy When Compiling Theatres On Call Rota : Advisory only
- Debtors : **GREEN** opinion
- Cash Receipting and Treasury Management : **GREEN** opinion
- Charitable Funds : **GREEN** opinion

RED opinion	The Board CANNOT take assurance that controls are

	suitably designed, consistently applied or effective
AMBER/RED opinion	The Board can take SOME assurance that controls are suitably designed, consistently applied or effective
AMBER/GREEN opinion	The Board can take REASONABLE assurance that controls are suitably designed, consistently applied or effective
GREEN opinion	The Board can take SUBSTANTIAL assurance that controls are suitably designed, consistently applied or effective

It was encouraging that all 4 reports on financial systems received **GREEN** ratings, justifying the decision to review these cyclically rather than annually. The Safety Thermometer audit had been undertaken at the request of the Trust and the **RED** rating arose due to inconsistencies between the data gathered at source during the Safety Thermometer audits and that entered onto the on-line data sets by the Trust clinical auditors. The Internal Auditors acknowledged that the Trust was being proactive in resolving the issues, with electronic hand held devices being introduced to capture data and avoid the existing manual upload process. The Internal Auditors expected that the issues would have been resolved by the time the follow up review took place.

The **AMBER** opinion on the Cost Improvement Programme arose as there had not been a process to undertake post implementation reviews once schemes have been implemented to check they had not adversely affected the quality of care being provided. Actions were being taken to address this.

The Committee had previously reported to the board two internal audits that had received **RED** ratings, these being Bank Workers : Pre-Employment Checks and Induction Attendance and also Compliance with the Appraisal/Personal Development Review Policy.

Responsibility for undertaking Pre-Employment checks for Bank staff would move to the Central recruitment team in the first quarter of 2014, which would address the issues identified in the audit.

Internal Audit were currently undertaking the follow up work in relation to Compliance with Appraisal/Personal Development Policy and as the Associate Director of HR and Operations Director were scheduled to give an Appraisal performance update report to the February Finance & Performance Committee on 27th February, it was agreed that Internal Audit would circulate the findings of the follow up review ahead of that date so that any outstanding issues could be discussed then.

Changes were proposed to the timings of some audits in the workplan for 2013/14. These included delaying the audit of the Assurance Framework and Reporting and Governance arrangements, as this would have duplicated much of the work undertaken by Deloitte in the recent Board Governance review; deferring the audit of the implementation of the Francis Enquiry recommendations as this needed to also incorporate the Keogh review recommendations; and rescheduling the CQC Compliance Monitoring Framework audit until after the CQC Wave 2 visit in the first quarter of 2014, again to avoid duplication. The Internal Auditor confirmed that none of the proposed changes to the plan would affect the ability to provide a Head of Internal Audit Opinion for the year and the Committee accepted that all the proposed changes to timings made sense in the light of changed circumstances.

Progress report from LCFS

Progress on LCFS remained in line with plan. There have now been 5 investigations

undertaken since 1st April 2013, of which 4 found no fraud and have been closed, with one remaining ongoing. Proactive reviews into pharmaceutical procurement and prescription exemption claims – the latter area costing the NHS overall £28 million in fraudulent claims last year – are currently underway, while the NHS Protect security review in which the LCFS assisted did not identify any issues.

Progress Report from External Audit

Dates for both the interim and final Trust audits for the 2013/14 accounts have been finalised. Frustratingly, guidance to Trusts is still awaited from Monitor on the Quality Accounts reporting process and mandatory indicators for the financial year ending in just over two months time. This is despite the deadline for signing off the Quality Accounts having been brought forward to 30th May.

The annual planning cycle has also been revised by Monitor, with the key changes being:

- The introduction of a five year strategic planning period, rather than the previous three years;
- The deadline for receipt by Monitor of detailed plans for years 1 and 2 and summary plans for years 3 to 5 brought forward to 4th April, rather than by early June as in previous years;
- Plans have to include locally agreed ambitions for improvements in outcomes;
- The requirement for assumptions on funding to have been discussed and agreed with commissioners;
- A 2014/15 cost efficiencies target of 4%.

Monitor has also updates the NHS Foundation Trust Code and 2013/14 Annual Reporting Manual (ARM). Changes to the Code include additional guidance around board members performance evaluation; the requirements for boards to have an externally facilitated board evaluation at least every three years; the requirement for boards to formally agree a vision statement of the Trusts purpose and intended outcomes; and specific guidance on remuneration arrangements, including that claw-back provisions should be considered in redundancy arrangements in the case of a director returning to work in the NHS. The Code also clarifies the interaction between boards and councils of governors, including on the information that should be provided – which includes clinical statistical data and operational data – plus places an explicit responsibility on the Trust Chair to take steps to ensure that governors have the skills and knowledge required for their role.

The ARM extends the requirements for the Audit Committee report to include the significant issues arising from the audit and how these were addressed; details on audit tenure and tendering policy; and an explanation of how the Committee has addressed the effectiveness of the external audit process. There is also a new board statement required, to the effect that "***the Annual Report, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy***".

Progress report from Clinical Audit

Progress on Clinical Audit had seen a further 30 clinical audits recommended for inclusion in the plan, together with a request from clinicians to remove 3 audits from the plan. The 3

audits for removal were Care of Women in Labour, which was being rescheduled to 2014/15 due to resource constraints; the Acute Medicine Mortality Review Audit which was no longer appropriate given the significant review work undertaken as part of the Keogh review process; and the End of Life Care : Application of the Medical Principles of the Liverpool Care Pathway in an Acute Hospital Setting Audit, which was no longer appropriate following the pathway being withdrawn. There are now a total of 213 audits contained in the plan.

The Committee noted the continued high quality and transparency of the reporting and also that the May meeting should see the first RAG risk rating for reports outcomes. This would then be further developed to show both the number of recommendations made for each audit and also the deadlines by which such recommendations should be actioned, although it was acknowledged that the timescales needed to make changes to clinical practices in some instances would make this level of analysis more challenging to achieve.

Proposed changes to Accounting Policies and segmental analysis for 2013/14 Annual Accounts

The Committee considered in detail the accounting policies on which the 2013/14 Annual Accounts would be prepared and agreed the following changes:

- Inclusion of a statement of the accounting convention used in the preparation of the accounts;
- The inclusion of a statement on the approach taken on consolidation, following the creation of Dudley Clinical Services Limited as a wholly owned subsidiary and also the requirement to consolidate Dudley Group NHS Charity due to the removal of the exemption previously applied to NHS bodies;
- An update of the accounting policy on provisions, to reflect the latest HM Treasury long term discount rates to apply to risk adjusted cashflows;
- The change in the calculation of the PDC dividend, with the net assets of the Trust on which the dividend is payable now including all cash balances apart from those held with either the Government Banking Service or National Loans Fund. This change has significantly reduced the ability for all Trusts to obtain higher interest income through depositing surplus funds with highly rated commercial banks;
- The inclusion of a new policy on Corporation Tax, as the subsidiary company does not receive the same exemption as the parent Trust;
- Changes to reflect changes to NHS organisation titles following the reconfiguration of the NHS from 1st April 2013;
- Listing of accounting standards that have been issued by the International Accounting Standards Board (IASB) but have not yet been adopted for the purposes of preparing NHS organisations accounts.

In addition, the Committee discussed the requirement to present in its Annual Accounts a segmental analysis that reflected the segments whose operational results are regularly reviewed by the Board. Previously the Trust reported only a single segment, of healthcare services. For 2013/14 however, there would be three segments required to be reported, to include Dudley Clinical Services Limited and also the Dudley Group NHS Charity. This approach on segmental analysis had been considered and agreed by the External Auditors.

Private Meeting with External and Internal Auditors

The Committee met privately with both the external and internal auditors, as it is required to do annually under its Terms of Reference. Both sets of auditors confirmed that there were no matters of concern that they wished to bring to the attention of the Committee.

The auditors did however make more general points, including that around half of all NHS organisations were now starting to experience some financial difficulty; that the levels of non-recurrent CIP and consequent carry over were becoming an increasing issue for many Trusts; and that non-recurrent payments from CCGs for activity made it difficult both to plan ahead and to manage costs optimally.

The auditors also noted the adverse impact on morale and potentially on the reputation of this Trust from the Keogh review process which would take time to repair, despite the decision that special measures were not appropriate.

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**No**	**Details:**
	NHSLA	**No**	**Details:**
	Monitor	**Yes**	**Details: Licence Compliance**
	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

To note the report and in particular:

a) **Note the RED internal audit opinion on the Safety Thermometer report and the actions being taken to address the issues raised;**

b) **Note the plan to circulate the follow up findings to the RED rated report on Compliance with Appraisal/Personal Development Policy ahead of the Finance & Performance meeting on 27th February, so that any unresolved issues can be discussed then;**

c) **Accept the changes proposed to the Internal audit workplan as agreed by the Audit Committee;**

d) **Accept the changes proposed to the Clinical Audit plan, as agreed by the Audit Committee;**

e) **Accept the changes proposed to Accounting Policies and to segmental reporting for the 2013/14 Annual Accounts, as agreed by the Audit Committee;**

f) **Note the changes made by Monitor to the NHS FT Code of Corporate Governance and the ARM;**

g) **Note that there were no matters of concern raised by the External or Internal Auditors in private session.**

STRATEGIC OBJECTIVES : *(Please select for inclusion on front sheet)*		
SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a “can do” attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

The Audit Committee was 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 In particular the Committee reviews the adequacy and effectiveness of all risk and control related disclosure statements including the Annual Report, Quality Report and Annual Governance Statement, underlying assurance processes and policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification. In addition the Committee reviews the findings, implications and management responses to the work of the External Auditors, ensures there is an effective Internal Audit function and that the organisation has adequate arrangements in place for countering fraud

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th February 2014 (PUBLIC)

TITLE:	How to ensure the right people, with the right skills, are in the right place at the right time		
AUTHOR:	Denise McMahon Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:

SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation

SGO2: Patient experience - To provide the best possible patient experience

SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude

SUMMARY OF KEY ISSUES:

This paper addresses the Trust action to provide assurance to the Board of Directors that Nurse staffing levels is progressing against the identified responsibilities identified by the Chief Nursing Officer report (November 2013).

IMPLICATIONS OF PAPER:

RISK	**Y** **Risk Register: Y**		**Risk Score and Description:** Nurse staffing levels are sub-optimal (20) Loss of experienced midwives (15)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** 13: Staffing
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance with the Risk Assessment Framework
	Equality Assured	**Y**	**Details:** Better Health Outcomes for all Improved patients access and experience
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
✓		✓	

RECOMMENDATIONS FOR THE BOARD:

To approve the proposed actions.

Background

Safe Nurse staffing levels has been a theme in the Robert Francis report, Keogh mortality visits and has culminated in the Jane Cummings, Chief Nursing Officer (CNO) in conjunction with the Quality Board launching a document called 'How to ensure the right people, with the right skills, are in the right place at the right time' in November 2013. This was presented and discussed at the Trust Board on 5th December 2013. This paper identifies 10 responsibilities for boards:

1: Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.
2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.
3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.
4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.
5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.
6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.
7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.
8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.
9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.
10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

Safer Nursing Care Evaluation Tool

The Keogh report recommended that although the Board had received a review of staffing levels which used a methodology of professional judgment and peer review it required that AUKUH (Association of UK University Hospitals). Safer Nursing care tool was used to review staffing levels and patient dependency. This was completed in July 2013 data was collected over a 20 working day period. There was a delay in inputting the data due to the national revision of the reporting process.

This data has now been reviewed by the Trust and is being analysed. In February there will be a rerun of the safer hospital care tool using the revised version.

It is recommended that the first time the tool is used the data is unlikely to be entirely reliable and should be used as a baseline. The results for the February collection should be available in April.

RCN – Mandatory Nurse Staffing Levels (March 12)

The RCN have recommended that staffing levels should be made mandatory. However, to date the Government have not adopted a mandatory stance on this.

The RCN recommends that in every ward area a minimum of 60% of the nursing workforce should be qualified Registered Nurses with 40% being care support workers.

Nurse to Patient Ratios

The Safe Staffing Alliance recommendation is that 'Under no circumstances is it safe to care for patients in need of hospital treatment with a ratio of more than 8 patients per registered nurse'.

The RCN position is that they would expect the actual level of staffing to be above one nurse to eight patients and depending on patient dependency and acuity, potentially much better than this.

In critical care areas the Trust meets the *Standards for Nurse Staffing in Critical Care Units: BACCN, RCN, and CCNN (2011).*

In the Neonatal Department the Trust meets the Neonatal Principles 2009/BAPM guidelines 2011.

In Paediatrics the Trust meets the Nurse staffing levels which are based on Royal College of Nursing (RCN) guidance: Defining staffing levels for Children's and Young People's Services (2003) and Mandatory Nurse Staffing levels (2012).

The Trust now posts this information on the ward on a daily basis so this is clearly visible to patients and visitors.

If the ward staffing falls below this level for any reason bank nurses are booked to uphold this ratio.

Trust Internal Nurse Staffing Assessment

This method and process was devised internally and presented to the Board in 2011.

It involves matrons using professional judgement and peer review to challenge the required levels on each shift and on each ward.

Using this method the Board agreed an extra investment of £1.3m for increasing nurse staffing in the most acute wards where patients were more dependant.

This tool has been revised so that it now incorporates the staffing ratio of 1:8 as recommended by RCN.

This methodology has been repeated as the results are currently being analysed.

NICE

National Institute of Clinical Excellence (NICE) have been commissioned by the National Quality Board to define mandatory staffing levels. This is expected to report in July 2014.

Until that time the Trust continues to employ 'best practice' and comply with 1:8 levels using bank and agency to mitigate where levels fall below this. This use of bank and agency is contributing to the Trust overspend and deteriorating financial position.

Nursing Care Strategy – The Way We Care

This strategy was launched in May 2013 and one element was that Director of Nursing has held fortnightly drop-in sessions for any member of staff to share concerns in a confidential way directly to Director of Nursing.

These have been used regularly by all grades of care staff and supports staff to speak out.

Overseas Recruitment

Nationally there is now difficulty in recruiting trained nurses. This is in large part due to reduction in numbers of nurses being trained by Universities.

To address this we have undertaken an overseas recruitment plan.

The team travelled to Portugal and Spain on week commencing 22nd January 2014 and offered 30 posts.

The team will travel to Romania on 17th February 2014 and Ireland in May. The aim is to recruit 75 nurses.

We continue to attract staff locally and have advertised a programme for nurses working in Nursing Homes that may wish to undertake a supported programme to be competent in the acute setting.

There is also a programme advertised for nurses trained overseas working locally as Care Support Workers because they are unable to complete or afford an adaptation programme.

Novice Programme

Although the emphasis nationally is on Registered Nurses, Care Support Workers provide a valuable contribution to both patient care and patient experience. As a Trust we have invested in delivering an innovative programme which was shortlisted for a National Award in 2013. We continue to recruit and train staff entering the NHS with no experience known as the 'Novice' programme. These Care Support Workers are all trained to Level 2. We have accreditation within the nursing team to deliver and assess this competency.

Conclusion

There is a multi faceted approach to ensuring that staffing levels are appropriate and monitored and satisfies the expectations set out in the Chief Nurse and Quality Board paper 'How to ensure the right people, with the right skills, are in the right place at the right time'.

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th February 2014

TITLE:	**Board Assurance Framework – January 2014**		
AUTHOR:	**Julie Cotterill Associate Director of Governance / Board Secretary**	**PRESENTER**	**Paula Clark Chief Executive**

CORPORATE OBJECTIVES: ALL

SUMMARY OF KEY ISSUES:

The Board must be able to demonstrate that it has been properly informed about the totality of its risks, both clinical and non clinical. The Assurance Framework provides the Trust with a comprehensive method for the effective and focussed management of principal risks and provides a structure for the evidence to support the AGS.

This report identifies the Trust Assurance Framework and specifically:

- The principal risks that may threaten the achievement of objectives
- Evaluates the assurance across all areas of principal risk.

In addition to the operational risk registers (reported to Risk and Assurance Committee) the Directors are currently managing 21 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (8 risks in total). The report shows the assurance to date of the effectiveness of the management and control of these risks. Action plans are in place, or being developed to address any gaps in control or assurance identified at this time. New assurance / updates highlighted in yellow

IMPLICATIONS OF PAPER:

RISKS	**Risk Register** **Y**	**Risk Score** **20 – 25 only**	**Details:** Refer to paper attached
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** All outcomes have elements that relate to the management of risk.
	NHSLA	**Y**	**Details:** Risk management arrangements
	Monitor	**Y**	**Details:** Ability to maintain at least level 1 NHSLA
	Equality Assured	**Y**	**Details:** Better Health outcomes Improved Patient access and Experience
	Other	**Y**	**Details:** Information requirements for the Annual Governance Statement –RR gaps in assurance and control

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD:

- To receive and approve the Board Assurance Framework.
- Note the assurance received to date on key risks and
- Current gaps in assurance and control.

THE DUDLEY GROUP NHS FOUNDATION TRUST
BOARD ASSURANCE FRAMEWORK – RISKS SCORING 20 AND 25 as at JANUARY 2014

Board Strategic Themes: Quality , Safety & Service Transformation, Reputation	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG01: To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation	a) Meeting and outperforming targets for HCAIs	Section C: Clinical & Quality Strategy	Outcome 8	F&P
		b) "Getting to zero" – promoting zero tolerance of harm events to patients		Outcome 16	CQSPE
		c) Ensuring we are fully compliant with all 16 CQC standards		ALL	R&A
		d) Deliberate focus on preventing premature deaths and improving other safety measures		Outcome 16	CQSPE
		e) Track external reputation using peer , SHA,CCG and patient feedback	Section B: Trust Strategic position in the local health economy	Outcome 6	CQSPE

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR045 **Risk Score: reduced from 25 to 20** **Mitigating Risk Score: 12** **Director Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	1. Diabetes management plans formulated by DOT Team and written in patients notes.	1. National external diabetes annual audit.	1.National Diabetes Inpatient Audit 2012 and National external diabetes annual audit results.(March 13) 1) CQPSE Cttee April 13 National Diabetes Inpatient Audit shows overall continuing improvements in diabetes care, Nationally the Trust ranks highly on the majority of outcomes. It is believed to be related to the impact of the Front Door Diabetes Team and the protocols developed in the Trust as part of the Think Glucose project. 1. Audit Committee May 13 - Annual Clinical Audit report 2012/13			1. Ensure diabetes assessment is a mandatory part of the new nursing EPR, and monitor Nursing Care Indicators. 1. Implement electronic referral to diabetes in ED/EAU October 2013

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **Risk Score: reduced from 25 to 20** **Mitigating Risk Score: 12** **Director Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	2. Standardised insulin administration and testing equipment within Trust	2. National external diabetes annual audit.	As above		2. Testing of insulin administration equipment not currently available in all areas beyond wards.	2 Areas without Diabetes Hypo boxes and Keto Meters to be identified and Hypo boxes to be made available.
			3. Diabetes protocols and guidance available on Hub for staff to use	3.Policies and guidelines	3. There is a review group meeting regularly to formulate local policy/guidelines for surgical patients 3. Hyperkalaemia Emergency Management Guidelines completed and being presented to Policy Group 31 Jan 2014 3. Blood Glucose and Ketone Monitoring Chart in place in clinical areas		3 Guidelines for surgical management of diabetes, hyperglycaemia and self-administration of insulin are yet to be ratified. 3. Staff do not follow guidelines, surgical pre-assessment do not refer patients in timely manner to enable optimisation of diabetes control pre-theatre.	3 Produce urgent Care Bundles for diabetic Ketoacidosis and Hyperkalemia. 3 Produce guidelines and load on Hub for: • Surgical Management of Diabetes • Hyperglycaemia (done-remove? • Self-administration of Insulin 3. Increase accessibility of Diabetes policies and guidelines on the HUB
			4. Staff training for diabetes on induction and then 3-yearly updates monthly updates for staff attendance now available for ward and department managers to monitor attendance compliance.	4. Mandatory Training records. 4 Mandatory training reports	4. Training registers and evaluation sheets 4.Diabetes update sessions records 4. Completed training included in April 2013 mandatory training reports 4. Workforce KPIs report 30th Jan 2014 to F & P shows 48.7 % compliance to training (Green) across the organisation.'	4. Mandatory training records show 38.7% at Sept 12	4. Staff do not always attend mandatory training	4 Community Directorate to identify requirements in Community.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **Risk Score: reduced from 25 to 20** **Mitigating Risk Score: 12** **Director Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	5. Link Diabetes Nurses on all wards.	5. Champions list	5. Think Glucose Champions on wards.			
			6. Staff responsible for prescribing, preparing and administering insulin are trained before doing so. (NPSA/2010/RRR013).	6. Mandatory Training Records	6. Workforce KPIs report 30th Jan 2014 to F & P shows 48.7 % compliance to training (Green) across the organisation.'	.	6. While nursing staff have this as part of Medicines Management Programme, there is no record of medical staff compliance with this control, and no evidence that this staff group have been requested to undertake this training	6. Improve knowledge and training of MAU and ED staff in the management of acute diabetes complications. 6. Ensure all medical staff who prescribe, prepare and administer insulin are trained 6 Improve Medicines Reconciliation Service on EAU.
			7. Datix monitoring for trends.	7. Datix Reports.	7.Quarterly aggregated report of incidents to CQPSE 7.Monthly Serious Incident Reports to CQPSE 7. Monthly Summary of key issues arising from CQPSE to Board 7. January 2014 shows a downward trend of incidents reported since October 2013 relating to mismanagement of diabetes.	7. Increase in diabetic related incidents Datix trend reports and reports from the diabetes outreach team have identified issues with inappropriate management of diabetes,		

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **Risk Score: reduced from 25 to 20** **Mitigating Risk Score: 12** **Director Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	8. Pharmacy Audit for missed doses and insulin errors.	8. Audit reports from Pharmacy	8. Annual Audit Results 8. Nurse Care indicator report to CQPSE (Medication) Nursing Care indicator report to CQPSE November 2013 showed compliance at Quarter 1 2013 98% and Quarter 2 2013 97 %			
			9. Nursing Care Indicators monitor Trust compliance with diabetes screening for each patient admission, reports sent by Nursing Directorate to Diabetes Team.	9. Nursing Care Indicator Audits	9. Monthly NCI audits of THINK GLUCOSE CQSPE - May 2013 "The greatest improvement has been in the Think Glucose criteria with an increase of 26% on previous year's performance (79% compliance)." THINK GLUCOSE Quality Dashboard Report for Month 8 (November) 2013/14 presented to Jan CQSPE showed Think Glucose compliance 94%			
			10. ED and EAU undertake routine blood glucose for all new admissions as part of their biochemical test screen as of 13/03/13		10. Effective from 13/03/13			
			11. Diabetes Outreach Team available for advice Mon – Fri 9am to 7pm and Saturday 9am to 5pm. Referral process in place.	11. Audit of patient referrals to Diabetes Outreach Team.	11.Audit Results			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **Risk Score: reduced from 25 to 20** **Mitigating Risk Score: 12** **Director Lead Director : R Cattell**			12 All admissions to the Trust must have – in addition to their U&E's – a blood glucose recording					

Board Strategic Theme: Patient experience	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG02: To provide the best possible patient experience	a) Mobilising the workforce with a passion for getting things right for patients every time	Section C: Clinical and Quality Strategy. Appendix 3E	Outcome 12, 13, 14	CQSPE
		b) Creating an environment that provides the facilities expected in 21st C healthcare and which aids treatment and or/recovery	Appendices 3 C & 3F	Outcome 8 Outcome 10	CQSPE
		c) Providing good clinical outcomes and effective processes so that patients feel involved and informed	Section C: Clinical and Quality Strategy.	Outcome 1,4	CQSPE

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
There are currently no Corporate Risks scoring 20 – 25 in this category								

Board Strategic Theme: Diversification	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG03: To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio	a) Adopting a more commercial attitude to developing services and broaden the Trust's income base to reduce reliance on NHS income alone	Section B: The Trusts Strategic position in the Local Health Economy	Outcome 6	F&P
		b) Providing excellent, appropriate and accessible services across community and acute care		Outcome 6	CQSPE
		c) Providing a re-shaped range of financially and clinically viable planned care services	Appendix 3b		F&P
		d) Developing the Trust wide clinical strategy including improved use of Trust resources, quality of care and financial efficiencies	Section C: Clinical and Quality Strategy.		CQSPE
		e) Investing in developments that support the drive for lead provider status in the Black Country	Section B: The Trusts Strategic position in the Local Health Economy	Outcome 6	F&P

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
There are currently no Corporate Risks scoring 20 – 25 in this category								

Board Strategic Theme: Clinical Partnerships	Strategic Goals		Key Priorities			Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG04: To develop and strengthen strategic clinical partnerships to maintain and protect our key services		a) Demonstrate a distributed leadership model with empowered clinical leaders			Section G: Leadership & organisational Development	Outcome 12, 13, 14	CQSPE
			b) Promoting risk sharing with CCGs			Appendices 3a & 3d	Outcome 6	F&P
			c) Developing clinical links with local GPs and healthcare practitioners			Appendix 3d	Outcome 6	CQSPE
			d) Develop new clinical networks that provide resilience through a more distributed service model			Appendices 3a & 3d	Outcome 6	F&P
Risk Ref	**Risk Description**	**Monitor / CQC / NHSLA ref**	**Current Controls**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**	**Gaps in Control**	**Mitigating Actions**
COR003 (OPO90) **Risk Score: 20** **Mitigating Risk Score: 12** **Lead Director : Richard Cattell**	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	1.Re-designation of surgical beds to medicine has taken place.	1. Board reports include elements of bed capacity etc.	**Reports to Board** April 13 - Transformation Report May 13 Estates Strategy Finance and Performance Reports Nov 2013 Transformation report		1. Occasional inability to protect surgical beds.	1. Implement the 'Enhanced Recovery' programme. (EPR project Timeline)
			2. CD/MSH review of elective admissions to prioritise if cancellations are imminent.	2. Surgical length of stay/ cancellation lists.- level of cancellations 2 Level of cancellations via reporting to CCG and LAT	2 Capacity Team operating training and Capacity HUB area			2. Empower non-medical staff to improve MDT-led discharge. (Ongoing)
			3. New capacity management system partially deployed.		3 New operating model for capacity meetings		3 MSH/medical staff not consistently engaged in Capacity Management	

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR003 (OPO90) **Risk Score: 20** **Mitigating Risk Score: 12** **Lead Director : Richard Cattell**	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	4. Discharge Co-ordinators DISCO.	4.Delayed discharge database managed, available and communicated	4. Discharge Process 4. Multi agency discharge planning forum meeting minutes/policy	4 Database only covers Dudley patients	4 Surges in Emergency surgical activity demand.	
			5..Escalation Policy and contingency capacity policy reviewed and deployed	5. Escalation policy	5."Ready to go " - Information on patient discharge pathways available on the HUB		5 . Understanding of policies by all staff	
			6. Daily capacity meetings. Using capacity HUB, standardised meeting template	6.Output capacity meetings 6. Capacity reports communicated after each capacity meeting 6. Four times a day capacity email alerts to directors, General managers		Nov 2013 Transformation report to the Board. Risk regarding the accelerated roll-out of the ward management plan (daily board round) process on the medical wards. Only 50% achievement has been reached as of the end of September.	6.Bed/Capacity Management approach/systems not aligned to predictive demand management within specialities/wards locally 6 Poor attendance at capacity meetings	
			7. Work with primary care and commissioners to curtail urgent care demands, provision of virtual ward etc. Rapid response teams and other admission avoidance schemes.	7.Revised ECIST action plan delivery overseen by LOS Transformation Steering Group	**7. Board April** and **June 13** - Transformation Report (including update of Urgent Care Redesign Report Transformation Programme Board Report presented to the Board Nov 2013 Bi-monthly Urgent Care working Group Minutes		7. Failure of all parties to contribute. 7. Failure of partners to agree	7. Engagement with all partners of all members of urgent care team from DGH

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR003 (OPO90) **Risk Score: 20** **Mitigating Risk Score: 12** **Lead Director : Richard Cattell**	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	9. Admit on the day of surgery to reduce pre-op LOS				Delayed Transfer of Care remains above MOA	
			10. IST recommendations roll out		Transformation Programme Board Report presented to the Board Nov 2013		Delayed Transfer of Care for Sandwell patients	

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR007 (OP080) **Risk Score: 20** **Mitigating Risk Score: 16** **Lead Director : Richard Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	1. Daily monitoring of the delayed discharges via the delayed list, ensuring its accuracy and that challenges by the ward to the patients care is being managed and escalated appropriately.	1. Escalation meeting daily at 9.15am. Information available on the HUB	1.Daily Delays Report 1. Monthly KPI reports to F &P on bed occupancy & medical outliers. 1. ED targets (part of performance information to monthly Board meetings) Bi monthly Urgent Care Working Group Minutes	Key Performance Targets report (month 9) to F& P (Jan 2013) A/E quality target Quarter 3 2013 reports 93.3% (red)		1. Confirming performance in order to gain monies allocated additional funding for schemes identified as part of Winter Plan.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR007 (OP080)** **Risk Score: 20** **Mitigating Risk Score: 16** **Lead Director : Richard Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	2. Ward-based Discharge Team support and plan discharge. Use of estimated discharge at ward level. Escalation to Medical Service Head as appropriate.		2. Daily delays report Transformation Programme Board Report presented to the Board Nov 2013		2.Poor service cover from multi-agency Discharge Teams because of vacancy, sickness, leave etc resulting in further delays. DISCO database. 2.Not ubiquitous cover across hospital	2. LOS Steering Group and ECIST actions to be implemented: Patient management plans Ward Management plans/ whiteboard meetings Cambridge Model
			3. Lead Nurse meetings with patients and relative to identify needs for discharge.	3. Lead Nurse Contact 3. Use of standard 'expectations' letter.			3. Patient or relative exercising "choice" exacerbates problem.	
			4. Early notification to LA via Section 2 to prepare for patients likely needs	4.Section notifications	4. Timeliness of Section Notifications			
			5. MOA - Local Authority and PCT signed off.	5 MOA 5. Capacity team: escalation to director of Operations as appropriate.	5. Signed MOA 5. Urgent Care Programme Board Minutes and actions April 2013 5 Bi weekly Urgent Care Working Group Minutes	5. Number of patients as per MOA is too high to prevent capacity issues.	5 DMBC overseeing a higher than agreed number of patients.	5. Negotiate a reduction of agreed number of DTOC's patients as per MOA

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR007 (OP080)** **Risk Score: 20** **Mitigating Risk Score: 16** **Lead Director : Richard Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	6. Agreed health economy escalation plan. -Provision of training on compliance with the escalation plan. -Issue of letter to prepare patients and family for discharge arrangements	6.Escalation Plan 6.Training Records 6.Letters to Patients	6. Compliance with Escalation Plan 6.Training undertaken May 2012			
			7. Utilisation of independent company Care Home Select (CHS) to support patients/ relatives in identifying suitable 24-hour care placement. Matron/Lead Nurse ensure that understanding of discharge processes is provided by all nurses/ carers.	7. Integrated Care Group Minutes and actions. 7. Activity Reports Care Homes				Urgent Care Working Group Review completed and presented to the Board
			8. Daily multi-agency teleconference at Level 2 or above.		8. Notes of meeting			
			9. Directorate solutions to manage delayed discharge.	9.Acute Medical Unit 9. Provision of non acute care	**Acute Medical Unit Business Case - Board 6th Oct , - F&P 25 Oct Additional Board** - July 12 Provision of Non Acute Care report – exploration of Trust options. None recurrent winter pressure monies secured on LHE initiatives, into all of 2013/14			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR007 (OP080)** **Risk Score: 20** **Mitigating Risk Score: 16** **Lead Director : R Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	10. Training of Bed Managers and Discharge Facilitators across Directorates.	10.Early understanding of financial constraints from Local Authority and planned use of new re-ablement monies to increase current capacity and response from Local Authority. Working with CCG and LA to manage delayed discharge database, improve admission prevention SW input.				
			11. Escalation of issue to Director level.					
			12. Manager of the day indentified for each Directorate.					

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR035 **Risk Score: 16** **Mitigating Risk Score: 12** **Lead Director: Richard Cattell**	Rising urgent care demand on ED as a result of poorly planned management across health economy	CQC outcome	1. Discussion with Local Walk-in Centre (WIC) with regard to protocol for pressure period management and triage back to WIC.	1 Protocols for joint pressure period management with WIC. Capacity Reports, ED Performance Reports 1. CCG Urgent Care Programme Board. Including support for WMAS in terms of suitable conveyance for patients.	Transformation Programme Board Report presented to the Board Nov 2013	1,2,4 Peaks in demand for ED may still not be manageable internally.		1,4 New Transformation Project and Urgent Care consultations underway. led by CCG. 1,4 Dudley Health Economy engagement with WMAS to support better conveyance of patients.
			2 . Operational policies for the management of 'Minors' stream and ambulance patients during pressure periods.	2.Operational policy and procedure within ED for alternative methods of managing 'Minors' category demand. Capacity Reports, ED Performance Reports 2,3 RAT Policy (ED). 1,4 CCG Urgent Care Programme Board. 4 Including support for WMAS in terms of suitable conveyance for patients.		2, Peaks in demand for ED may still not be manageable internally		2,3 Action Plan to Sustain Delivery of 4-hour Emergency Access Target.
			3 . Creative use of other ED areas, other than treatment cubicles, during pressure periods.	3 Operational policy and procedure within ED for alternative methods of managing 'Minors' category demand. Capacity Reports, ED Performance Reports		3 Establishment review process (Nursing) for specialist areas in the Trust, like ED, is not yet complete		

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
			4 .Management of ambulance conveyances by liasing with WMAS to influence disposition of patient on a patient by patient basis	4 CCG Urgent Care Working Group. 4 Including support for WMAS in terms of suitable conveyance for patients.	Bi weekly Urgent Care Working Group Minutes	4 Peaks in demand for ED may still not be manageable internally 4 Local Urgent Care forum has been restarted to enable economy wide solutions to the urgent care demand		

Board Strategic Theme: Staff Commitment	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG05: To create a high commitment culture from our staff with positive morale and a "can do" attitude	a) Developing a profound sense of mission and direction	Section A: Trust Vision & Strategy Section G: Leadership & Organisational Development	Outcome 12, 13, 14	Board
		b) Embedding staff owned and driven transformation and listening into action as "business as usual"		Outcome 12, 13, 14	CQSPE
		c) Becoming employer of choice for those wanting to work in healthcare in the Black Country through excellent leadership, staff development and succession planning		Outcome 12, 13, 14	CQSPE
		d) Ensuring staff are able, empowered and responsible for the delivery of effective care		Outcome 12, 13, 14	CQSPE
		e) Promoting the Trust's values and living them everyday		Outcome 12, 13, 14	CQSPE
		f) Embedding diversity and equality	Section G: Leadership and Organisational Development	Outcome 12, 13, 14	R&A
		g) Providing a proactive learning environment – uni, multi and interdisciplinary	Appendix 3a	Outcome 12, 13, 14	F&P

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR026 **Risk Score: 20** **Mitigating risk Score: 10** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	1. Ward staffing levels have been reviewed with Matrons and presented to the Board. The AKUH Safer Care Staffing Tool has been used to determine staff levels. This will be repeated in February.	1.Staff Survey Results 1 AK Dependency Tool adopted – Data collected awaiting results	Workforce KPIs reported to F&P monthly. **CQSPE Committee** – May 2013 National Staff Survey - Update on Activity Workforce KPIs reported to F&P in Jan 2014 reports international recruitment commencing Jan 2014	1/3.Nursing skill mix review for specialist departments will conclude in April. Further investment is likely. Workforce KPIs reported to F&P in Jan 2014 shows increase in vacancy rate to 252.72	1 Staffing levels fall below acceptable safe levels. Optimal skill mix not fully funded. Further financial investment required (£600k) Also X ref to Keogh Action Plan - workforce and planning issues and associated actions	To present AKUH report to the Board of Directors

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont COR026 **Risk Score: 20** **Mitigating risk Score: 10** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	2. Rosters managed and monitored. Matrons and Lead Nurses, midwives & AHP Leads identify shortfalls in staff levels and rectify	2 / 4 Datix Incident Reporting captures shifts with staffing concerns. Reported to CQPSE Committee	CQSPE - May 2013 Aggregated Report of incidents **Board May 13 -** F&P Report **Income & Expenditure Position – Year to 31:03:13 (Appendix 5) and investment in front line staff.** The Trust has successfully recruited in excess of 50 graduates and qualified nurses Board 6th Feb 2014 – Report – 'How to ensure the right people with the right skills are in the right place'			
			3. Significant investment in the workforce.	3. Financial investment made in high risk wards in medical directorate.	International recruitment drive January 2014 recruited 30 nurses to date. International recruitment in Romania in February 2014	1/3.Nursing skill mix review for specialist departments will conclude in April. Further investment is likely.		
			4. Nurse bank established.	2 / 4 Datix Incident Reporting captures shifts with staffing concerns reported to CQPSE Committee				

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont COR026 **Risk Score: 20** **Mitigating risk Score: 10** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	5. Continue to use bank staff to cover vacancies. Move staff to under resourced areas.	5. Agency expenditure remains high. (Reports on agency staffing at F&P Committee). 5 Use of in house Bank and external Agency staff	Reports on agency staffing at F&P Committee.	**F&P Committee – May 2013 - Income & Expenditure Summary April 2013 Agency (medics, qualified and unqualified and others) spending and trends reported. Upward trend in all but Medics.** Income and Expenditure report to F & P January 2014 reports high agency costs incurred across trained and untrained nurses (to achieve 1 nurse to 8 patient ratio)		
			6. Accredited training programme established for novices and new graduates.	6 Training Records 6 Programme for Registered nurses to return to acute practice in progress.				
			7. Matrons report to Board and Nursing Care Indicators to CQPSE.	7. Nursing Care Indicators reported at least quarterly to CQPSE. 7.Monthly Matrons presentation to Board	**7.CQPSE** NCI reports – Aug, Nov 12, Mar 13, May 13 - 12 wards on level 1 escalation, 4 wards on level 2 escalation.			
			9 Staffing levels audited as part of Nursing Care Indicators		NCI report November 2013 reported to CQSPE showing improving position			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont COR026 **Risk Score: 20** **Mitigating risk Score: 10** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	10. Rosters managed and monitored. Matrons and Lead Nurses and Midwives and AHP Leads identify shortfalls in staff levels and rectify.		NCI report Nov 2013 reported from July – Sept 2013 there were 9 wards escalated to level 2 and 3 wards level 3 escalation			
			11.Roster on 'pool' team daily. Two trained and two CSW on every shift to provide short term cover (reporting to EAU)					
			12 Overseas recruitment of Nurses from Portugal and Spain		International recruitment drive Jan 2014 recruited 30 nurses to date. International recruitment in Romania in February 2014			
			13 RCN best [practice (1:8 general areas, 1:1/1:4 in specialty areas) posted on ward board daily and monitored.	13 Daily nurse to patient ratio displayed on all wards. 13. RCN best practice daily values recorded.	Snap shot Exceptions report to the Board 6th February 2014			Exceptions reports to the Board (CQSPE) from March 2014

Enabling objectives	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	To deliver an infrastructure that supports delivery	a) Enhancing our reporting and analytic framework to support the delivery of operational objectives	Monitor Compliance with Terms of Authorisation Financial Risk Rating		F&P
		b) Upgrading and investing in the Trust's IT infrastructure and systems			F&P
		c) Embedding the three year rolling financial plan and CIP to sustain FRR 3 and EBITDA margin levels			F&P
		d) Ensuring leadership development at all levels		Outcome 12, 13, 14	CQSPE

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR 034 **Risk Score: 25** **Mitigating Risk Score: 20** **Lead Director: Paul Assinder**	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £12.45m (4% of budget). The Trust has Experienced difficulty identifying sufficient CIP opportunities and anticipates that of this £12.4m target, £2.6m will not be deliverable and £6m will be recurrent	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1. The Board has approved a programme of CIP savings proposals.	1. Board and Board Committee Reports. Monthly CIP updates to F&P Committee including attendance by Directorates to present their latest position	**1. F&P Cttee** -Jan 13 - Financial projections 2013/14 onwards -Feb13- Report on IT CIP) -March 13 – Financial Plan - March 13 - Financial Budget Package 2013/14 - April 13 - Income & Expenditure Summary Draft Outturn 2012/13 - May 13 - Income & Expenditure Summary April I & E Summary Oct 13 – June Nov 13 - July Dec 13 -Aug Monthly CIP Directorate presentation reports to F&P Commission confirmed for external turnaround review	1 Absence of alternative CIP schemes to 'call forward' when slippage occurs. December 2013 forecast under delivery of CIP of 2.6 m	1. After the first ~~4~~ 8 months of 2013/14, delivery of the CIP target is £1.817m behind plan. Whilst some of this is attributable to a timing difference linked to the QIA process, It now seems increasingly likely that the Trust will fall short of its CIP target by approx £2m The Trust has not identified sufficient deliverable saving schemes to achieve the require financial contribution of £12.45m for 2013/14	1 Horizon scanning of potential new saving ideas commenced. Initial look at using an external company to pay agency medics resulting in a VAT saving (information supplied and seeking to arrange meeting for October). Proposal now developed and needs to be considered by the Director of Finance in January Development of a process to promote successful CIP ideas that have worked well in other organisations with a challenge to apply here. Brand developed - requires rollout of ideas Trust to commission external turnaround advice to undertake an independent benchmarking exercise Feb 2014

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont . **COR 034** **Risk Score: 25** **Mitigating Risk Score: 20** **Lead Director: Paul Assinder**	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £12.45m (4% of budget). The Trust has Experienced difficulty identifying sufficient CIP opportunities and anticipates that of this £12.4m target, £2.6m will not be deliverable and £6m will be recurrent	Monitor Compliance with Terms of Authorisation Financial Risk Rating	2. A Programme Management Office (PMO) capability is established and has been operating effectively for some months.	2. PRINCE level project management of individual schemes.	2. Transformation & CIP PMO established and resourced	2.Delays in agreement of schemes & delivery by PFI Contract Efficiency Group	2. Some schemes remain to be fully developed and implemented. Some schemes will deliver benefits that are unlikely to yield cash savings in 2013/14.	
			3. Regular reports are made to the Board's Finance & Performance Committee, Directors and TME.	3.Detailed scrutiny of Directorate and Corporate CIP Schemes at Directorate Performance Review Meetings and weekly Directors Meetings. 3. Reports to TME 3 Meetings held with each Directorate chaired by the Director of Operations.	3.**F&P Committee** 2013/14 Financial Efficiency paper 29th Nov 2012 3. Financial efficiency process and plans (Jan 13) 3 Monthly CIP Directorate presentation reports to F&P	Some concern that schemes include a level of duplication between Directorate specific plans and Corporate – wide savings. .	3. Many schemes are not recurrent creating pressure in future years. 3. The efforts of managers and Trust staff is diverted on the management of day-to-day operational pressures rather than the achievement of efficiency savings.	
			4. All CIP proposals are risk-assessed for impact upon clinical standards and signed off by the Medical Director and Nursing Director	4.CIP Risk assessments	4 CIP risk assessments (2013/14) **4.F&P Committee** Financial Plan (March 13) March 13 - Financial Budget Package 2013/14			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont . **COR 034** **Risk Score: 25** **Mitigating Risk Score: 20** **Lead Director: Paul Assinder**	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £12.45m (4% of budget). The Trust has Experienced difficulty identifying sufficient CIP opportunities and anticipates that of this £12.4m target, £2.6m will not be deliverable and £6m will be recurrent	Monitor Compliance with Terms of Authorisation Financial Risk Rating	5.General Managers are required to attend the QIA sessions to offer additional advice & understanding on schemes.					
			6. A CIP tracker is updated monthly. This lists all of the schemes with planned monthly savings, the status of the scheme and whether it has gone through the Quality Impact Assessment process.		Example CIP QIAs Cost Improvement Programme (CIP) Identification, Monitoring and Reporting RSM Tenon Audit **Report 12.13/14**			
			7. A programme has been scheduled for each Directorate to attend F&P Committee to update members on their progress.					
			8. Separate sessions have been co-ordinated by the Director of Operations with each Directorate to assess the achievements of current plans, the possibility of exploring future opportunities and planning for future years		IBP sessions presently being undertaken to 32 clincial specialties			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont . **COR 034** **Risk Score: 25** **Mitigating Risk Score: 20** **Lead Director: Paul Assinder**	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £12.45m (4% of budget). The Trust has made a poor start to the year's CIP programme (£1.8m off plan at month 4). This has continued into month 05 (£2.361m behind plan) although part of shortfall relates to timing issue linked to requirement to have fully signed off Quality Impact Assessments before budgets can be removed from the ledger. It is anticipated that there will be a much improved performance in September that will claw back the majority of the shortfall. As at the end of November, the Trust has achieved £8.696m CIP (full year effect) and £190k cost reduction. However, the Trust remains £1.817m behind the planned achievement to November and is forecasting a shortfall of just over £2m against the year-end target		9. CIP /Transformation Team in place. Traditional and service re-design and drive towards Lean. Support on longer term DIP opportunities by the Transformation Programme.	Session held in May to scope methodology and deliverability of length of stay savings culminating in plan of closing 60 beds by Halloween as a result of efficiency gains	Transformation programme update – Sept F&P			
			10. Monitor approval of plan.	10. Monitor approval of plan.	10. Monitor Finance and Governance Risk Ratings			
			11. Directorate plans include the development of alternative schemes to counterbalance slippage		Chief Executive Report to the Board Dec 2013			
			12. Separate monthly forecast sessions are held with the finance lead (and potentially general manager if required) to run though year end estimates in more detail. Each Directorate has been set a control total target to achieve.					

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR 42 **Risk Score 25** **Mitigating Risk Score: 20** **Lead Director: Paul Assinder**	Failure to deliver financial balance in 2013/14as a result of further efficiency abatement to NHS Tariff and clinical cost pressures, the Trust is required to deliver unprecedentedly high cash releasing Cost Improvement s in 2013-14. A Transformation, IT and Traditional CIP combined Programme of £15.3m, 5.9% of budget has been developed. This has a very high risk of failure.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1. CIP in place.	1. Monthly Progress reports	1 F&P Committee – May 2013 Income & Expenditure Summary April 2013 Income & Expenditure Summary to F&P Oct 13 – June Nov 13 - July Dec 13 –Aug Monthly CIP Directorate presentation reports to F&P	Audit Committee May – Deloitte Report		
			2. Transformation Programme Board established.	2. Minutes of Transformation Project Board	**2/3 Board – 1st Nov** Transformation programme Structure Report and 4th April 13 Transformation Programme Board 2/3 Board – 6th June 2013 Transformation Programme update Board – 7th November 2013 Transformation Programme update			2 Promoting successful schemes that have delivered efficiencies in other hospitals to gain clinical buy in. 2. Development of a specialty analysis to highlight areas to focus on, commencing with 4 specialties identified by Board, T&O, Rheumatology, Pain, Renal.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont **COR 42** **Risk Score 25** **Mitigating Risk Score: 20** **Lead Director: Paul Assinder**	Failure to deliver financial balance in 2013/14as a result of further efficiency abatement to NHS Tariff and clinical cost pressures, the Trust is required to deliver unprecedentedly high cash releasing Cost Improvement s in 2013-14. A Transformation, IT and Traditional CIP combined Programme of £15.3m, 5.9% of budget has been developed. This has a very high risk of failure.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	3. CIP Transformation Team in place.	3/4.Transformation & CIP PMO established and resourced.	3/4Transformation Project Board inaugural meeting January 2013. Board – 7th November 2013 Transformation Programme update	3. /4 Delivering widespread clinical change will be a cultural 'hearts and minds' issue that is difficult to measure.	3 / 4 Given the transformational nature of savings sources in 2013-14, the increased participation of clinicians in promoting clinical practice changes, is essential. This is in serious doubt given current trends in activity pressures and recent media publicity about patient safety issues.	3. Directors to take personal responsibility for the delivery of individual CIP projects.
			4. Traditional and service redesign and drive towards LEAN.					
			5. Detailed monthly progress reports.	5.Monthly Progress reports	5. F&P Committee – May 2013 Income & Expenditure Summary April 2013 Income & Expenditure Summary to F&P Oct 13 – June Nov 13 - July Dec 13 –Aug		5. The controls have delivered effective CIP savings scheme in previous years but the size of the savings target is greater and the need is for greater transformational change to deliver significant financial benefit.	

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR043 **Risk Score 20** **Mitigating Risk Score:16** **Lead Director: Paul Assinder**	The Trust will be working to a much more onerous NHS Standard Acute Contract in 2013-14 than hitherto. The DoH and NHS England already declared CCGs MUST invoke financial penalties for non-compliance issues, including: • Never Events • Infections • Re-admissions • RTT waits over 52 wks • 18 weeks RTT • Cancelled Operations Crystallisation of this risk will have a major impact upon the Trust's income in 2013-14 and seriously compromise financial stability. - Target performance levels for 2013/14 set by DoH are extremely challenging for infections.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1 Detailed monthly monitoring of exposure to penalties by Directorates and Corporate Information Teams.	1. Independent audit scrutiny of data capture and reporting. 1. Monthly discussions with Commissioners. 1. Agreed with CCG that they will waive the ambulance turnaround penalties (greater than 30 minutes) from April to September. From October onwards they will be charged at 75% to reflect the potential inaccuracy in the recording of arrival times by the ambulance service.		1. In the absence of clear targets and definitions, data capture and reporting processes may be inadequate. 1. The Commissioners have initiated penalties in the first 2 months of the year for A&E and Ambulance breaches		1 Continue to negotiate with Commissioners deployment of any funds recovered through the imposition of fines / penalties This will include a mitigating argument regarding the number of ambulance arrivals within an hour.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont **COR043** **Risk Score 20** **Mitigating Risk Score:16** **Lead Director: Paul Assinder**	The Trust will be working to a much more onerous NHS Standard Acute Contract in 2013-14 than hitherto. The DoH and NHS England already declared CCGs MUST invoke financial penalties for non-compliance issues, including: • Never Events • Infections • Re-admissions • RTT waits over 52 wks • 18 weeks RTT • Cancelled Operations Crystallisation of this risk will have a major impact upon the Trust's income in 2013-14 and seriously compromise financial stability. - Target performance levels for 2013/14 set by DoH are extremely challenging for infections.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	2 Escalation procedure of risk issues to Directors.	2. Directorate Performance Review Meetings 2. Inclusion of risk within financial figures (forecast as at November assumed £750k will be incurred for penalties). However, subsequent information indicates that penalties could be more in the region of £1m-£1.25m	An interim balanced score card is now in use. A new performance management framework will be fully deployed by Q3 of the 2013/14 financial year		2 Continuous increases in emergency activity compromise effective risk management processes.	
			3 Regular performance reports to Directors/F&P Committee and Board	3. Detailed monitoring by commissioners and strict escalation and investigation of breaches regime in place. 3. Detailed assessment of exposure for each potential penalty presented to F&P, TME and Board in June. Ongoing updates provided to F&P/Board/TME of the fines applied to date and risk of future fines.			3 Clinical Departments are not sufficiently sighted on such performance risks and target achievement is always subservient to safety and quality concerns Poor / inadequate IT solutions in place to provide constant monitoring of target achievement in certain instances.	
			4 Corporate and departmental dashboards in place for monitoring.		Performance Dashboard - HUB			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont **COR043** **Risk Score 20** **Mitigating Risk Score:16** **Lead Director: Paul Assinder**	The Trust will be working to a much more onerous NHS Standard Acute Contract in 2013-14 than hitherto. The DoH and NHS England already declared CCGs MUST invoke financial penalties for non-compliance issues, including: • Never Events • Infections • Re-admissions • RTT waits over 52 wks • 18 weeks RTT • Cancelled Operations Crystallisation of this risk will have a major impact upon the Trust's income in 2013-14 and seriously compromise financial stability. - Target performance levels for 2013/14 set by DoH are extremely challenging for infections.		5.Breach analysis and reporting regime in place		Key Performance Targets Report for F&P Oct 13 – Month 6 Nov 13 – Month 7 Dec 13 – Month 8	5. Absence of Ambulance data is hindering Trust validation of figures and ability to construct a mitigating argument regarding inappropriate number of ambulance arrivals within a given time period		

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meetings held on 30th January 2014**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: S06 Enabling Objective			
SUMMARY OF KEY ISSUES: • **The Trust has generally continued to perform well against the long list of access and waiting target set by the NHS nationally and locally.** • **However for the Quarter to date, the A&E 4 Hours target is being missed and Cdiff numbers exceed trajectory.** • **The Committee referred a deterioration in the SHMI Mortality Index to the CQSPE Committee.** • **Financially the Trust has once again performed poorly with a deficit of £0.9m in December recorded. The YTD deficit is now £1.4m** • **The Committee noted with some concern some further slippage on CIP schemes.**			
IMPLICATIONS OF PAPER:			
RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in Q4 & Q1 and risk for Q3** **Risk to C. Diff target** **Financial deficit now forecast**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **The Trust has rated itself 'Red' for Governance & '3' (good) for Finance at Q3. The Trust remains on quarterly monitoring by Monitor.**

	Other	**N**	**Details:** **Significant exposure to performance fines by commissioners**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

NB: Board members have been provided with a complete copy of agenda and papers for this meeting.

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the Committee's major concern about the level of overspending in the Trust; the Committee's intention to refer the increase in the SHMI rating (July 2012 to June 2013) to the Clinical Quality Safety and Patients Experience Committee for investigation; and the increase of £270,000 capital spend on the Simulation Laboratory project.

The Dudley Group NHS
NHS Foundation Trust

Report of the Director of Finance and Information to the Board of Directors

Finance and Performance Committee Meeting held on 30th January 2014

1. Background

The Finance & Performance Committee of the Board met on 30thJanuary 2014. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports. The Committee noted in particular the following matters:

2. Allocate Nurse Rostering Project

The Committee considered a report from the Deputy Director of Nursing on progress with the roll out of this project. This remains on course to complete in March 2014.

3. Cost Improvement Programme – Directorate of Specialty Medicine

The Committee considered a detailed report on the Directorate's £1.2m Cost Improvements Programme (CIP). To date savings of £1.1m have been actioned with £420k achieved to date.

The Directorate demonstrated a reduction in length of stay in elderly care (Dec 2012 to Dec 2013 from 18.18 to 9.58 days. This allowed a 44 bed closure and achievement of the CIP target. However, activity and capacity pressures elsewhere resulted in the Trust 'reopening' these beds on A2 and C3. To date they remain open and although the CIP scheme has been achieved in principle, no savings have accrued to the Trust.

The target for 2014-5 of £665,000 will be achieved through further length of stay savings and the full implementation of bowel cancer screening.

4. Simulation Unit Capital Scheme

The Committee received a report from the Deputy Director of Finance justifying an increase in the approved capital costs of this project from £120,476 to £394,725. The increase was generally attributed to an underestimate in the original business case of the extent and cost of works necessary to create this facility.

The Committee agreed to recommend to the Board an increase in the capital scheme of £270,000.

5. Workforce KPIs

The Committee received a report from the Director of Human Resources, noting the following:

a. Absence
The Trust absence rate for the month of November is 3.63% (3.64% previously) and was 4.02% in 2012. The 2013-14 target is 3.50% and YTD performance is 3.56%.

b. Turnover
Turnover continues to remain consistent and within target at 7.91% (7.82% in Oct)

c. Pre-employment Checks
Pre-employment checks managed through the Centralised Recruitment Department perform at 100%, together with 93% for Medical Workforce recruitment.
Staff bank also performed at 65.3% (87.5% previously).

d. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small increase on previous months to 75.7%. No red rated subjects.
Appraisals have decreased this month to 82.5% (84.5% previously).

e. Professional Registration
100% of Professional registrations checks have been performed.

f. Vacancies
The current live vacancy rate has increased significantly to 252 FTE due to widespread nurse recruitment to the graduate and novice programmes.

g. Employment Tribunal Summary
The Committee noted that the Trust had 4 live ET cases submitted during the year.

6. Financial Performance for Month 9 – December 2013

The Trust made a trading loss of £869,000 in December although a deficit was planned. The major problems were the level of pay expenditure, particularly agency spending, which is now running at unprecedented levels, despite the Trust never employing so many people and a c ontinued failure to deliver CIP savings plans. Emergency control total balances, agreed last month with Directorates are largely being missed.

For the 9 months period in total the Trust is now recording a deficit of £1, 128,000.

The forecast for the year in total is now for a deficit of £1,500,000 although a this sum is, itself dependent upon a significant relaxation of the NHS contract penalty regime by the CCG and the generation of significant additional income at the year end.

The Committee noted with concern, the following:

- Pay (all sources) increased in Dec 2013 by £1.2m, 8% on Dec 2012.
- Pay for the year to date exceeds 2012-13 same period by £8.7m, 6%
- CIP will be underachieved by £2.2m, 18%, in 2013-14

The Trust's balance sheet and liquidity position remains relatively strong, although significant overspending is putting unnecessary strain on cash reserves. The Committee noted, with concern that NHS debtors had increased significantly this year due to major changes to commissioner organisations. The Committee asked that where contractually available, interest should now be charged on the late payment of outstanding amounts.

Capital spending is now below phased plans due to slippage on IT and medical equipment programmes and a revised profile has been submitted to Monitor.

The Committee noted the engagement by the Chief Executive and Finance Director of an experienced Turnaround Director and PwC to support the identification of additional CIP opportunities in short order.

7. Performance Targets and Standards

The Committee noted the following matters:

a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for December was 94.3% and for Quarter 3 it is 93.3% against a 95% target.

b) Never Events

The Trust had no 'never events' in December.

c) C Difficile Infections

The Trust had 3 C. Diff infections in December. However for the year to date we were recording 37 (annual target 38). The Committee has expressed concern about the ambitious nature of this target in 2013-14

d) Mortality Indices

The Committee noted that the Standardised Hospital Mortality indicator for period July 2012 to June 2013 had increased from 1.11 previously to 1.13 and now falls outside the expected range

The Committee noted that the Medical Director will prepare detailed reports on mortality to the Board and Clinical Quality Committees and the Committee requested that the deterioration in SHMI be investigated.

8. **Monitor Q3 Submission**

   Under delegated authority this submission was approved.

9. **Matters for the attention of the Board of Directors or other Committees**
   a. **Recommendation of approval of additional capital spend of £270,000 on the Simulation Lab Project.**
   b. **The Board is asked to note the Committee's intention to refer the increase in SHMI to June 2013 for investigation by the Clinical Quality Safety and Patients Experience Committee**.
   c. **Major concern about the trends in overspending should be noted by the Board**

PA Assinder
Director of Finance & Information

APPENDIX 1

THE DUDLEY GROUP NHS FOUNDATION TRUST

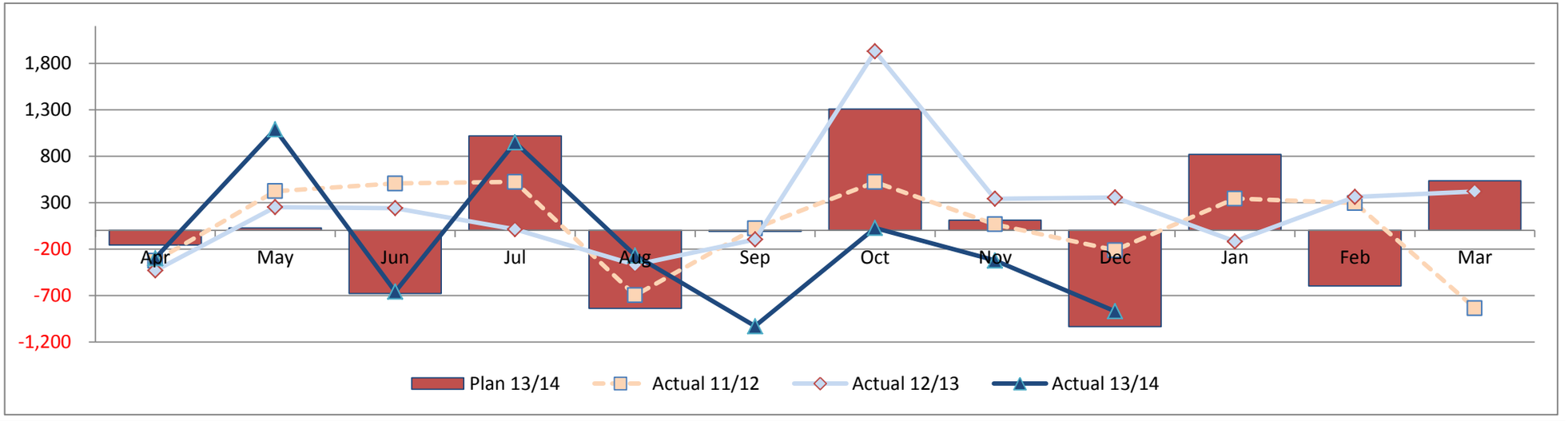
FINANCIAL SUMMARY **DEC 2013**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£24,724	£25,746	£1,022
PAY	-£15,378	-£15,526	-£148
CIP	£327	£0	-£327
NON PAY	-£8,798	-£9,185	-£387
EBITDA	**£875**	**£1,035**	**£160**
OTHER	-£1,910	-£1,904	£6
NET	**-£1,035**	**-£869**	**£166**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£231,824	£232,560	£736
PAY	-£138,206	-£137,988	£218
CIP	£2,143	£0	-£2,143
NON PAY	-£78,905	-£79,027	-£122
EBITDA	**£16,857**	**£15,545**	**-£1,311**
OTHER	-£17,112	-£16,929	£183
NET	**-£256**	**-£1,383**	**-£1,128**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£308,887	£309,892	£1,005
PAY	-£184,833	-£184,031	£802
CIP	£3,616	£0	-£3,616
NON PAY	-£104,322	-£104,672	-£351
EBITDA	**£23,348**	**£21,188**	**-£2,160**
OTHER	-£22,848	-£22,638	£210
NET	**£500**	**-£1,450**	**-£1,950**

NET SURPLUS/(DEFICIT) 12/13 PLAN & ACTUAL **DEC 2013**



Key Comments

£869k deficit in December (planned for £1.035m deficit so £166k above plan). Cumulatively deficit of £1.383m (£1.128m behind plan).

The cumulative income position is now £736k ahead of plan. This includes £2.25m transitional support (pro rata of £3m), £400k Winter Pressure monies 2/5 of of £1m) partially abated by a risk reserve of £292k. Note the risk reserve itself has been abated to factor in the potential for a positive year end settlement with the CCG and to ensure a degree of consistency between the year to date and forecast positions.

December spend is almost identical to the record high of November with siginficant overspends in pay (high agency) and non-pay.

Increased costs resulting in failure of Directorates to deliver control totals. As such, the year end forecast has now deteriorated to an estimated deficit of £1.450m. The Director of Operations has arranged urgent meetings to discuss the requirement for Directorates to deliver control total targets.

2013/14 EXPECTED RIGHTS AND PLEDGES FROM THE NHS CONSITUTION 2013/14

The Dudley Group NHS Foundation Trust

APPENDIX 2

Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	A&E	2% of revenue derived from the provision of the locally defined service line in the month of the under - achievement	A&E 4 hour wait	94.3%	95%	↑	●
5	Cancer		14 Day – Urgent GP Referral to Date First Seen	99.9%	93%	↑	●
5	Cancer		14 Day – Urgent GP Breast Symptom Referral	98.6%	93%	↓	●
5	Cancer		31 Day – Diagnosis to Treatment for All Cancers	100%	96%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs	100%	98%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Radiotherapy	-	-	-	-
6	Cancer		31 Day – 2nd/Subsequent Treatment – Surgery	100%	94%	→	●
6	Cancer		62 Day – Referral to Treatment after a Consultant upgrade	98.4%	85%	↑	●
6	Cancer		62 Day – Referral to Treatment following National Screening	97.1%	90%	↓	●
6	Cancer		62 Day – Urgent GP Referral to Treatment for All Cancers	89.1%	85%	↓	●
9-10	Diagnostics		Percentage of diagnostic waits less than 6 weeks	99.9%	99%	↓	●
-	MSA	Retention of £250 per day the patient affected	Mixed Sex Sleeping Accommodation Breaches	0	0	→	●
7	RTT	Deduction of 0.5% for each 1% under-achievement, to a max of 5%*	Admitted % Treated within 18 Weeks	93.6%	90%	↑	●
8	RTT		Non-Admitted % Treated within 18 Weeks	99.0%	95%	↓	●
7	RTT		Incomplete % waiting less than 18 Weeks	96.9%	92%	↓	●
	RTT	£5,000 per patient	Zero tolerance RTT waits over 52 weeks	0	0	→	●
	A&E	£1,000 per breach	Trolley Waits in A&E >12 hours	0	0	→	●
-	Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payments*)	Failure to publish a Declaration of Compliance of Non-Compliance pursuant to clause 4.24. *Retention of monthly sums will continue for each month or part month until either a Declaration of Compliance or Declaration of Non-Compliance is published.*	Annual – Trust Compliant			●
-	Compliance		Publishing a Declaration of Non-Compliance pursuant to clause 4.26.				●
4	HCAI	Lesser of 1.5% of inpatient revenue or £50,000 per case above 38 threshold.	C Diff – Post 72 hours	3	4	↑	●
4	HCAI	Non-Payment of inpatient episode	Zero Tolerance for MRSA	0	0	→	●
11	Never Events - Recovery of costs of procedure and no charge to the commissioner for any corrective procedure.			0			
12-13	Monitor Summary Report		Governance Risk Rating	2			
14-15	Mortality Reports		2013/14 Qtr 1 SHMI	1.13		↓	
16	CQC Surveillance Model – Intelligent Monitoring October 2013:		Risk Rating Score & (Banding)	7 & (4)			
17	Dr Foster – Hospital Guide 2013		HSMR	100.7			

One month behind

⇩ Position Deteriorating ⇧ Position Improving ⇨

⇧ Within Target ⇧ Outside Target ⇧

NEVER EVENTS

Description	Q1	Q2	Q3	Q4	YTD
Never Events : In hospital maternal death from elective caesarean section	0	0	0	-	0
Never Events : Inpatient suicide by use if no collapsible rails	0	0	0	-	0
Never Events : Intravenous administration of mis-selected concentrated potassium chloride	0	0	0	-	0
Never Events : Misplaced naso- or orogastric tube not detected prior to use	0	0	0	-	0
Never Events : Retained Instruments Post Operatively	0	0	1	-	1
Never Events: Air embolism	0	0	0	-	0
Never Events: Entrapment in bedrails	0	0	0	-	0
Never Events: Escape of a transferred Prisoner	0	0	0	-	0
Never Events: Failure to monitor and respond to oxygen saturation	0	0	0	-	0
Never Events: Falls from unrestricted windows	0	0	0	-	0
Never Events: Inappropriate administration of daily oral methotrexate	0	0	0	-	0
Never Events: Intravenous administration of epidural medication	0	0	0	-	0
Never Events: Maladministration of Insulin	0	0	0	-	0
Never Events: Misidentification of Patients	0	0	0	-	0
Never Events: Opioid overdose of an opioid-naïve Patient	0	0	0	-	0
Never Events: Overdoseof Midazolam during conscious sedation	0	0	0	-	0
Never Events: Severe scalding of Patients	0	0	0	-	0
Never Events: Transfusion of ABO-incompatible blood components	0	0	0	-	0
Never Events: Transplantation of ABO or HLA-incompatible organs	0	0	0	-	0
Never Events: Wrong gas administered	0	0	0	-	0
Never Events: Wrong Implant/Prosthesis	0	0	0	-	0
Never Events: Wrong route of Administration of Chemotherapy	0	0	0	-	0
Never Events: Wrong route of administration of oral/enteral treatment	0	0	0	-	0
Never Events: Wrong Site Surgery	0	0	0	-	0
Never Events: Wrongly prepared high-risk injectable medication	0	0	0	-	0

Never Event consequence (per occurrence)
In accordance with applicable guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care.

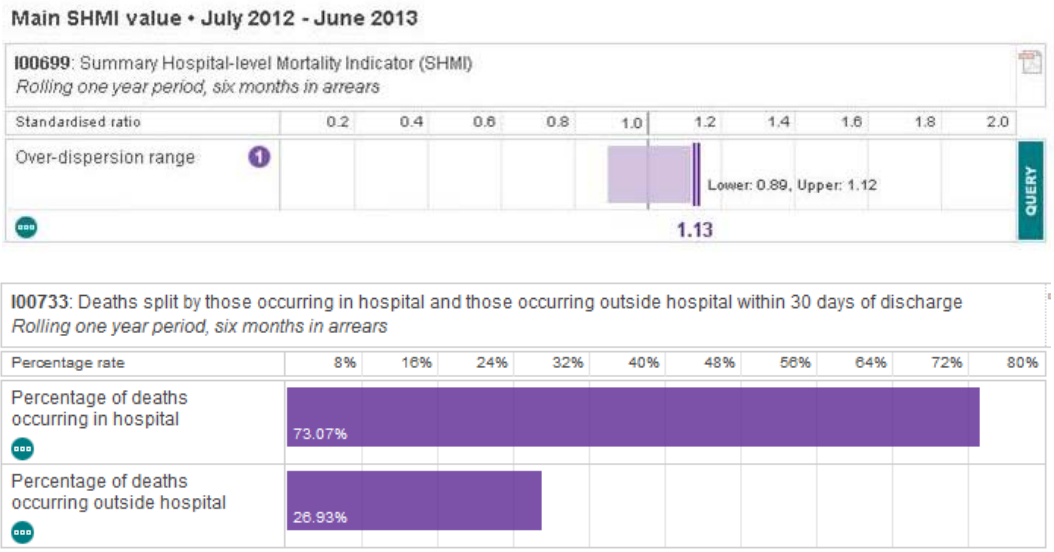
Method of Measurement
Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report.

APPENDIX 3

Dudley Group FT MORTALITY - SHMI **Quarterly** KPI Report

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR - Next update April 2014

Please note that this data is under an embargo until 29th January 2014



Source: NHS Choices

SHMI	Source	2012/13 Q3		2012/13 Q4		2013/14 Q1	
	NHS Choices	1.08		1.11		1.13	

Within over dispersion range

Outside of both Poisson and over dispersion range

THE DUDLEY GROUP NHS FOUNDATION TRUST

CONTRACTUAL FINES NOTIFIED as at DEC 2013

	Q1	Q2	Oct	Nov	Dec	Q3	Q4	Cumulative	
National Quality									
MRSA >0	**£0**	**£0**				**£0**		£0	
C Diff >38	**£0**	**£0**				**£0**		£0	
RTT wait > 52 weeks	**£5,000**	**£0**				**£0**		£5,000	
Ambulance Handover >30 Mins	**£0**	**£0**	£60,150	£49,800		**£109,950**		£109,950	
Ambulance Handover >1 hour	**£77,000**	**£44,000**	£55,000	£41,000		**£96,000**		£217,000	
Trolley Waits in A&E >12 hours	**£0**	**£0**				**£0**		£0	
Urgent operation cancelled >1	**£0**	**£0**				**£0**		£0	
Failure to publish Formulary	**£0**	**£0**				**£0**		£0	
Duty of Candour	**£0**	**£0**				**£0**		£0	
Operational Standards									
RTT Admitted > 18 weeks (90%)	**£10,439**	**£12,354**				**£0**		£22,793	
RTT Non Admitted > 18 weeks (95%)	**£5**	**£81**				**£0**		£87	
RTT Incomplete > 18 weeks (92%)	**£867**	**£1,107**				**£0**		£1,974	
Diagnostic Waits > 6 weeks (99%)	**£0**	**£5,843**				**£0**		£5,843	
A&E Waits > 4 hours (95%)	**£50,563**	**£0**				**£0**		£50,563	
Cancer outpatient >2 weeks (93%)	**£0**	**£0**				**£0**		£0	
Breast Symptoms >2 weeks (93%)	**£0**	**£0**				**£0**		£0	
Cancer first treat >31 days (96%)	**£0**	**£0**				**£0**		£0	
Cancer subseq surgery >31 days (94%)	**£0**	**£0**				**£0**		£0	
Cancer subseq drugs >31 days (98%)	**£0**	**£0**				**£0**		£0	
Cancer subseq radio >31 days (94%)	**£0**	**£0**				**£0**		£0	
Cancer GP to treat >62 days (85%)	**£0**	**£0**				**£0**		£0	
Cancer screen to treat >62 days (90%)	**£0**	**£0**				**£0**		£0	
Cancer Cons. to treat >62 days (85%)	**£0**	**£0**				**£0**		£0	
Mixed Sex Accommodation >0	**£0**	**£0**				**£0**		£0	
Cancelled Ops re-book >28 days	**£0**	**£0**				**£0**		£0	
TOTAL FINES	**£143,875**	**£63,385**				**£205,950**	**£0**	**£413,209**	

Key Comments

The table includes invoices to September (with the exception of Ambulance Turnaround to November).

Ambulance Turnaround fines are deteriorating and incorporate penalities for the >30 minutes target from October based on 75% as a proxy to allow for inaccuracies within the Ambulance service data. However, at present levels, this could still equate to a year end fine of **£750k**. It should be noted that the Trust has not yet agreed the fines from October as this is subject to local validation and the mitigation of the number of ambulances arriving within an hour.

A&E waits > 4 hours - failure to achieve the Q3 target will result in a further fine of approx £50k.

C-Diff > 38 - latest information as at the start of January indicates that the Trust has breached the target by 1. Based on the average monthly performance, this would rise to a breach of 11 by year end and could equate to a penalty of **£900k.** However, discrepancies in reporting data across the country regarding classification of unavoidable cases may offer a mitigation to eliminate this fine.

RTT > 52 weeks revised back to 1 breach as expected.

RTT > 18 weeks fines relate mainly to Urology, ENT, Gynaecology. The CCG have issued a contract query for these.

Generally, the CCG are keen to work with the Trust to resolve any issues that are leading to fines being invoked.

Due to an increased level of risk of greater fines, the income position now assumes a year end financial pressure of **£1m**. However, from a forecast perspective it is currently assumed that this will be returned via a year end settlement.

Board of Directors Members Profile.

Paula Clark – Chief Executive

As the Chief Executive, Paula leads the Executive Team to ensure that effective management systems are in place and that Directors and Senior Managers have clear objectives and are assigned well-defined responsibilities in line with the Trust's strategy and organisational objectives.

As a leader Paula provides visible examples of a positive culture for the Trust and drives the Trust Management executive to reflect a positive culture in their behaviour and decision making to continuously improve the Patient Experience within the Trust.

John Edwards – Chairman

Johns ensures that the Board and its committees function effectively and in the most efficient way: discharging their role of collective responsibility for the work of the Trust. John decides: on committee membership; ensures they have the correct Terms of Reference, assigns the appropriate committee's to deal with the key roles in running the Trust and ensures the Committee chairs report accurately to the Board in line with the relevant committees meeting cycle. John is also Chair of the Council of Governors and Chairs the Transformation Committee and the IT Project Board.

Paul Assinder – Director of Finance and Information

Paul provides strategic financial and business advice to the Board of Directors. He has lead responsibility for statutory accounts and audit as well as informatics, information technology, contracting, procurement and supplies. Paul is also Secretary to the Board of Directors and key liaison director for the FT regulator, Monitor.

Richard Beeken – Director Strategy, Performance and Transformation

Richard is responsible for developing the Trusts Long Term Strategy and for driving transformational change programmes within the organisation and local health economy. He provides leadership of the facilities and estates function via the PFI contract, in addition to security and health and safety management. In his role he also leads Emergency Planning and Business Continuity Planning for the Trust.

Denise McMahon – Director of Nursing

Denise provides professional leadership, management and direction for: Nursing and Midwifery Strategy, Education and Professional Conduct; Infection Prevention and Control and Integrated Governance. Denise also has collective corporate responsibility for strategic and operational performance as an Executive Director and member of the Trust Board.

Paul Harrison – Medical Director

Paul provides professional medical leadership for the organisation, including the role of Responsible Officer for revalidation. He contributes to the Boards strategic discussions by bringing perspective on clinical issues as a practising clinician. He is responsible for medical education, research and development and medical workforce issues. Paul and is also lead on Mortality and Morbidity issues.

Richard Cattell – Director of Operations

Richard is Executive Lead for operational management and delivery in clinical services on a day to day basis. He is responsible for the successful delivery of all national and local performance targets and quality standards, via each of the organisation's clinical directorates. Negotiation of and adherence to the contract the Trust has with our CCG commissioners is a vital part of his role.

Annette Reeves – Associate Director of Human Resources

Annette provides leadership and strategic management for the Human Rescources Directorate and gives advice to the Board on issues relating to functions under her control and their impact on the wider service issues to the Trust. She is responsible for developing strategies which meet NHS/legislative/best practise requirements and the needs of the Trust. She participates in the corporate management of the Trust, ensuring the Trust's strategic and operational objectives are met to facilitate the highest quality of services for patients.

David Badger – Non Executive Director, Deputy Chairman and Chair of the Finance and Performance Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act. David is Deputy Chair of the Trust and also Chair's the Finance and Performance Committee.

David is also responsible for the following:
Member - Clinical Quality Safety and Patient Experience Committee
Member - Risk and Assurance Committee
Member - Remuneration Committee
Member - Nominations Committee
Member - Transformation Programme Board
Member and link to Trust Board - Organ Donation Committee
NED liaison - Council of Governors
Assigned - Governor Development Group
Assigned - Governor Membership Engagement Committee
Attendee - Governor Appointments Committee
Board representative - Contract Efficiency Group

David Bland – Non Executive Director and Chair of the Clinical Quality, Safety and Patient Experience Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

David is also responsible for the following:
Chair of the Clinical Quality, Safety and Patient Experience Committee
Non Executive Director Lead for Patient Experience
Non Executive Director Lead for Patient Safety
Member of Risk and Assurance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Member of Charitable Funds Committee
Member of Council of Governors Committee
Member of the Dudley Clinical Services Limited (subsidiary of the Trust

Jonathan Fellows - Non Executive Director and Chair of the Audit Committee

As a Non Executive Director it is Jonathans responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Jonathan is also responsible for the following:
Chair of Audit Committee
Member of Finance and Performance Committee
Member of Charitable Funds Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Assigned to the Governors Governance Committee
Board representative - Contract Efficiency Group

Richard Miner – Non Executive Director and Chair of the Charitable Funds Comittee

As a Non Executive Director it is Richard's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Richard is also responsible for the following:
Chair of the Charitable Funds Committee
Non Executive Director Lead for Security Management
Member of Finance and Performance
Member of Audit Committee
Assigned to the Governors Governance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Chair of the Dudley Clinical Services Limited (subsidiary of the Trust)

Ann Becke – Non Executive Director and Chair of the Risk and Assurance Committee

As a Non Executive Director it is Ann's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Ann is also responsible for the following:
Chair - Risk and Assurance Committee
Member – Audit Committee
Member – Clinical Quality, Safety and Patient Experience Committee
NED Lead for Safeguarding
Board Representative – Dudley Children's Partnership
Non Executive Director Liaison for West Midlands Ambulance Service
Member – Remuneration Committee
Member – Nominations Committee
Member – Arts and the Environment Panel

Assigned – Governor Sub Committee Membership Engagement
Assigned – Governor Sub Committee Strategy
Member – Dudley Clinical Education Centre Charity