The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 8th January, 2015 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 – Paul Harrison**		D Badger	To Note	9.30
2.	**Declarations of Interest**		D Badger	To Note	9.30
3.	**Announcements**		D Badger	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 4th December 2014	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 4th December 2014	Enclosure 2	D Badger	To Action	9.30
5.	**Patient Story**		L Abbiss	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 Nurse Staffing Report	Enclosure 5	D Mcmahon	To Note & Discuss	10.10
	7.3 Moving Patients Out of Hours	Enclosure 6	J Scott	To Note	10.20
	7.4 Complaints Report	Enclosure 7	J Cotterill	To Note	10.30
	7.5 Board Assurance Framework	Enclosure 8	J Cotterill	To Note	10.40
	7.6 Corporate Risk Register	Enclosure 9	J Cotterill	To Note	10.50
	7.7 CQC Closure Report	Enclosure 10	P Clark	To Note	11.00
	7.8 Quality Accounts Report	Enclosure 11	D Mcmahon	To Note & Approve	11.10
	7.9 Research and Development Report	Enclosure 12	J Neilson	To Note	11.20
	7.10 Listening into Action Report	Enclosure 13	J Dietrich	To Note	11.30
	7.11 Palliative and End of Life Care Report and Presentation	Enclosure 14	J Bowen	To Note	11.40

	7.12 Non Executive Director Committee Changes	Enclosure 15	D Badger	To Note	11.50
8.	**Finance** 8.1 Finance and Performance Report	Enclosure 16	D Badger	To Note & Discuss	12.00
9.	**Date of Next Board of Directors Meeting** 9.30am 5th February, 2015, Clinical Education Centre		D Badger		12.10
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).		D Badger		12.10

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 4th December, 2014 at 9:30am in the Clinical Education Centre.

Present:

John Edwards, Chairman
David Badger, Non Executive Director
Richard Miner, Non Executive Director
Jonathan Fellows, Non Executive Director
Paul Harrison, Medical Director
Denise McMahon, Nursing Director
Paul Taylor, Director of Finance
Paula Clark, Chief Executive

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Julie Cotterill, Associate Director of Governance/Board Secretary
Anne Baines, Director of Strategy and Performance
Jon Scott, Chief Operating Advisor
Roger Wilson, HR and OD Consultant

14/099 Note of Apologies and Welcome

Apologies were received from David Bland and Ann Becke.

14/100 Declarations of Interest

There were no declarations of interest.

14/101 Announcements

There were no announcements made.

14/102 Minutes of the previous Board meeting held on 4th December, 2014 (Enclosure 1)

The minutes of the previous meeting were approved by the Board as a true and correct record of the meetings discussion and signed by the Chairman.

14/103 Action Sheet, 4th December 2014 (Enclosure 2)

All items appearing on the action sheet were for update at a future Board meeting.

The Chief Operating Advisor confirmed that the new food trolleys will not be in place by the end of January as detailed on the action sheet, as limitations in the contract do not allow the Trust Board to demand their implementation. The Board noted that the new menus will come online at the end of February and noted the delay in the implementation of the new trolleys.

New menus to come online at the end of February. The new heated trolleys will not be available at the end of January as requested at the November Board meeting due to limitations in the PFI contract.

14/104 Patient Story

The video was of a male patient who had experienced chest pain from a suspected heart attack. The patient was waiting for invasive angiography. The patient had a very good experience except for a small delay in waiting for the angiogram and this was as a result of waiting to go to New Cross Hospital.

The Board noted that the patient had presented at his GP who was not available.

The Chairman confirmed that there is a lesson to be learned from patients who present in ED on a Friday with suspected MI as they may have to wait at Russells Hall Hospital over the weekend for transfer if they require invasive angiography and we need both to to manage the patient's expectations and engage with New Cross over their provision of weekend support as the Heart and Lung centre for the Black Country.

14/105 Chief Executive's Overview Report (Enclosure 3)

The Chief Executive presented her Overview Report, including the following highlights:

Friends and Family: For information to the Board. The Chief Executive confirmed that the CQUIN target is within our grasp.

CQC Update: The Chief Executive confirmed that the report had been published the previous day. The Board noted that the Trust had achieved 30 'good' ratings and 8 'requires improvement' ratings, with an overall score of 'requires improvement'. Mike Richards had confirmed that he felt the Trust was very close to achieving a good rating. Mr Miner asked if the Chief Executive felt that the Trust had improved since the review had been undertaken and therefore would now be rated as 'good'. The Chief Executive confirmed that there had been several improvements since the review eight months ago, particularly around increasing staffing levels and incident reporting. There is work to be undertaken around governance and the Trust will look at the recommendations in the report. The Medical Director confirmed that expectations for DNaR reporting are constantly changing but consultants are being trained by our legal advisors.

Mr Badger commented that the Trust can take a lot of assurance from the report. He confirmed that he was disappointed that the Board did not have the opportunity to consider the report itself or with stakeholders before its publication. Mr Badger was also disappointed to have not received information from the CQC on how its algorithm works, despite requesting this on a number of occasions. He was also concerned that there is no transparency around how the evidence is applied and moderated across all Trusts.
Mr Fellows confirmed that it would be helpful for the Board to have sight of the review panel's report.

The Chairman confirmed that there is an issue with the way the CQC and other regulators acknowledge the role of a Foundation Trust Board. The Board should be clear with the CQC that it requires sight of the algorithm and how it is used, and also how evidence is applied and moderated. The Chairman stated that it is eight and a half months since the visit took place and the value of the report is questionable. It would be difficult to produce an action plan after this period of time but a closure report will be presented to the January Board.

The Chairman confirmed that the Trust and Health Economy owes a huge debt of gratitude to the Chief Executive and Director of Governance/Board Secretary and their Executive colleagues for their hard work in aiding the CQC to deal with factual accuracy issues and produce a report that, eventually, was acceptable to the Trust and CQC.

ED Performance: Positive performance at over 95% noted for November given the high level of capacity. The Chief Operating Advisor confirmed that there has been a huge spike in Paediatric attendances. The Nursing Director stated that there is a huge amount of Norovirus in schools and other local trusts. The Chief Executive confirmed that Malling Healthcare are working with the Trust to undertake Primary Care streaming at the front door. Funding for this had been made available from winter pressure monies.

Nursing Professional Referrals: Item taken for information as requested at a previous Board meeting.

Acute Trust Complaints Report: Board members noted the league table included at the back of the report. On balance the Trust is in the pack for its complaints performance.

CQC closure report to be presented at the January Board meeting.

14/106 Patient Safety and Quality

14/106.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Nursing Director presented the exception report given as Enclosure 4, including the following points to note:

MRSA: No cases to report.

C.Diff: The Nursing Director confirmed that the Trust has 13 cases less than it did at this point last year.

Norovirus: Being experienced in several other local organisations but no cases to note at the Trust to date.

Ebola: The Trust is up to date with national requirements.

The Chairman noted the good performance and positive report.

14/106.2 Nurse Staffing Report (Enclosure 5)

The Nursing Director presented the Nurse Staffing report given as Enclosure 5.

The Board noted that four other Trust's are now adopting the same approach.

There was a slight increase noted in October with 53 shifts amber or blue against 33 shifts in September which equates to a rise of 1.9%. The Trust does not feel that this represents a risk to the organisation.

No red rated shifts to note in the report. Mitigations are included on page three.

Mr Badger asked about the detail on the table in report, specifically around the pattern for ward B4. He asked if issues are dealt with at a local level or escalated elsewhere. The Nursing Director confirmed that there had been some movement of staff on B4 and the Trust is aware of this.

The Chairman noted the report and the mitigations.

14/106.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)

The Director of Governance/Board Secretary, presented the Clinical Quality, Safety and Patient Experience Committee Exception report given as Enclosure 6. The key items to note were:

- Update on Mortality: The Trust was below the 85% target to review all deaths by specialty within 12 weeks by March 2015. Issues were noted to be around process. The Medical Director confirmed that other blockages are also being experienced but the position is improving. The Chairman acknowledged the Medical Director's strong leadership around all mortality issues.

- Aggregated Incident Report: This report had been re-submitted to the CCG in response to CQUIN requirements. The Chairman stated that the Board needs to note the importance of not signing up to anything unless is it certain around delivery requirements. David Badger agreed that the same should be said around the signing of the contract and clarity around CQUINS.

- Summary of issues from the Quality and Safety Group: Real time audits had demonstrated improvements in answering call bells within 30 seconds. The Committee also noted that five well-being workers were in post on the wards and a further 30 had been recruited.

- Response to the Local Supervising Authority Midwifery Officer's Report: The Board noted the positive response.

The Chairman noted the exception report.

14/106.4 Workforce Committee Exception Report (Enclosure 7)

The Chief Executive presented the Workforce Committee Exception Report, given as Enclosure 7.

The report is provided for information. Industrial action was a key item on the agenda. More industrial action is expected going forward. The Medical Director endorsed the comments for the potential of further action.

In relation to the Workforce KPIs, the Trust is putting pressure on achieving the 85% appraisal rate and improving mandatory training.

It was pleasing to note that registration checks and pre-employment checks were at 100%.

A rigorous vacancy control process was now in place led by the Director of Strategy and Performance.

The Chairman noted the report.

14/106.5 Draft People Plan (Enclosure 8)

Mr Roger Wilson, HR and OD Consultant, presented the Draft People Plan, given as Enclosure 8.

The report highlights the direction of travel for the HR Strategy. The Board noted that there are four key strands to the Strategy which are to:

- Recruit, retain and re-structure
- Maintain a healthy workplace
- Develop a high performing culture
- Enhance staff satisfaction

Mr Wilson confirmed that that the next phase is to look at how we engage our staff governors.

Mr Badger, Non Executive Director, confirmed that he was comfortable with the content of the paper but suggested that the Trust needs to consider it from the perspective of a member of staff. There should be an example of routes that staff can follow included in the paper. Mr Wilson confirmed that this will be picked up during the next phase with staff governors.

The Director of Strategy and Performance commented that the section on values should be nearer to the top of the report to highlight its importance. Mr Wilson agreed that this should be given a more prominent focus. The Director of Strategy and Performance also suggested that the OD list should specifically include the management of change and also give prominence to links with Transformation. Mr Wilson confirmed that this could link into the organisational change element. The Director of Finance and Information agreed that the tone of that element is very important and he did not currently feel that it had the hard edge element in the paper that needs to be communicated.

The Chief Operating Advisor agreed with the Director of Finance and Information that there are elements of the paper that need to be stronger around the Trust's expectations from staff.
Mr Wilson confirmed that the detail that sits behind the document will be included in the implementation plans.

Mr Fellows, Non Executive Director, confirmed that it would be helpful to get a view from staff governors around the management of poor performance and how phasing will work. Page 17 of the paper confirms that it is expected that all staff will have an appraisal/performance review and the Trust needs to raise this expectation with staff governors.

The Nursing Director agreed with the Chief Operating Advisor that there needs to be much more prominence given to evaluation and the implementation plan is too late for this to happen.

Mr Badger, Non Executive Director, confirmed that we also need to include what the member of staff can expect from the Trust.

The Director of Strategy and Performance confirmed that she is currently looking at the performance management system and business planning process and these must link into the document.

The Chairman asked Mr Wilson to use the comments from Board to adapt the draft Plan. He confirmed that the Strategy needs to paint a very clear picture, it must be clear about the Trust's expectations of its staff and also staff expectations of the Trust. The document needs to be much stronger around management and leadership and also include motivational aspects including linking in a total reward strategy.

Mr Wilson to use the Board's comments on the paper to adapt the draft Plan.

14/106.6 Charitable Fund Report (Enclosure 9)

Mr Miner, Non Executive Director and Chair of the Chair of the Charitable Funds Committee, presented the Charitable Fund Report, given as Enclosure 9.

He was pleased to present the report as there were a number of positive aspects to note. The Trust's fundraising efforts are improving and the Charities Fundraiser is working effectively.

The Trust had spent £196k more than funds received during the current year but this had been an agreed policy for the present time.

New developments were included in the report and a statement of financial activity and balance sheet were attached to the back of the report.

The Trust was focussing on improving opportunities for staff and patients to access charitable funds.

Mr Badger, Non Executive Director, asked for his thanks to be noted for the Organ Donation sculpture contribution. The Board noted that charitable fund monies are donated and bequeathed for a purpose and the Trust must spend as much as possible and it should not sit within a bank account.

The Chairman agreed that it was pleasing to note the report. He asked how much money committed to charitable causes was yet to be drawn down. Mr Miner confirmed that there are plans against all funds and details can be provided. The Chairman confirmed that it would be helpful to circulate the detail.

The Chairman noted the report and noted the thanks around the Organ Donation sculpture. He also noted the positive contribution from Trust charitable football match.

Mr Miner to circulate plan details to Board members.

14/106.7 Quality Accounts (Enclosure 10)

The Nursing Director presented the Quality Accounts Report, given as Enclosure 10.

The Board noted the position at the end of Quarter two position, including three key areas to note as follows:

The Trust was on track to meet all quality priorities except for pressure ulcers which is a cause for concern.

Section B and C of the paper was for consideration by the Board and included a range of suggestions from the public for areas to be included in future accounts. Broad agreement had been reached on topics.

The Board noted as the Trust no longer produced a quarterly newsletter, details were being published on the Trust's website.

The Director of Finance and Information asked about the grade 4 pressure ulcer incidents and what were the lessons learnt. The Nursing Director confirmed that management action had been taken and the tissue viability team had retrained all staff on the ward. There had been no re-occurrence of situation.

Mr Badger, Non Executive Director confirmed that he was not comfortable with the issue of pressure ulcers in the community, how they are measured and how the Trust can have an influence on reducing them. The Nursing Director confirmed that this is really difficult and the key is good documentation, but it is a constant challenge for the Trust. The Board noted that all RCAs go through a pressure ulcer panel.

The Chairman noted that the Quality Accounts were on track with the exception of pressure ulcers. The Board noted the report.

14/107 Finance

14/107.1 Finance and Performance Report (Enclosure 11)

Mr Badger, Non Executive Director and Committee Chair presented the Finance and Performance Committee report, given as Enclosure 11.

Mr Badger urged caution with report but confirmed that the meeting of the Finance and Performance Committee the previous week had felt very different to previous meetings and there was encouraging news on the financial side as well as around performance and there had also been significant signs of improvement against the Turnround Plan.

The Board noted that the Trust must still reduce expenditure but the run rate is improved and coming into balance.

Turnround is having an impact and there is good news from the workforce workstream with rigorous vacancy control.

The overall Trust projection is down to £8.6m against the plan of £6.7m overspend.

Performance KPIs:

ED position was 93.4% for October and the capacity position remains volatile.
The Trust must hit 96% for remainder of December to meet the Quarter three target.

The 18 week RTT position continues as per plan and had improved again to over 92%.

The underperformance on diagnostic waits continues to be monitored by the Committee and should return to trajectory in the next few months.

Mr Badger commented on Section 6 of the report and it was important for the Board to note the significant different feeling around money. The Committee had talked about savings and the reduction of 200 staff and work plans are in place to address this.

The Chief Operating Advisor confirmed that ED performance in November stood at 95.6%. It was reported at the Committee the position was 93.37% for the quarter but this now stood at 94.43% so performance was improving in the right direction. The Trust hoped to achieve quarter four.

The Director of Finance and Information commented on the activity growth being experienced and that this presents an affordability issue for the CCG.

The Chairman noted the report, noted the good performance and noted the caveat around activity growth and CCG affordability.

14/108 Any Other Business

Mr Badger, Non Executive Director, confirmed that this was the last Board meeting in public being Chaired by Mr Edwards before he leaves the Trust at the end of the month. He passed on thanks for Mr Edwards tremendous contribution to the work of Board and Trust and wished him well for the future.

The Chairman thanked Mr Badger and the Board for their best wishes and said that the time he had spent at the Trust had been the most interesting and fascinating four years of his career.

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

14/109 Date of Next Meeting

The next Board meeting will be held on Thursday, 8th January, 2015, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
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Action Sheet
Minutes of the Board of Directors Public Session
Held on 4th December 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/095.4	Moving Patients Out of Hours	Update report on moving patients out of hours to be brought back to the January 2015 Board.	JS	8/1/15	On Agenda
14/073.4	Complaints Report	Director of Governance to ensure that personal liability and clinical negligence claims reported year by year is included in the next complaints report.	JC	4/12/14	To January Board – On Agenda
14/084.6	Corporate Risk Register	Executive Team to consider risks around changes at Board level, Turnround Plan and ownership and IT implementation and bring back the updated Board Assurance Framework to the December Board meeting.	JC	4/12/14	To January Board – On Agenda
14/104	Chief Executive's Overview Report	CQC Closure Report to be presented to the January Board.	PC	8/1/15	On Agenda
14/106.6	Charitable Fund Report	Mr Miner to circulate charitable fund plan details to Board members.	RM	8/1/15	
14/106.5	Draft People Plan	Mr Wilson to use the Board's comments on the paper to adapt the draft plan.	RW	31/1/15	
14/095.9	Food and Nutrition Report	Deputy Director of Operations to make representation to the PLACE assessors regarding patients preference for hot meals, investigate October scores and confirm if there is a downward trend and also notify the PFI partners that the Board wishes to see the new menus and trolleys in place by no later than the end of January 2015.	RG	31/1/15	See item 14/103 below.
14/095.10	Audit Committee Exception Report	The Board to consider when to next review its effectiveness and governance.	JC	5/2/15	

		Report back to Board from the Estates Team on emergency planning, IT business continuity and how we hold our PFI partners to account.	RG	5/2/15	
14/103	Action Sheet	New menus to come online at the end of February 2015. The new heated trolleys will not be available at the end of January as requested at the November Board meeting due to limitations in the PFI contract.	RG	5/3/15	
14/095.5	Safeguarding Quarterly Report	Future Safeguarding Reports to include learning from patient stories.	DM	5/3/15	

Enclosure 3

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 8th January 2015

TITLE:	**Chief Executive's Report**		
AUTHOR:	**Paula Clark**	**PRESENTER**	**Paula Clark**

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Test Performance
- Dalton Report
- Planning Guidance 2015/16

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To note contents of the paper and discuss issues of importance to the Board

The Dudley Group NHS
NHS Foundation Trust

Chief Executive Update – 8th January 2015

Friends and Family Test:

Community, Day Case and Outpatient FFT update

The Friends and Family Test was launched across Community, Day Case and Outpatient services on the 1st October. It is pleasing to see a growing number of responses during the quarter. Table 1 below shows provisional response numbers and percentage scores for information.

Table 1 Community, Day Case and Outpatient FFT

Areas/ all sites	No. of responses	Percentage of those extremely likely or likely to recommend the service
Community	211	95.7%
Day Case	419	97.4%
Outpatients	518	92.8%

Many respondents are taking the opportunity to provide comments with the overwhelming amount being positive.

Data submission to NHS England will commence in early 2015. The first return nationally will be for community patients responding to the FFT question in January 2015. We are awaiting final reporting requirements and details of the submissions timetable

FFT Inpatient and A&E provisional December 2014 results 01.12.14 – 12.12.14

Inpatient areas - From October 2014 the scores for those who would be extremely likely and likely to recommend the Trust to a friend or family members is calculated as a percentage. The Trust continues to benchmark well both nationally and regionally. The Dudley Group scored 96% against both the national and regional average of 94%.

A&E areas - During week one and two the response rates continued to fall from 28% at the end of November to 15% by the end of week two in December. The Patient Experience Engagement Lead is working closely with nominated staff in A&E to develop actions to improve the response rates. Those who say they are extremely likely or likely to recommend A&E to friends and family has fallen below the top 30% of trusts.

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec W1	Dec W2
	01.04.14	01.05.14	01.06.14	01.04.14	01.07.14	01.08.14	01.09.14	01.07.14	01.10.14	01.11.14	01.12.14	08.12.14
Date range	30.04.14	31.05.14	30.06.14	30.06.14	31.07.14	31.08.14	30.9.14	30.09.14	31.10.14	30.11.14	07.12.14	14.12.14
Number of eligible inpatients	1886	2023	1951	5860	2073	2004	1912	5987	2049	1892	382	381
Number of respondents	644	519	483	1646	577	548	447	1577	509	708	146	109
Ward FFT score	82	86	85	84	81	82	79	80.8	80	86	85	85
Ward FFT score in percentage								97%	96%	97%	97%	96%
Ward footfall	34%	26%	25%	28%	28%	27%	23%	26%	25%	37%	38%	29%
Number of eligible A&E patients	4258	4605	4679	13542	4843	4551	4552	13970	4255	4094	948	991
Number of respondents	686	614	1159	2459	1712	847	581	3141	1188	791	165	149
A&E FFT Score	64	53	57	57	70	71	56	67.7	61	60	67	54
A&E FFT score in percentage								90%	85%	88%	88%	82%
A&E footfall	16%	13%	25%	18%	35%	19%	13%	22%	28%	19%	17%	15%
TRUST FFT Score (A&E/Inpatient)	73	68	66	68	73	75	69.9	72	67	72	76	67
TRUST footfall	22%	17%	25%	21%	33%	21%	15%	24%	27%	25%	23%	19%

Inpatient FFT Score	82+	A&E FFT Score	68+	FFT Scores key	Top 20% of Trusts (based on March 14 scor
	79-81		65-67		Top 30% of Trusts (based on March 14 scor
	<79		<65		Below top 30% of Trusts (based on March
Response rate:					
Response rate A&E	<15%	15-20%	20%+		
Response rate Inpatients	<25%	25-30%	30-40% +	40%+ *	

Please note that from October 2014 the FFT score is also represented as a percentage

The Dudley Group NHS
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FFT results Maternity provisional December 2014 results 01.12.14 – 12.12.14

There has been a modest improvement in the combined response rate for maternity areas with response rates improving from 23% at the end of November to 26% at the end of week two. We are continuing to work with the team involved to maintain an improving picture.

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	1.12.14 to 12.12.14 interim
Maternity - Antenatal	Score	64	80	78	79	66	71	72	71	69	82
Score in percentage								97%	98%	97%	100%
	Response rate	14%	18%	13%	21%	19%	26%	22%	16%	15%	12%
Maternity - Birth	Score	62	85	83	90	94	98	93	87	91	94
Score in percentage								100%	98%	100%	100%
	Response rate	44%	33%	34%	30%	23%	24%	25%	14%	30%	36%
Maternity - Postnatal ward	Score	57	85	79	87	94	96	92	83	87	93
Score in percentage								100%	98%	100%	98%
	Response rate	43%	31%	32%	29%	23%	24%	25%	14%	31%	36%
Maternity - Postnatal community	Score	86	90	85	85	85	76	82	70	82	100
Score in percentage								100%	100%	100%	100%
	Response rate	16%	9%	15%	13%	12%	11%	11%	8%	10%	10%
Combined	Score	63	85	81	86	88	88	87	80	86	
	Response rate	32%	24%	25%	24%	20%	21%	21%	13%	23%	26%

% of footfall (response rate)	<15%	15%+

Antenatal	80+	76-79	<76	FFT	Top 20% of Trusts (based on March 14 scor
Birth	89+	86-88	<86	Scores	Top 30% of Trusts (based on March 14 scor
Postnatal ward	81+	75-81	<75	key	Below top 30% of Trusts (based on March
Postnatal community	90+	84-89	<84		

Dalton Report:
Sir David Dalton has now published his report. This has implications for the Trust in terms of our strategic direction in the medium to long term and participation in wider Black Country partnerships with our neighbours in particular Walsall and Sandwell and West Birmingham trusts.

The summary is attached for discussion.

The Forward View into Action: Planning Guidance for 2015/16
NHS England, Monitor and the NHS Trust Development Authority have produced a joint publication called "The Forward View into Action: Planning for 2015/16". The document sets out the first steps for implementing the five year forward view as well as maintaining operational delivery to meet the standards within the NHS Constitution 2015/16.

A summary of the guidance is attached.

Examining new options and opportunities for providers of NHS care

The Dalton Review

December 2014

Examining new options and opportunities for providers of NHS care

The Dalton Review

December 2014

The variation in the quality of health and adult social care is too wide. This unacceptable variation in quality needs to be widely acknowledged and addressed.

That care can be delivered in different ways does not justify poor quality for some people, settings or locations. Everyone should receive good quality care, no matter how or where it is being delivered. This means improving the care that is inadequate or requires improvement, while leaving others to flourish to develop their good and outstanding care.

The state of healthcare and adult social care in England 2013/14

Care Quality Commission, October 2014

Letter to the Secretary of State

Dear Secretary of State for Health

It was a privilege to be asked by you to lead this review into exploring ways to address the challenges faced by providers of NHS care. I believe that our NHS is the best healthcare system in the world, yet I know that not all of our patients are experiencing the standards they deserve. The recently published *NHS Five Year Forward **View*** describes the enormous challenges that the NHS faces. It emphasises that new care models are needed to support and care for people. This is the right approach. Yet, describing new care models is different from delivering them. This Report complements the *Forward View* and provides the organisational 'delivery vehicles' that can help translate its ideas into reality. I have confidence that NHS leaders and staff have the will and the capability to deliver what is needed.

We have significant variation in the standards of service provided by our healthcare organisations, and that troubles me. There are some excellent providers and some poor providers – and a lot in the middle. Why should any family have to accept that a relative living in one area can be confident in accessing excellent care whilst another, with the same needs living elsewhere, cannot? We might understand some of the reasons for this variation, but we shouldn't tolerate the extent of it. All of our staff want to provide the best – and we must do our best to ensure that they can.

Whilst some providers have a track record of high performance, it is increasingly clear that, for a significant number of others, their existing organisational model will not deliver financial and clinical sustainability. The tests for Foundation Trust status, which were introduced 10 years ago, enable proper judgement to be made on good organisational governance and viability – and must be retained. Yet, a decade on, 93 NHS Trusts still have not achieved this standard. This must not continue.

The District General Hospital, established by the 1962 Hospital Plan now, in isolation, can struggle to meet the needs of the population. This is well known to those of us who provide and commission healthcare, and we are now at a point where patients and their families are beginning to understand that too. The time is right to change the way we think about the organisation of service provision. Institutions should not be preserved just because they exist. Boards should not pursue self-protectionist strategies, using the 'interests of patients' as camouflage. If an organisation is not able to provide high standards, reliably, to the population it serves, then its continuation in its current form should be called into question. Safeguarding reliable, high quality care to patients is more important than preserving organisations.

There are no 'right' or 'wrong' organisational forms – what matters is what works. This Report does not champion one organisational model over any other but recognises that it is for our system leaders to pursue the models that will deliver the greatest benefits to the populations they serve.

Some models will enable ***collaborative*** solutions: where shared services, working across organisational boundaries, meet standards, seven days a week; or where new integrated governance arrangements for primary and secondary care bring greater coherence to a locality. Other ***contractual*** or ***consolidated*** models will allow opportunities for successful organisations to bring their proven leadership, processes and expertise into organisations which are unable to demonstrate clinical and financial viability.

Leaders of successful organisations should be 'system architects': using their social entrepreneurial spirit to develop innovative solutions to their challenges and to codify and spread their success, so that the best standards of care can be available, reliably, to every locality in the country. I strongly believe that our leaders should be encouraged to be aspirational and to strive for improvement – and that organisational achievement

should be recognised. The Report recommends a system of '*credentialing*' for our best organisations, building on the existing assessment systems of Monitor and CQC and drawing on the evidence of the characteristics of high reliability organisations. This new 'kitemark', beyond FT status, would enable commissioners to identify those organisations with the capability and greatest likelihood of successfully spreading their systems into organisations that are in persistent difficulty.

It is notable that all of the European countries we visited have developed new organisational forms as a response to the challenges they faced. Many have seen the development of hospital groups and the use of management contracts. These new forms have enabled the standardisation of best practice – and the delivery of this at a lower management cost overhead. It is perplexing that these forms have not been pursued in England. This may be due just as much to leadership mindset, as to some of the system impediments and weak incentives. This must be addressed.

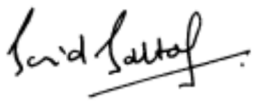
Competition law must not be seen as a barrier to developing innovative organisational solutions. There must be no doubt that patient benefit is and will be the key judgement in progressing new organisational forms. Some have said that it takes too long and costs too much to make changes. I agree – and so this Review makes recommendations to streamline processes, making it easier, quicker and less costly to transact organisational change.

I know that NHS change can be slow, due in part to an institutionally low tolerance to risk. It is important that this time we don't miss the opportunity to act with urgency. I very much hope that boards will now develop an *Enterprise Strategy* – utilising innovative approaches for growth to deliver better care for patients – and develop the internal capacity and capability required to deliver improvement. Significant support for transactions must be made available to help organisations to gear up to deliver change. I am also recommending that national bodies accelerate change by supporting the costs of initial transactions so that we have **demonstrators**, capable of prototyping the new models and transferring their experience and learning to others.

I am indebted to the people who have supported this Review: to my Expert Panel and to the Chairs' Group; to colleagues across Europe and the world who have allowed us to have insight into their systems; to the many people who have taken their time to participate in the numerous engagement events and to provide their views. I have been superbly supported by the Department of Health Review Team.

The Expert Panel has looked at the evidence of what works and presented this as a menu of organisational forms. We have listened and found a widespread appetite for change. We believe successful organisations should be encouraged to develop further and support organisations in persistent difficulty. There will be risks in taking this agenda forward, but I am confident that the NHS is capable of managing these. The prize will be a sustainable NHS, for the long term. We must support our NHS leaders and staff to reduce variation currently experienced and to deliver reliable, high quality care to all.

Yours sincerely



Sir David Dalton
Chief Executive
Salford Royal NHS Foundation Trust

December 2014

Executive summary

The NHS is rightly recognised as a world leading health system, highly valued by the public and those who work in it. There have been a number of remarkable successes over the last decade, but not all NHS providers have improved at the same rate, resulting in an unacceptable extent of variation in quality of care across the country. All patients and carers should expect and receive reliable standards of care, no matter where they live.

It is not only currently challenged providers who should strategically consider their future alongside that of their wider health economy partners. The NHS Five Year Forward View signposts the need for new models of care to respond to the challenges faced by the NHS. Even the best providers will struggle to meet the challenges of the future without looking outside traditional organisational boundaries and considering how their form could better support new clinical models and ways of working. Assuring the clinical and financial sustainability of the provider sector requires a wider range of options for both providers and regulators, and these must be embraced by leaders across the sector.

The evidence of the Review identified a number of organisational forms which could help providers to make these changes, which should be considered by all boards as part of their strategic planning processes. The Review also identified barriers and improvements to the system architecture surrounding these models, and makes recommendations to provider boards and to national bodies accordingly.

The organisational forms considered in this Review have different characteristics, benefits and barriers. Many are already being used in the NHS. It is clear that there should be no national blueprint or one size fits all. Accordingly, this Report does not impose wholesale change. It identifies five themes:

i. One size does not fit all

ii. Quicker transformational and transactional change is required

iii. Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact

iv. Overall sustainability for the provider sector is a priority

v. A dedicated implementation programme is needed to make change happen

i. One size does not fit all

Organisational forms should develop to deliver the models of care which best suit local circumstances. They must not be centrally dictated. System leaders understand their own population need and geographies, and therefore need to be enabled and supported to identify and implement the best clinical models for their patients. In doing so, they need to examine their current organisational form to determine whether or not an alternative form would deliver better outcomes for their populations.

Too often, organisations seek to retain the status quo at the expense of operating outside of traditional organisational boundaries and fail to adopt best practice or pursue wider system leadership which could deliver improvements for patients. Shifting the mindset of board members towards one of joint ownership and governance with other organisations should change the unhelpful perception of service change by boards of 'winning or losing' for their organisation to one of 'winning' for their patients and wider community.

The Review considered a number of organisational forms which have the potential for wider adoption across NHS providers: federations, joint ventures, service level chains, management contracts, integrated care

organisations and multi-service chains or Foundation Groups. The Report and its supporting evidence packs explore the potential of each form to offer solutions to local challenges. In the future, it suggests, organisations are likely to operate more than one organisational form for their service portfolio.

Who	Recommendation
Trust boards	As part of the 2015/16 business planning process, trust boards should consider their response to the NHS Five Year Forward View and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their populations.
Trust boards	Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.

ii. Quicker transformational and transactional change is required

System leaders need to collectively own the transformation required across their local health economy. Historically transformation and transaction processes have been lengthy and protracted, particularly the early stages of planning and gaining consensus across the local health economy. Simplifying these processes will both accelerate opportunities for improvements in patient care and reduce the costs of transactions. The 'rules' also need to be explained and understood further as perception of competition and legislative issues can cause organisations to become overly risk averse.

Who	Recommendation
NHS England and Clinical Commissioning Groups	NHS England should require Clinical Commissioning Groups (CCGs) to set out in their five year strategic commissioning plans: a. the future care/service models they wish to support; and, b. how they will use their allocated funds for service transformation to support providers to deliver the agreed transformational and organisational change. Where multiple CCGs and providers are taking forward service transformation across a shared geographical area, NHS England should help broker agreement as to how costs are met between all parties.
Department of Health	A single, unified process with standardised documentation outlining clear criteria should be developed to support future transactions. This should include guidance for all parties including Governors.
Department of Health, Monitor and NHS Trust Development Authority (TDA)	A Tender Prospectus that has the parameters of the transaction clearly laid out should be made available to all potential bidders in the interests of speed and transparency.
Secretary of State for Health	The Secretary of State should set a requirement to the national bodies that, except in exceptional circumstances, all transactions should be completed within one year or less from the time the decision is taken by the board of the NHS Trust Development Authority (TDA) or Monitor.

iii. Ambitious organisations with a proven track record should be encouraged to expand their reach and have greater impact

Transformational change requires strong and capable leadership. There are many successful NHS organisations and individual leaders with a track record of delivering consistently high quality healthcare to patients, but many have not thought beyond their current organisational boundaries. Leaders of successful organisations should become 'system architects', encouraged to use their entrepreneurial spirit to develop innovative organisational models and to codify and spread their success to other localities. Recognising these successful organisations, supporting them to develop enterprise strategies that expand their reach and developing new incentives will encourage more successful organisations to have greater impact with less successful ones.

Who	Recommendation
Monitor and the Care Quality Commission (CQC)	A new credentialing process, to recognise successful organisations capable of spreading their systems and processes to other organisations, should be developed by July 2015. This should build on CQC and Monitor ratings, with a good or outstanding rating a prerequisite. Once agreed, Monitor should be responsible for the process and the first wave of credentialing should be completed by October 2015.
Monitor and the CQC	A list of all credentialed organisations should be published on both Monitor and the CQC websites and made available to every Clinical Commissioning Group.
Clinical Commissioning Groups and providers	CCGs and providers should use this list of credentialed organisations to identify new partner organisations most likely to deliver transformational improvement.
Monitor and the TDA	A procurement framework should be developed which allows interested credentialed organisations the ability to register for management contract and acquisition opportunities. This framework should be live from or before April 2016. Inclusion on this register would mean that an organisation automatically passes the pre-qualification questionnaire (PQQ) stage of any tendering processes. The framework should then be used by the TDA and Monitor to procure support for challenged organisations.
Trust boards	Trust boards should consider new operational and strategic leadership roles required in order to support the new organisational models, and put development plans in place accordingly.
Leadership Academy	The Leadership Academy should support the development of the requisite skills and experience for the new operational and leadership roles and build these into the career paths and leadership and development training of current and future NHS leaders.
Department of Health, Monitor and CQC	The Department of Health, Monitor and the CQC should agree a 'grace period' for acquiring organisation with an agreed trajectory of finance, performance and quality standards improvement for the acquired or contractually managed organisation, separate from the overall performance of the combined organisations. This 'grace period' should take into account historical quality issues and the impact of any agreed financial investment adjustments.
Monitor and the TDA	Monitor and the TDA should ensure that – where appropriate – an acquiring or contractually managed organisation can start to create integrated operational structures, once the Heads of Terms have been agreed, so that these may be run in shadow form prior to the final decision on the transaction being taken.

iv. Overall sustainability for the provider sector is a priority

There are currently 93 NHS Trusts. A proportion of these will become Foundation Trusts, but many will not reach the required standards in their current organisational form. Equally, there are some Foundation Trusts that would not meet the requisite standards for authorisation today and may be significantly challenged both clinically and financially. Long-term solutions need to be identified for these organisations, supported by appropriate governance models, to ensure that all patients can continue to access safe and reliable high quality care.[1]

Who	Recommendation
TDA	The TDA should publish the categorisation of and plans for each of the 93 NHS Trusts in the Foundation Trust pipeline, along with the trajectory and milestones for when and how each organisation will achieve Foundation Trust status or other sustainable organisational form.
Department of Health	The Department of Health should hold the TDA to account for meeting the trajectory and milestones for each of the 93 organisations.
TDA	The TDA should consider accelerating the solutions for patients and communities currently served by organisations in persistent difficulty, by running batched procurements for category B1 and B2[1] NHS Trusts.
Monitor and the TDA	The buddying system should be expanded, beyond the special measures trusts, into a partnering system to allow organisations with the potential to improve early access to support and guidance from credentialed organisations. Arrangements should be developed to identify and remunerate trusts capable of providing support. Should buddying not result in the required improvement within a defined time period, a re-categorisation of the NHS body should be considered so that further action can be enacted quickly.
Monitor	Monitor should consider using their existing categorisation process to drive more rapid interventions. Where Monitor determines that a FT is in 'persistent difficulty', it should require that FT to produce a plan with clear improvement timescales. If the FT is subsequently unable to demonstrate improvement against this plan, Monitor should compel that FT to present a new sustainability plan. This may include adopting a new organisational form or pursuing a transaction with a 'credentialed' organisation.

v. A dedicated implementation programme is needed to make change happen

In order to implement the ideas in this Report, two activities should occur in parallel: firstly, NHS leaders should be supported to develop awareness and knowledge of the available models and implementation approaches through a widespread programme of sharing learning and best practice; secondly, there should be a programme of demonstrator sites that can stimulate and accelerate change. This programme will support providers to develop and test new organisational forms in practice. Particular attention should be given to supporting successful organisations stepping in to improve delivery of high quality services in challenged health economies.

[1] Category B1 are described as organisations that cannot reach FT status in their current form and where an acquisition by another organisation is likely to be the best route to sustainability.

Category B2 are described as organisations that cannot reach FT status on their own and where a franchise, management contract or other innovative organisational form is likely to be the best route to sustainability.

Who	Recommendation
Department of Health	The evidence and findings from the Review should be communicated across the health sector, alongside the business planning round, through a national programme of learning and sharing best practice.
Department of Health, Monitor and the TDA	The national bodies should support a number of demonstrator sites where organisations implement a change to their organisational form. This should be evaluated and the learning shared with the wider sector.

Conclusion

The extent of variation of standards of care across the country and the challenges all providers of NHS services face must be addressed as soon as possible. The NHS Five Year Forward View signposts organisations to consider new and innovative solutions to address quality and financial challenges; the recommendations of this Review complement the NHS Five Year Forward View and support providers to deliver the changes required. The evidence from the Review suggests that addressing these five key themes will accelerate the transformational change that is required to help overcome the challenges facing the NHS. Effective and speedy implementation is now required in order to have the greatest impact for patients. The government, national bodies and patients should have confidence in NHS leaders to make the necessary changes a reality.

The forward view into action: planning for 15/16

INTRODUCTION

The planning guidance published on Friday 19 December 2014 by NHS England, in partnership with five arms length bodies, sets out first steps for implementing the Five Year Forward View (5YFV) as well as maintaining operational delivery to meet the standards within the NHS Constitution for 15/16. The guidance is published alongside CCG allocations.

The guidance places considerable new emphasis on aligning planning nationally and locally. The joint national guidance includes common planning assumptions, priorities and a shared timeframe for assurance across NHS England, Monitor and TDA with CCGs, FTs and trusts asked to refresh one year plans for 15/16. Locally, health economies are encouraged to develop collaborative plans which align realistic activity and financial assumptions between commissioners, providers on the existing planning units for 14/15 (p.5).

To support the delivery of the high level ambitions set out in *the forward view into action* Monitor and the TDA have published detailed guidance for this year's annual planning review (APR) process for foundation trusts and NHS trusts respectively.

SUMMARY

A NEW RELATIONSHIP WITH PATIENTS AND COMMUNITIES

- In line with the 5YFV, the planning guidance places **considerable emphasis on the role of prevention** in managing demand and building a new partnership with patients and communities. CCGs are encouraged to work with local authorities to reduce health inequalities and improve outcomes for health and wellbeing
- A **national evidence based diabetes programme** will be published in March 2015 for roll out in 16/17.
- Following the 5YFV, there is a **sustained focus on the healthy workplace** including proposals for helping people return to work, NICE guidelines for a healthy workplace and an expectation that all NHS employers take 'significant actions' in 15/16 to improve the health and wellbeing of their staff. (This is also reflected in the standard contract which requires providers to maintain a food and drink strategy in line with the Hospital Food Standards Report)
- The NHS standard contract requires providers **to show progress in developing interoperable digital health records from 2018.** From 2015, patients will have access to their online GP record
- **CCGs are expected to lead an expansion of personal health budgets** including providing them as an option for people with learning difficulties, and to develop integrated personal commissioning with a year of care budget for individuals in a number of demonstrator sites.
- The guidance flags **the roll out of choice within the mental health sector next year** as well as the development of new options to **develop choice in maternity services**
- There is a focus on **supporting carers and encouraging volunteering** including an expectation that CCGs work with local authorities to draw up plans to support carers and to work with the voluntary sector
- **NHS employers are asked to lead the way in developing a diverse workforce which reflects the communities they serve, including the implementation of the new race equality standard.**

CO-CREATING NEW MODELS OF CARE

New models of care:

The planning guidance describes the models proposed within the 5YFV as 'a menu of additional, voluntary options.' However the main focus of this section is on intention to progress the following four models of care:

Contact: Miriam Deakin, head of policy, miriam.deakin@nhsproviders.org or Amber Davenport, policy advisor, amber.davenport@nhsproviders.org

- Multi-speciality community providers (MCPs)
- Integrated primary and acute car systems (PACS)
- Additional approaches to creating smaller viable hospitals, which may include implementing new organisational forms advocated by the Dalton Review such as specialist franchises and management chains; and
- Models of enhanced health in care homes.

These models will be progressed via:

- Focused support for 'vanguard sites'
- Allowing more permissive approaches to change right across the country
- Intervening to create the conditions for success in the most challenged systems
- NHS England will also work with the LGA to establish 21st century care in a number of new garden cities (potentially Ebbsfleet, Bicester and other urban populations including the former Olympic village).

Each care and organisational model will receive a co-designed package of support to accelerate change, demonstrate 'proof of concept', identify and share learning. These support packages will be co-ordinated by a New Models of Care Board. The £200m transformation fund will be used to support these sites. Aspiring MCPs will have opportunity to bid for the annual £250m primary care infrastructure fund.

Those in 'vanguard' local areas or organisations (those areas which have made tangible progress towards new models already) are asked to put themselves forward to england.fiveyearview@nhs.net for consideration by Monday 2 February with a short proposal setting out their plans for local transformation, how this fits with the models of care described in the 5YFV, the benefits expected over set timescales, demonstrate the level of collective support there is among local leaders and how each will contribute and identify how national partners could accelerate plans. The first sites will be agreed in February in a process overseen by the New Models of Care Board, co chaired by NHS England and Monitor. The first support programmes will be developed by the end of March.

There will also be a role for 'UK and international innovators' to develop 'test bed sites' alongside the new models of care to deploy and evaluate the benefits of new technologies and innovations. The guidance is clear that there is a key role for AHSN's to play in partnership with others in this space.

The guidance includes some early indications of likely conditions for successful transformation including strong and collaborative local leadership, a strong financial position, and good plans for the future (p.12). The guidance promotes a locally led approach in which health economies are strongly encouraged to develop a shared vision of health and care for their populations in the context of the choices outlined in the 5YFV, refreshing medium term strategies and take actions in 15/16 which create the conditions for rapid early adoption. The six national partners commit to developing a deeper understanding of how far these conditions are present across the NHS by April 2015.

A new regime for challenged systems:

While all organisations and localities are encouraged to consider how they will move to new models of care, the guidance describes a 'new success regime' (p.12) led by NHS England, Monitor, TDA and others (including LGA and CQC) in the minority of local health economies with longstanding challenges regarding quality, finance, poor relationships. More detailed guidance on the operation of the regime is due in 2015 but is likely to include:

- A single, aligned accountability mechanism for the national bodies to oversee the process and ensure that all relevant local parties are held to account
- The agreement of a single, collective short term plan for the health economy setting out what needs to be achieved during the period of intervention
- Access to external support to address the particular issues facing the health economy including clinical, financial and performance expertise
- Support from high performing health economies and organisations to accelerate progress and build capacity in the challenged health economy
- The development of a clear medium term plan for transformation across the health economy
- Conditionality for any transitional financial support.

A new deal for primary care:
In January, NHS England will publish more detail on a ten point plan in development with the Royal College of GPs and the General Practitioners' Committee to make use of the £1bn Autumn Statement additional funding for primary care over the next four years. The plan will focus on tackling the immediate workforce pressures facing GPs and attracting more doctors into training. Those CCGs which take on more responsibilities under co-commissioning will have greater freedom to take local action. In addition to this, £100m has been made available by the Prime Minister's Challenge Fund to improve access to general practice.

Urgent and emergency care, maternity cancer and specialised services:

- Commissioners and providers should prioritise the strategic and operational task of implementing the urgent and emergency care review which will be reinforced in 15/16 quality premium incentives for CCGs and the CQUIN framework for providers. Urgent and emergency care networks which build on existing resilience groups should be established by April 2015 and oversee planning and delivery of regional or sub-regional care system. Further guidance is due in the summer of 2015
- An NHS England review of maternity services will make recommendations to develop and sustain the service as well as to develop choice for maternity care, by summer 2015
- A revised national cancer strategy will be developed in partnership with the relevant charities
- For specialised care, where quality and patient volumes are closely related, such as trauma, stroke and cancer care, NHS England confirms its intention to consolidate delivery. By summer 2015, NHS England will begin a first round of service reviews working with local partners. 2015/16 will also see providers prepare for new standards for congenital hear disease which will be finalised for implementation in full from April 2016.

PRIORITIES FOR OPERATIONAL DELIVERY 15/16

- Reiterates a commitment to delivering the access targets in the NHS Constitution in 15/16. However commissioners and providers are encouraged to set realistic and aligned assessments of both capacity and demand. There is a caution against reducing winter capacity unless it is clear that demand is reducing
- CCGs are encouraged to refresh existing plans to improve against the NHS Outcomes Framework
- A revitalised National Quality Board will bring together the key players nationally in support of quality across the system and undertake an initial review of barriers to quality improvement
- There is a commitment to build on the publication of surgical outcome data for 13 specialities in 15/16 and both CCGs and providers are expected to embed the transparency agenda
- Use of CQC inspection reports and ratings are endorsed as a means to understand quality and for providers to learn from each other
- There will be a concerted focus on patient safety, including embedding responses to the Francis, Berwick and Winterbourne View reports, establishing patient safety collaboratives, supporting the 'sign up to safety campaign' and new CQUINs (see below)
- CCGs and providers should work to improve anti-biotic prescribing in primary and secondary care
- Acute providers should agree service delivery and improvement plans with commissioners setting out how they will make progress with at least five of the ten clinical standards for seven day services in 15/16 (recognising that the tariff does not include additional resources for seven day working in 15/16). In 16/17 the standard contract will require providers to comply with at least five of the ten standards, with the remaining standards to be mandated through the contract from April 2017 onwards
- Commissioners will need to work with mental health providers to plan the roll out of new access and waiting time targets for mental health services within 15/16 as well as meet commitments for dementia, improve access to IAPT, support for a first episode of psychosis and liaison psychiatry. CCGs should work with partners to invest in CAMHS and reduce out of area placements and there is a focus on improving services for eating disorders following the announcement of £30m additional funding for those services
- The Winterbourne View concordat charges commissioners with reducing reliance on residential provision for people with learning disabilities, autism or mental health issues.

ENABLING CHANGE

- The new National information Board and the recently published framework 'Personalised Health and Care 2020' will lead change in a number of areas including **access to GP records by 2015, developing a 'paperless NHS, further embedding use of the NHS number as primary identifier.** Commissioners are expected to plan for the roll out of inter-operable digital records
- Nationally, a **new Workforce Advisory Board chaired by HEE will support the implementation of new models of care** with an initial focus on retention (including for emergency medicine, nursing and GPs), providing support in local health economies where workforce shortages are impeding improvement, delivering the flexibilities required to support new models of care including reskilling, and identifying new roles. Each health economy is expected to engage with its LETB to identify workforce needs
- There will also be a focus on **innovation and new technologies** including an expansion of the 'commissioning through evaluation' programme, increasing the proportion of devices subject to NICE guidance, the roll out of the genome programme and the role of AHSN's in research and development.

FUNDING 15/16 AND DRIVING EFFICIENCY

- The 5YFV describes the need for 2-3% efficiency per year across NHS expenditure over the next parliament in return for additional investment. The planning guidance acknowledges that this is a stretching target as previous long-run efficiency is closer to 2% and has been supported by pay restraint and other top-down cost containment policies such as medicines pricing. The planning guidance cites the possibility of 'closing gaps' between the highest and lowest performing providers to release further efficiencies, delivering productivity gains due to better use of technology, reducing reliance on agency staff and accelerating efficiencies to 3% by the end of the 5 year period by moving at pace to new models of care.

The planning guidance and the 17 December NHS England board paper outline how NHSE will deploy the £1.98bn given in the 2014 Autumn Statement. NHS England describes its intentions as follows:

- A £200m investment fund will promote transformation in local health economies, with a particular focus on investment in the new care models set out in the Forward View
- Deliver funding growth for primary care in line with other local services
- Ensure mental health spend rises in real term in every CCG and grows at least in line with the CCG's overall allocation growth. Mental health services will be supported through £110m in additional funding for the introduction of mental health access standards, consisting of £40m spending on Early Intervention in Psychosis services funded through local contracts; £40m for improving liaison psychiatry services and reducing waiting times under the Improving Access to Psychological Therapies (IAPT) programme, and; £30m for improving treatment for children and young people with eating disorders, distributed on a national basis.
- Accelerate progress towards bringing all CCGs receiving less than their target funding to within 5% of target by 2016/7 whilst also directing funding towards distressed health economies
- Provide full cover for expected growth for each commissioning stream, eliminating the structural deficit in specialised commissioning, and reflecting the rapid growth in these services
- Enable earlier and more effective planning for operational resilience
- Reconfirm plans to deliver 10% cash savings in CCG and NHS England administration costs for redeployment to the frontline
- Give CCGs priority access to £400m drawdown available.

There is a keen focus in the planning guidance on the need for commissioners and providers to work together to align assumptions about demand and capacity. This should be underpinned by common planning assumptions from NHS England, Monitor and TDA. There is reference to the national bodies requiring 'revisions' to planning where discrepancies between commissioner and provider plans cannot be explained (p.24):

- Commissioners and providers are encouraged to reflect on local pressures including population growth and demand, with average ONS population growth at 1.3% and national activity pressure (before application of demand management) at around 3% a year. The document also acknowledges steeper growth in demand

in recent years in a number of services. NHS providers will wish to discuss with commissioners the level of activity they commission and ensure they have capacity to meet it in a safe and sustained way
- In their statutory consultation notice NHS England and Monitor have set the national efficiency factor at 3.8%. Net of an assumed 1.93% uplift for pay and price inflation, the final tariff deflator will mean prices will decrease by 1.9% in 2015/16. Under this tariff package, if NHS providers only deliver 3% efficiency it is estimated that the net provider deficit will reach £1.1bn by the end of 2015/16. As part of the tariff package commissioners and providers must jointly agree plans for reinvesting the balance of the marginal rate for non elective admissions – as noted in the tariff documents, the marginal rate is now set at 50% rather than 30%. Reinvestment plans should be published on commissioner websites no later than 30 April
- The levels of ambition for the Better Care Fund should be reviewed if there is material change in the risk to delivery
- All commissioners should set aside 1% non recurrent spend in 15/16 which will be released in line with risk assessment co-ordinated with NHS England's regional teams and invested in line with transformational priorities. Commissioners and providers needs to agree the extent of non recurring resources that may be deployed to enable transformation of services
- There is a clear note within the guidance that the additional Autumn Statement funds are intended to meet operational pressures for 15/16 and will not be supplemented with additional non recurrent pots of funding (such as for winter pressures) throughout the year. We note that in 14/15, the sector has received £700m additional funding for this purpose.

NHS England will publish the CQUIN and Quality Premium guidance in January. However, as usual, commissioners will offer providers CQUINs of up to 2.5% contract value (excluding drugs, devices and other pass through costs etc.):

- Indicators for dementia and delirium care remain in place with minor updates
- Picking up the operational focus on patient safety, there will be two new indicators, one for care of patients with acute kidney injury and one for the identification of sepsis
- New national CQUIN theme on improving urgent and emergency care across local health communities
- Other 14/15 CQUINs including the national safety thermometer and the friends and family test will be covered by the standard contract rather than a CQUIN in 15/16.

2015/16 PLANNING REQUIREMENTS

To support the delivery of the ambitions set out in *the forward view into action: planning for 2015/16* Monitor and the TDA have published detailed guidance for this year's annual planning review (APR). For 2014/15 foundation trusts and trusts were required to develop and submit five year strategic plans, alongside their two year operational plans. This year, all foundation trusts and NHS trusts are required to submit a **one year operational plan for 2015/16.**

Requirements of foundation trusts for 2015/16

There have been two major changes to Monitor's requirements following the initial planning timetable published in their November 'FT bulletin': Foundation trusts are now required to submit a one year operational plan only for 2015/16 (rather than a two year plan); and foundation trusts are now required to submit a high-level draft plan at the end of February 2015 in advance of the submission of the final detailed plan in April 2014.

Submission of a new five year strategic plan is not required as part of this process. However, Foundation trust's may be required to submit a new five year strategic plan later in 2015, with 2016/17 being "year one", as Monitor, the TDA and NHS England continue to develop a longer term planning framework for providers and commissioners based on the Five Year Forward View.

For 2015/16 planning the high level draft operational plan is required by **midday on 27 February 2015**, and should include:

- a summarised financial template, providing high-level financial projections with relevant underlying assumptions, for 2015/16; and
- a three page brief narrative setting out the key assumptions, the degree of confidence in these assumptions and the extent of alignment with commissioners' plans.

Monitor will undertake a high-level desktop review of the draft operational plans, to identify key issues or concerns that should be addressed or explained in the foundation trust's final operational plan submission. Their review will be focussed on: the key assumptions underpinning financial projections, the cohesion, plausibility and risk of the financial projections and the degree of alignment with the main commissioners' plans. Where appropriate feedback on draft operational plans will be provided to Foundation Trusts in March 2015.

The final, detailed operational plan is required by **midday on 10 April 2015**, and the key components of the detailed plan should include:

- An operational narrative (not for external publication);
- a redacted summary of the operational plan narrative (in a format suitable for external publication); and
- a financial template (including the completion of one year of detailed financial forecasts).

Following the submission of the final operational plans Monitor will undertake a risk-based desktop review between April and May 2015, and will also incorporate the review of quarter four returns. Feedback on the final operational plan will be provided to each Foundation Trust in June 2015. In the planning guidance Monitor reiterate their focus on ensuring Foundation Trusts are capable of meeting current operational and financial requirements ('resilience') and delivering a credible strategy for achieving required performance levels into the long term ('sustainability'). Monitor state that plans will be assessed on a case-by-case basis; however Monitor will be most concerned by a lack of engagement in the planning process or by overly optimistic planning as these can indicate broader failures of governance. Regulatory action following a review of the submitted plans may include enhanced scrutiny, re-submission of plans or investigation.

Foundation trusts are also now required to take part in a weekly contract tracker, which will involve Monitor collecting weekly updates from foundation trust (every Thursday) on the status of their contracts, in order to track their progress and highlight risks of misalignment. Monitor is also encouraging foundation trusts to take part in the contract dispute resolution process run by NHS England and the TDA, in order to help ensure that all commissioners and all providers have in place mutually agreed contracts prior to the start of the financial year. **Please note while this is a voluntary process for foundation trusts and the arbitration stage will not be mandatory, Monitor may regard an unsigned contract as a risk in their review of plans**. Please see the *dispute resolution process for the 2015/16 contracting process* for more detail.

Financially distressed foundation trusts (those which currently, or expect to, require DH funding) will be subject to additional reporting requirements. Please refer to appendix 2 to the main guidance document and Section 10 of Monitor's technical guidance for more detail.

Requirements of NHS trusts for 2015/16

- NHS Trusts will be required to produce a Board-approved, commissioner-aligned one year plan for 2015/16. The components of the plan will include:
  - strategic context and direction, including the impact of strategic commissioning intentions and service changes;
  - approach taken to improve quality and safety;
  - delivery of operational performance standards
  - workforce plans;
  - financial and investment strategy, including risk analysis and mitigation plan; and
  - organisational relationships and capability.
- NHS Trusts will also be required to take part in the weekly contract status tracker update each Thursday from 29 January.

Deadlines for NHS trusts

- An initial plan must be submitted by **13 January 2015** setting out aggregate and high level financial, activity, quality and workforce projections for 2015/16, and forecast outturn for 2014/15.
- A full draft plan must be submitted by **27 February 2015**, following a national stocktake of contract status on 20 February 2015. The full draft plan must set out detailed information on the areas mentioned above. For example on 13 January only an aggregate activity plan must be submitted, by 27 February an activity plan with monthly profiles, splits by commissioner and trajectories against C Difficile must be submitted.
- The final full plan must be submitted by **10 April 2015**, following the completion of the dispute resolution process with NHS England.

- The NHS TDA is asking each NHS Trust to prepare its own description of the planning process that the Trust is following to ensure the Board is engaged, there is sufficient resource and support and that necessary planning actions are being undertaken at the right time. The description of the planning process is to be prepared at the outset of the planning period and submitted with the first plan submission on 13 January 2015.
- The NHS TDA will review the planning process and follow up any issues or risks through the regular Integrated Delivery Meetings with Trusts.
- The overall one year Operational Plan must be approved by the Trust Board by 31 March 2015 in advance of submission on 10 April. Confirmation of this approval is to be provided by the Trust Chief Executive on the final submission date of 10 April 2015.

During the planning process each NHS Trust is required to prepare a summary of their one year plan in narrative form which will look at the previous year, the year ahead and the components of the one year plan outlined above. The TDA has provided a template for the narrative. As long as the key elements are covered NHS trusts are free to amend the template to suit their needs.

To support and assist NHS Trusts in developing robust financial plans, the NHS TDA will provide a number of practical tools covering benchmarking, and to triangulate finance, activity and workforce plans. The likelihood is that this will involve intensive interaction with trust boards. The NHS TDA will also move its development and support activity onto a more programmatic footing to provide dedicated longer-term support for NHS trusts. This will include generating partnerships with world-leading organisations to focus on reducing harm and waste in NHS Trusts; and reviewing NHS Trust development and improvement plans to identify cohorts of organisations who face similar challenges and could benefit from shared improvement opportunities.

The NHS TDA intends to work with trust boards to support and assist the development of robust demand and capacity plans and to ensure that contracts reflect the right approach to risk sharing between providers and commissioners. The TDA will also be working with providers to assess their long term sustainability

SUBMISSION AND ASSURANCE OF PLANS

NHS England, Monitor and TDA will still assure plans for CCGs, foundation trusts and NHS trusts respectively in line with their statutory duties. However a more joined up approach to assurance will collectively focus on:

- finances to secure delivery and compliance with the planning guidance
- that finance and activity projections are supported by reasonable and deliverable planning assumptions including level of assumed efficiency savings and underlying growth
- triangulation of finance and activity
- agreed demand and capacity plans
- coherence with LETB work plans
- coherence with other planning and output assumptions
- robust local relationships which are key to ensuring delivery.

Members will wish to familiarise themselves with the full timetable in the guidance however the following key dates may be particularly useful to note:

- 23 December, publication of full planning guidance (including technical appendices from Monitor, TDA)
- Jan 2015, publication of final tariff
- 13 Jan 2015, submission of headline plan data (CCGs and providers)
- From 29 Jan, weekly contract tracker to be submitted (CCGs, NHS England, NHS Trusts)
- 20 February 2015, national contract stocktake
- 27 Feb, submission of full draft plans (CCGs and providers) followed by an assurance process by NHS England, Monitor or TDA respectively (to 30 March)
- 11 March 2015, contracts signed post mediation
- 12-23 March, contract arbitration, with outcomes notified by 25 March
- By 31 March 2015, plans approved by boards of CCGs, foundation trusts and NHS trusts
- 10 April, sign off for local plans followed by further assurance and reconciliation of operational plans.

The guidance states that NHS England, Monitor and TDA 'will consider it a 'major failing' of a health economy if agreement is not reached (including on contracts) prior to the start of the financial year. Where this is not achieved a dispute process will apply (as set out at a high level in the timeframes below).

NHS PROVIDERS' VIEW

The introduction of a common set of priorities and planning assumptions which have been agreed across the key arms length bodies is particularly welcome, as is support for a more collaborative, partnership approach in local health economies whereby NHS providers can work with their commissioners and other key partners to produce coherent plans for the benefit of their communities. This represents a welcome shift in direction, as does the language of both the 5YFV and the planning guidance which seeks to enable local, collaborative change. We will carefully monitor the changing role of the national statutory bodies in local health economies to ensure there are clear structures and accountabilities that govern this interaction and respect local autonomy and accountability.

We will be keen to understand how the planning assurance process is operating in practice for our members including with regard to sharing information with partner organisations. We will for instance seek further clarification about any competition issues which may arise from information sharing so as to reassure our members that their primary focus should be on collaborative working, as per the guidance.

We also welcomed the additional Autumn Statement funding and we are pleased to see the funds mainstreamed predominately to meet operational pressures, as well as to support transformation. The additional funding for mental health access standards and the real terms increases to mental health CCG spending are welcome, and we will work with NHS England on the assurance process to monitor the delivery of this commitment. However we note that the overall financial climate for NHS providers remains particularly challenging given rising demand, a tough efficiency deflator and new pricing mechanisms for specialised services. An additional £700m resilience funding was provided for the sector in 14/15 in non recurrent pots of funding which will not be repeated for 15/16 and both commissioners and NHS providers will therefore remain under some pressure to meet rising demand despite the Autumn Statement increase in funding. We will keep a watching brief to ensure that these additional funds reach the frontline via providers in an effective and rules-based manner.

While we understand the focus on a one year refresh of plans for 15/16 (an election year), multiyear budgets and planning cycles would provide both commissioners and NHS providers across the acute, mental health, community and ambulance sectors with a much more stable basis to plan for the medium term transformational change required over the next five years. We will continue our work with Monitor, DH and HMT on developing these multi-annual frameworks.

NHS Providers has welcomed the introduction from April 2015 of the first NHS workforce race equality standard in the NHS contract. The new national standard by itself clearly will not transform race equality and contractual levers are widely accepted as a blunt instrument to drive cultural change. However, we support this move as an opportunity to galvanise the concerted action clearly required across the system to support boards of providers in sharing and delivering good practice in this area.

We have some concerns with the proposal to introduce a weekly contract tracker for foundation trusts and trusts. This undermines the flexibility providers need to have at a local level to agree their contracts with commissioners. There are valid and legitimate reasons why providers and commissioners have not managed to sign a contract by the deadline and there are currently mechanisms in place at a local level to ensure that formal arbitration is used where necessary. While we can see a role for Monitor, NHS England and the TDA to support commissioners and providers to arbitrate in some circumstances, this has to be a local decision driven by the contracting parties rather than by the national bodies. Furthermore, both Monitor and NHS England have formal roles in the design of the

national tariff and contract and therefore we see there being a potential conflict of interest should they step in to facilitate with arbitration of CCG and specialised services contracts at a local level. We will be making a full response to the consultations on both the national tariff and the NHS standard contract.

We look forward to working with members and helping to share their learning as they develop new models of care, and we welcome both the support for 'vanguard' areas where local leaders are already leading innovative and collaborative change, as well as the promise of 'permissions' for the vast majority of our members to develop new models of care.

However we have some reservations about the new and interventionist regime described for the minority of local health economies in extreme difficulties. As noted earlier, given the diverse roles and remits of the different national bodies, including NHS England (both commissioner and arms length body), Monitor (a regulator), NHS TDA (an oversight body) and the LGA (a membership organisation) we will be seeking to discuss with the national bodies what the respective roles of these bodies could be in supporting change in local health economies, while respecting the autonomy and local accountabilities of provider boards, and indeed of CCGs. We note that while collaborative and integrated working is essential to serve the best interests of patients, and to operate efficiently, there is no 'accountability' mechanism for a local health economy as such.

We look forward to working with colleagues in NHS England, Monitor, TDA and the other national bodies to ensure we play a full role on behalf of our membership in the implementation of the 5 year forward view, including in sharing peer based learning from the development of new models of care.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 8th January 2015 - PUBLIC

TITLE:	Infection Prevention and Control Exception Report		
AUTHOR:	Denise McMahon – Director of Nursing Dr Elizabeth Rees - Consultant Microbiologist/Infection Control Doctor/ Director of Infection Prevention and Control	**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:

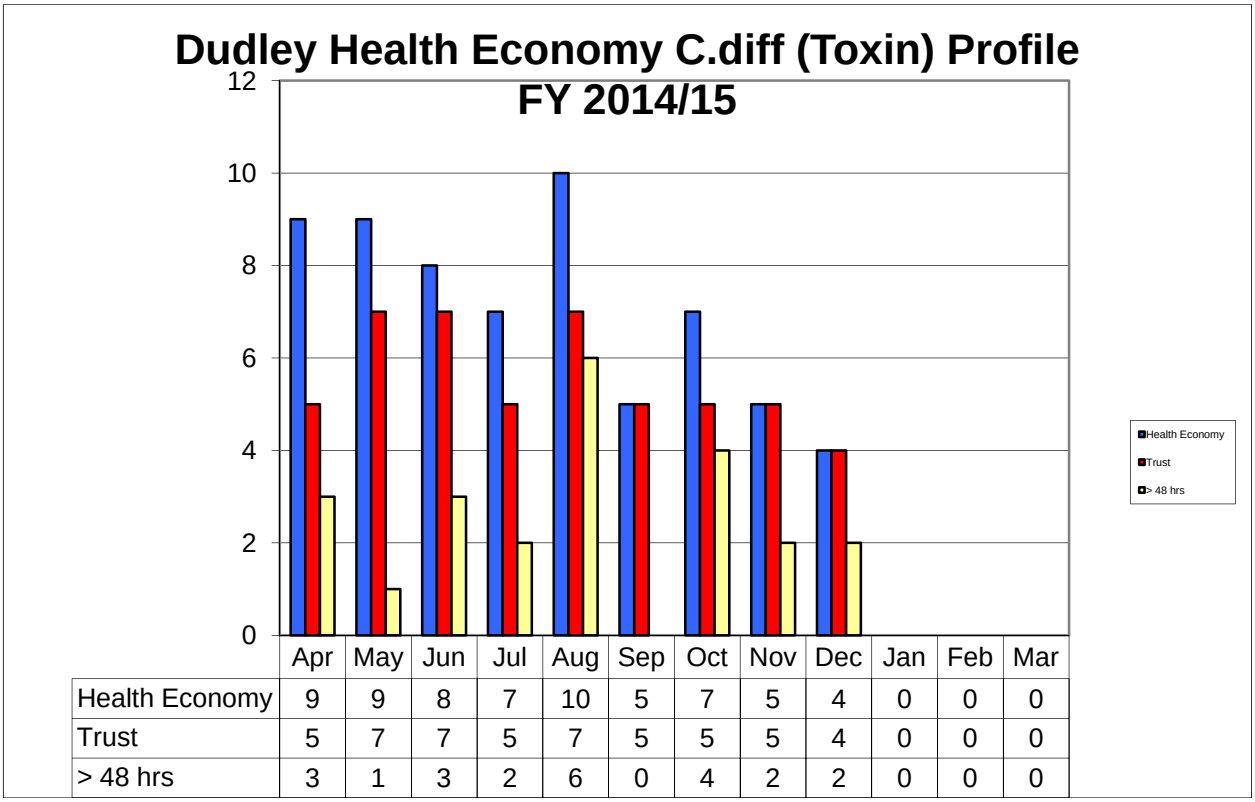
Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

Summary:

Clostridium Difficile – The target for 2014/15 is 48 cases, equivalent to 20.5 CDI cases per 100,000 bed days. At the time of writing (22/12/2014) we have 2 post 48 hour cases recorded in December 2014 against a trajectory for the month of 3 cases.



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

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], has commenced. To date, 20 cases have been reviewed with the CCG of which 16 were determined as being associated with lapses in care. The main themes identified are: 6 cases were associated with poor documentation, 6 cases were associated with issues related to antibiotic prescribing, 5 cases were associated with delayed sample collection, 1 case was associated with delayed isolation, 3 case was associated with poor environmental scores and 1 case was associated with poor hand hygiene scores. As can be seen some cases had more than one lapse identified.

MRSA bacteraemia (Post 48 hrs) – There have been no post 48 hour MRSA bacteraemia cases identified so far this year.

Norovirus – There are no wards currently affected.

Ebola – Public Health England (PHE) have issued further advice, which the Trust is adopting, including displaying public information at entry points into the Acute Trust. A recent update of the ACDP guidance and algorithm for Viral Haemorrhagic Fevers has been released by Public Health England and this is replacing the previous guidance.

Reference

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

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 8th January 2015

TITLE:	**PART 1 Six Monthly Nurse Staffing Report** **PART 2 Monthly Nurse/Midwife Staffing Position – November 2014**		
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:

PART 1

This is the second six monthly detailed review of nurse staffing levels using as a basis the Safer Nursing Care Tool (SNCT) comparing the results with the present staffing levels based on the Ward Review undertaken earlier in the year. Both methods are described in the paper and the results of each are provided and compared with a number of caveats. Where required, a number of actions are suggested.

PART 2

The second part of the paper contains the latest monthly assessment (for November 2014) of both day and night shifts on all wards indicating if they were staffed (green) or were not staffed to the planned levels for both registered (amber) and unregistered staff (blue), with the day shift registered figures also taking into consideration the 1:8 nurse to patient ratio for general wards. Unsafe staffing will also be charted (red). The planned levels for each ward vary dependent on the types of patients and their medical specialities and national ratios apply to specialist areas such as intensive care, midwifery and paediatric areas.

When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined and an assessment of any impact on key quality indicators has been undertaken.

As previously stated, there is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. As this is a recent requirement, the format will evolve as time progresses but no changes have been made to the format since August 2014. The monthly report indicates a fall in the numbers of shifts since the previous month that were not staffed to the planned levels.

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 discuss and review the staffing situation and actions being taken and agree to the publication of the paper into the public domain, as required.

The Dudley Group NHS Foundation Trust

PART 1 Nurse Staffing Review

Introduction

This paper provides an overview of the nurse staffing situation at the Trust. It is the second six monthly paper following the recommendations of the national publications 'How to ensure the right people, with the right skills, are in the right place at the right time' and 'Hard Truths' authored by Jane Cummings, Chief Nursing Office for England and Mike Richards, Chief Hospital Inspector at the Care Quality Commission. It contains data from both the initial (February 2014) and more recent exercise (September 2014) using the Safer Nursing Care Tool (SNCT) for all wards in the Trust for which the tool is applicable and the comparative internal extensive Ward Review process undertaken in January/February 2014. From the first paper, the Trust Board decided to adopt the figures from the Ward Review and agreed an extra £3million funding to increase the nurse establishment.

In Part 2, the paper provides the now monthly information for the month of November on actual staffing levels at the Trust in relation to planned registered and unregistered staff.

A. Safer Nursing Care Tool (SNCT)

1. Introduction

The AUKUH (Association of UK University Hospitals) staffing tool was formally launched at the CNO Summit on 1 November 2007. Further development work was then carried out by the NHS Institute and later, The Shelford Group. Following an extensive review of the tool, its definitions and multipliers, commissioned by the Shelford Group's Chief Nurses' Sub-Group, it was relaunched as The Safer Nursing Care Tool in mid 2013.

It can be seen there have been a number of organisations involved in this tool and a number of changes to it.

2. The Trust and the Safer Nursing Care Tool

The Trust has now used this tool on three occasions. The six monthly exercise requires staff on all wards to assess every patient's dependency (and categorising every patient into 1 of 5 care groups) over a twenty day period (Monday to Friday over four weeks). As the descriptions of each category are open to interpretation, it can be seen that it contains a professional judgement of which group every patient falls into. There therefore needs to be consistency of assessment.

3. Specialties the tool covers

It is worth noting that the originators of the tool indicate that this is an 'adult, generic' tool. It states that the tool is being further developed to better reflect the complexities of caring for older people in acute care wards. It stated in July 2013 that this latter version 'is almost ready for use', although this has not been published to date. It also states a tool is being developed for Accident and Emergency Departments.

4. Second Element of the Tool

As well as determining the level of acuity/dependency of all patients and calculating the nurse staffing required per ward based on the actual needs of those patients, the second element of the tool describes Nurse Sensitive Indicators (NSIs) such as infection rates, complaints, pressure ulcers and falls. It is recommended that these should be monitored to ensure that the staffing levels determined in Element 1 are enabling the delivery of expected patient outcomes.

Links between patient dependency, workload, staffing and quality have been established in recent years. Evidence in the literature links low staffing levels and skill mix ratios to adverse patient outcomes. Monitoring Nurse Sensitive Indicators is therefore recommended to ensure that staffing levels, deliver the patient outcomes that we aim to achieve. However, even with optimum staffing establishments poor patient outcomes may result due to other reasons such as high turnover, sickness, leave or unfilled vacancies.

The initial six monthly report did not include this element with the Board regularly receiving separate reports on quality data such as complaints, nursing care indicators, incidents, safety thermometer results, healthcare associated infections and patient and staff experience data. However, this paper attempts to cover this element by including some of the relevant data that is produced for the Trust's monthly 'Ward Performance Reports'. Some of that data consists of the Trust's own Nursing Care Indicators (NCIs), however, due to changes in some of the criteria of this system in September 2014 it is not possible to make historical comparisons on all criteria after this date. In addition, due to issues with the Datix system it is not possible to provide incident data by ward for November.

5. Overview of SNCT Data

There are some fixed parameters with the SNCT e.g. the times allocated to each patient category. With regards to the parameters that are within the power of the Trust, it has been decided to use an average 23% time out/headroom for annual leave etc (only one value for all staff can be used and the tool suppliers suggest between 22-25%) while the accompanying Ward Review (see Section B below) data used 23.2% for permanent RN staff and 22.46% for permanent unqualified staff. In addition, within the SNCT it was decided to use the same RN to unqualified split throughout (60:40 split RN to unqualified staff) unlike the Ward Review, which has used differing figures for each ward. The SNCT default 68:32 has not been used.

It also needs to be pointed out that the SNCT calculation does not take into consideration the national at least 1:8 RN/patient ratio directive for day shifts while this forms the basis of the RN calculations in the Ward Review. This therefore means that when comparing the two calculations (SNCT/Ward Review) only the total WTE should be looked at.

The tool also provides 'benchmarks' of the average percentage of each category of patient per speciality from the wards that took part in research on which the tool is based.

B. Ward Review

Matrons, the Director of Nursing and her Deputy discussed and debated the nurse requirements of each area, ensuring consistency with the recent national guideline of the at least 1:8 registered nurse to patient ratio for day shifts. This method therefore consists

of experienced nurses considering a range of issues associated with a ward, from its layout, the range of associated support staff such as ward clerks etc, the types of patient and their dependencies, skill mix within the team, the specialties of medical staff using the ward and such issues as the throughput and turnover of patients, any associated ward attenders etc. The system looked at the staffing and grade mix needs for each of the seven days of the week both for the day and night shifts for both RN and unqualified staff. The resultant figures went through a number of iterations, ensuring that there was consistency between similar wards etc. With expert help from the Finance Department this resulted in detailed data for each ward from which an establishment and associated cost was calculated. The whole process was validated by Mr S Davies, who was the Interim Turnaround Director at the time and checked by Price Waterhouse Cooper.

C. Data

Section 6 below contains the summaries of key data from both the two SNCT data collections and the Ward Review for each ward as well as the available Nurse Sensitive Indicators (NSIs), as described above.

In summary, with regards to the comparison between the ward review and SNCT figures, this needs to be interpreted with caution for the following reasons:

- For some of the wards there have been changes to the bed numbers and specialities
- It also needs to be remembered that the SNCT figures below do not take into account the workload associated with the numbers of admissions, discharges, transfers, escorts or deaths that occur on a ward and all of these activities take nursing time. Each ward will be different in this respect with some wards having a stable population of patients while others having possibly more than one person in a bed space during a twenty four hour period.
- In addition, the SNCT tool is based purely on the patient types and numbers in the 20 day study periods which do not include weekends.
- There are different percentages added in for relief/time-out/headroom
- Most importantly, the 1:8 RN/patient ratio for day shifts is not built into the SNCT.

6. SNCT and Comparative FTE Data

Ward A1

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med
1	60	76	40
2	5	0	10
3	34	24	48
4	1	0	1
5	0	0	2
Beds	14 +4flex	14+4 flex	
Av Pat	18	17	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	13.7	11.9	12.27
HCAs required/ratio	9.2	8.0	8.22
Total FTE required	**22.9**	**19.9**	**20.49**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	100	100	98
Pain Management	100	100	
Man Hand/Falls Assessment	100	98	93
Falls Assessment			100
Tissue Viability Assessment	100	100	100
Nutritional Assessment	95	93	94
Fluid Balance Management	85	93	88
Medication Assessment	99	100	100
Infection Control	88	100	
Think Glucose	100	100	
Documentation	95	93	
Bowels	100	100	
Incidents			
Minor Incidents	8	7	-
Moderate Incidents	0	0	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	1

Commentary: During the SNCT study periods there were Flex and EMU beds open but the Ward Review does not take these into consideration. The dependency of patients from February to September seems to have reduced. As there are 14 beds on the ward, decreasing day RN staff would result in a ratio of 1:14. Both the two SNCT studies and the ward review have had similar results. Occupancy remains high. NSI results are good.

Conclusion: No action required.

Ward A2

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med
1	17	20	32
2	0	0	2
3	83	80	66
4	0	0	0
5	0	0	0
Beds	42	42	
Av Pat	41.8	41.3	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	40.2	39.3	34.35
HCAs required/ratio	26.8	26.2	32.88
Total FTE required	**67.0**	**65.6**	**67.23**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	97	100	100
Pain Management	100	83	
Man Hand/Falls Assessment	100	95	100
Falls Assessment			97
Tissue Viability Assessment	89	97	100
Nutritional Assessment	100	100	100
Fluid Balance Management	98	100	95
Medication Assessment	100	98	100
Infection Control	100	92	
Think Glucose	100	100	
Documentation	93	91	
Bowels	**70**	100	
Incidents			
Minor Incidents	10	6	-
Moderate Incidents	1	1	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	0

Commentary: NSIs have been variable but show improvement. Both the two SNCT studies and the ward review have had similar results

Conclusion: No action required.

Ward A3

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Rehab
1	19	29	38
2	0	0	7
3	80	71	52
4	0	0	4
5	0	0	0
Beds	28	28	
Av Pat	27.9	28	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	26.6	25.5	18.58
HCAs required/ratio	17.7	17	21.92
Total FTE required	**44.4**	**42.6**	**40.50**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	98	96	96
Pain Management	100	100	
Man Hand/Falls Assessment	100	100	100
Falls Assessment			98
Tissue Viability Assessment	100	100	98
Nutritional Assessment	98	98	100
Fluid Balance Management	95	100	99
Medication Assessment	100	100	100
Infection Control	94	100	
Think Glucose	90	100	
Documentation	96	94	
Bowels	72	93	
Incidents			
Minor Incidents	12	5	-
Moderate Incidents	0	0	-
Major/Tragic Incidents	0	0	-
Complaints	0	2	0

Commentary: Occupancy remains high. Both the two SNCT studies and the ward review have had similar results. As the ward has 28 beds decreasing the day RN staff would result in a ratio of 1:9.3. NSIs are good and have improved.

Conclusion: No action required.

Ward A4

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Stroke
1	35	65	21
2	14	20	7
3	47	11	67
4	4	4	6
5	0	0	0
Beds	12	12	
Av Pat	11.2	11.8	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	9.7	8.5	10.2
HCAs required/ratio	6.4	5.6	5.48
Total FTE required	**16.1**	**14.1**	**15.68**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	90	98	96
Pain Management	95	100	
Man Hand/Falls Assessment	93	100	100
Falls Assessment			100
Tissue Viability Assessment	100	100	100
Nutritional Assessment	100	92	100
Fluid Balance Management	100	100	100
Medication Assessment	100	100	100
Infection Control	100	100	
Think Glucose	100	100	
Documentation	98	89	
Bowels	100	100	
Incidents			
Minor Incidents	0	2	-
Moderate Incidents	0	0	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	0

Commentary: Patient dependency has reduced. Occupancy remains high. NSIs have been variable but have improved. Both the two SNCT studies and the ward review have had similar results. As there are 12 beds on the ward, reducing day RN staff would result in a ratio of 1:12.

Conclusion: No action required.

Ward B1

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Surgery
1	81	79	62
2	18	3	15
3	0	18	22
4	0	0	1
5	0	0	0
Beds	26	26	
Av Pat	18	17	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	15.4	16.6	18.58
HCAs required/ratio	10.3	11.1	10.96
Total FTE required	**25.7**	**27.7**	**29.54**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	94	100	99
Pain Management	98	98	
Man Hand/Falls Assessment	68	86	75
Falls Assessment			100
Tissue Viability Assessment	88	98	93
Nutritional Assessment	26	96	97
Fluid Balance Management	90	93	86
Medication Assessment	100	86	82
Infection Control	88	98	
Think Glucose	100	100	
Documentation	97	94	
Bowels	50	89	
Incidents			
Minor Incidents	0	3	-
Moderate Incidents	0	0	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	0

Commentary: Dependency has increased while occupancy remains the same. NSIs have improved from January 2014. Both the two SNCT studies and the ward review have had similar results, although the Ward review has a slightly higher FTE which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges. With 26 beds, reducing day RN staff would result in a ratio of 1:8.7

Conclusion: No action required except there needs to be continued close monitoring of the NSIs.

Ward B2 Trauma

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Trauma
1	65	68	34
2	16	13	5
3	19	19	57
4	0	0	2
5	0	0	3
Beds	24	24	
Av Pat	23.2	23	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	16.8	16.4	17.79
HCAs required/ratio	11.2	11	13.7
Total FTE required	**27.9**	**27.4**	**31.49**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	95	97	96
Pain Management	100	100	
Man Hand/Falls Assessment	98	100	75
Falls Assessment			100
Tissue Viability Assessment	97	98	100
Nutritional Assessment	100	100	78
Fluid Balance Management	100	100	86
Medication Assessment	98	100	100
Infection Control	100	92	
Think Glucose	100	100	
Documentation	100	100	
Bowels	94	100	
Incidents			
Minor Incidents	9	6	-
Moderate Incidents	3	3	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	1

Commentary: Occupancy remains high and dependency remains the same. Incident numbers have improved. Both the two SNCT studies and the ward review have had similar results, although the Ward review has a slightly higher FTE which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges. NSI results are good although there has been some recent deterioration.

Conclusion: No action required except there needs to be continued close monitoring of the NSIs.

Ward B2 Hip

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Ortho
1	62	68	42
2	19	3	22
3	19	29	34
4	0	0	1
5	0	0	0
Beds	30	30	
Av Pat	28.4	28.7	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	20.6	21.1	18.58
HCAs required/ratio	13.8	14	19.18
Total FTE required	**34.4**	**35.1**	**37.76**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	98	92	98
Pain Management	98	100	
Man Hand/Falls Assessment	97	98	100
Falls Assessment			100
Tissue Viability Assessment	90	95	100
Nutritional Assessment	89	89	100
Fluid Balance Management	98	93	86
Medication Assessment	100	100	100
Infection Control	100	**74**	
Think Glucose	100	100	
Documentation	98	100	
Bowels	84	95	
Incidents			
Minor Incidents	9	6	-
Moderate Incidents	3	2	-
Major/Tragic Incidents	0	2	-
Complaints	0	6	0

Commentary: Dependency has increased and occupancy remains high. There was a relative high number of complaints in August and two incidents of high grade pressure ulcers. A review of the whole B2 ward has since taken place and a number of measures put in place to address issues identified, for example: the ward has now been formally fully split into two wards (B2 Hip and B2 Trauma) with two lead nurses and an increased number of staff approved. A second lead nurse has now been in post from 5th October 2014. An increased input and audit of the ward via the tissue viability team shows an improvement in pressure area care. Complaints are showing a downward trend since August. As there are 30 beds on the ward, decreasing the day RN staff would result in a ratio of 1:10. NSIs have improved in November.

Conclusion: No action required other than continue closely monitoring NSIs.

Ward B3

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Surgery
1	54*	43	62
2	12*	11	15
3	34*	46	22
4	0	0	1
5	0	0	0
Beds	28+10SAU	38+4HDU	
Av Pat	35	29.2	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	27.6	24.2	26.07
HCAs required/ratio	18.4	16.2	21.92
Total FTE required	**46.0**	**40.4**	**47.99**

*Not including SAU

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	94	96	96
Pain Management	100	95	
Man Hand/Falls Assessment	94	84	53
Falls Assessment			97
Tissue Viability Assessment	100	87	96
Nutritional Assessment	98	**72**	**77**
Fluid Balance Management	100	92	93
Medication Assessment	100	99	100
Infection Control	100	95	
Think Glucose	100	87	
Documentation	97	80	
Bowels	100	89	
Minor Incidents	4	5	-
Moderate Incidents	1	0	-
Major/Tragic Incidents	0	0	-
Complaints	0	1	0

Commentary: For the initial SNCT survey, B3 had 28 beds and SAU (10 beds) was based on B3 but treated separately during the study and so the SAU results have been added to the 28 bed results for a comparison with the new 38 bed ward. As there are now 42 (38 plus 4 HDU) beds on the ward, decreasing the RN staff during the day would result in a ratio of 1:9.5. Occupancy has fallen considerably. NSIs deteriorated from January and so the ward has been on escalation level 2 to address the amber and red scores.

Conclusion: The reduced bed occupancy suggests the need for a review of the ward's function. NSIs need to be continued to be closely monitored.

Ward B4

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Surgery
1	81	71	62
2	5	5	15
3	14	25	22
4	1	0	1
5	0	0	0
Beds	48	48	
Av Pat	45.1	43.1	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	30.4	30.9	32.38
HCAs required/ratio	20.3	20.6	27.40
Total FTE required	**50.7**	**51.6**	**59.78**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	97	92	99
Pain Management	100	98	
Man Hand/Falls Assessment	86	74	78
Falls Assessment			79
Tissue Viability Assessment	93	67	93
Nutritional Assessment	97	32	100
Fluid Balance Management	97	83	98
Medication Assessment	99	100	100
Infection Control	95	74	
Think Glucose	60	18	
Documentation	88	82	
Bowels	87	64	
Minor Incidents	5	7	-
Moderate Incidents	1	2	-
Major/Tragic Incidents	0	0	-
Complaints	1	1	0

Commentary: Dependency has increased. NSIs considerably deteriorated in August but have improved since. The two SNCT studies suggest smaller FTE than the ward review, which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges.

Conclusion: No action required except NSIs need to be continued to be closely monitored.

Ward B5

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Surgery
1	87	97	62
2	9	2	15
3	5	1	22
4	0	0	1
5	0	0	0
Beds	32	30+4GAU	
Av Pat	21.9	33.3	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	14.0 (23.2)	20.2	26.86
HCAs required/ratio	9.3 (15.4)	13.4	16.44
Total FTE required	**23.3** (**38.6**)	**33.6**	**43.30**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	100	100	98
Pain Management	100	100	
Man Hand/Falls Assessment	100	100	100
Falls Assessment			80
Tissue Viability Assessment	100	100	100
Nutritional Assessment	88	50	100
Fluid Balance Management	98	100	97
Medication Assessment	97	100	100
Infection Control	100	75	
Think Glucose	100	100	
Documentation	100	90	
Bowels	90	100	
Minor Incidents	5	1	-
Moderate Incidents	2	2	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	1

Commentary: There were 22 beds on B5 for the initial SNCT study but now there are 20 beds + SAU (10 beds) and Gynaecology Assessment Unit (GAU) (4 beds). The figures in brackets on the first study include the SNCT figures for SAU and GAU to assist with any comparison. As there are 30 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:10. Occupancy has increased with dependency slightly decreased. NSIs are variable, resulting in action plans at escalation level 2 in September with a return to green RAG rating by October 2014. The latest SNCT study suggests a smaller FTE than the ward review, which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges, which is a significant issue for this ward with the two assessment units.
Conclusion: No action required other than continue closely monitoring NSIs.

Ward B6

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % ENT
1	88	87	73
2	2	2	12
3	10	11	7
4	0	0	3
5	0	0	6
Beds	29	17	
Av Pat	28.2	16.4	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	18.3	10.7	13.06
HCAs required/ratio	12.2	7.1	8.22
Total FTE required	**30.4**	**17.8**	**21.28**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	94	100	100
Pain Management	100	100	
Man Hand/Falls Assessment	89	100	100
Falls Assessment			100
Tissue Viability Assessment	98	100	100
Nutritional Assessment	98	90	100
Fluid Balance Management	91	93	100
Medication Assessment	100	100	100
Infection Control	100	53	
Think Glucose	67	100	
Documentation	94	83	
Bowels	100	80	
Minor Incidents	9	1	-
Moderate Incidents	1	1	-
Major/Tragic Incidents	0	0	-
Complaints	1	1	0

Commentary: B6 had 29 beds during the first study but then lost 12 beds. Decreasing the day RN staff would reduce the ratio to 1:8.5. Dependency remains similar despite the change in number of beds. NSIs have shown considerable improvement since January 2014. The latest SNCT study suggests a smaller FTE than the ward review, which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges. NSIs are good and have improved considerably.

Conclusion: No action required.

Ward C1

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med
1	39	24	40
2	14	29	10
3	47	47	48
4	0	0	1
5	0	0	2
Beds	48	48	
Av Pat	47.9	47.9	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	40.3	42.0	31.59
HCAs required/ratio	26.9	28.0	32.88
Total FTE required	**67.2**	**70.0**	**64.47**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	92	94	91
Pain Management	92	100	
Man Hand/Falls Assessment	100	99	97
Falls Assessment			100
Tissue Viability Assessment	100	100	100
Nutritional Assessment	81	90	72
Fluid Balance Management	89	92	89
Medication Assessment	100	100	100
Infection Control	100	100	
Think Glucose	100	100	
Documentation	83	86	
Bowels	100	100	
Minor Incidents	8	5	-
Moderate Incidents	0	0	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	0

Commentary: As there are 48 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:9.6. Occupancy remains high with dependency increasing. NSIs have deteriorated and the ward is on stage 1 escalation. Both the two SNCT studies and the ward review have had similar results

Conclusion: No action required other than continue closely monitoring NSIs.

Ward C3A

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med Eld
1	12	23	32
2	7	0	2
3	81	77	66
4	0	0	0
5	0	0	0
Beds	52	24	
Av Pat	48.1	24	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	-	22.5	17.79
HCAs required/ratio	-	15	16.44
Total FTE required	**-**	**37.5**	**34.23**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	80	96	100
Pain Management	100	100	
Man Hand/Falls Assessment	86	100	100
Falls Assessment			100
Tissue Viability Assessment	92	100	100
Nutritional Assessment	97	94	100
Fluid Balance Management	100	98	100
Medication Assessment	100	100	100
Infection Control	100	100	
Think Glucose	100	100	
Documentation	94	95	
Bowels	100	100	
Minor Incidents	16	9	-
Moderate Incidents	0	5	-
Major/Tragic Incidents	0	0	-
Complaints	0	1	0

Commentary: At the initial SNCT study this ward had 52 beds and this was reduced to 24. The latest SNCT study and the ward review have had similar results. NSIs are good and improving.

Conclusion: No action required.

Ward C3B

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med Eld
1	12	30	32
2	7	0	2
3	81	70	66
4	0	0	0
5	0	0	0
Beds	52	28	
Av Pat	48.1	27.8	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio		25.2	18.58
HCAs required/ratio		16.8	21.92
Total FTE required		**42.0**	**40.50**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	80	96	100
Pain Management	100	100	
Man Hand/Falls Assessment	86	100	100
Falls Assessment			100
Tissue Viability Assessment	92	100	100
Nutritional Assessment	97	94	100
Fluid Balance Management	100	98	100
Medication Assessment	100	100	100
Infection Control	100	100	
Think Glucose	100	100	
Documentation	94	95	
Bowels	100	100	
Minor Incidents	16	9	-
Moderate Incidents	0	5	-
Major/Tragic Incidents	0	0	-
Complaints	0	1	0

Note: At the initial SNCT study this ward had 52 beds and so there is no useful WTE comparison from that time. As there are 28 beds on ward C3B, decreasing the day RN staff would reduce the ratio to 1:9.3. Dependency has improved. NSIs have improved. The latest SNCT study and the ward review have had similar results. NSIs are good and improving.

Conclusion: No action required.

Ward C5

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med
1	53	53	40
2	12	3	10
3	27	36	48
4	8	8	1
5	0	0	2
Beds	48	48	
Av Pat	47.7	47.4	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	37.9	38.5	31.59
HCAs required/ratio	25.3	25.7	32.88
Total FTE required	**63.1**	**64.2**	**64.47**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	96	100	97
Pain Management	81	98	
Man Hand/Falls Assessment	86	77	100
Falls Assessment			100
Tissue Viability Assessment	78	90	100
Nutritional Assessment	74	96	100
Fluid Balance Management	98	97	100
Medication Assessment	100	99	100
Infection Control	97	88	
Think Glucose	22	79	
Documentation	91	95	
Bowels	100	95	
Minor Incidents	10	3	-
Moderate Incidents	2	2	-
Major/Tragic Incidents	0	0	-
Complaints	0	1	2

Commentary: Occupancy remains high and dependency has increased. NSIs have improved considerably. Both the two SNCT studies and the ward review have had similar results.

Conclusion: No action required.

Ward C6

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Surgery
1	89	88	62
2	4	2	15
3	7	10	22
4	0	0	1
5	0	0	0
Beds	20	20	
Av Pat	19.1	17.2	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	12.2	11.1	15.82
HCAs required/ratio	8.1	7.4	10.96
Total FTE required	**20.3**	**18.5**	**26.78**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	92	100	89
Pain Management	96	100	
Man Hand/Falls Assessment	100	100	61
Falls Assessment			100
Tissue Viability Assessment	100	100	100
Nutritional Assessment	100	98	75
Fluid Balance Management	100	100	100
Medication Assessment	89	100	90
Infection Control	94	100	
Think Glucose	100	100	
Documentation	84	92	
Bowels	98	100	
Minor Incidents	6	4	-
Moderate Incidents	0	0	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	0

Commentary: Dependency remains similar with a slight drop in occupancy. With 20 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:10. Dependency remains similar with a slight drop in occupancy. NSIs have deteriorated and the ward is on escalation stage 2. The ward review has a slightly higher FTE which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges.

Conclusion: No action required other than continue closely monitoring NSIs.

Ward C7

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med
1	68	64	40
2	2	1	10
3	30	35	48
4	0	0	1
5	0	0	2
Beds	36	36	
Av Pat	35.7	35	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	26.2	26.5	26.86
HCAs required/ratio	17.5	17.7	21.92
Total FTE required	**43.7**	**44.1**	**48.78**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	94	97	89
Pain Management	100	98	
Man Hand/Falls Assessment	87	89	61
Falls Assessment			100
Tissue Viability Assessment	98	100	100
Nutritional Assessment	56	94	75
Fluid Balance Management	75	89	100
Medication Assessment	99	98	90
Infection Control	100	100	
Think Glucose	28	31	
Documentation	79	87	
Bowels	90	100	
Minor Incidents	10	7	-
Moderate Incidents	3	2	-
Major/Tragic Incidents	0	1	-
Complaints	0	0	0

Commentary: Occupancy remains high and dependency has increased slightly. NSIs remain variable and have deteriorated recently since August and so the ward is o escalation stage 1. As there are 36 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:9. FTEs from the SNCT and the ward review are similar.

Conclusion: No action required other than continue closely monitoring NSIs.

Ward C8

	Feb 14	Sep 14	
Patient Level	% of patients	% of patients	Benchmark % Med
1	69	83	40
2	2	2	10
3	29	15	48
4	0	0	1
5	0	0	2
Beds	36+4 flex	36+4flex	
Av Pat	40.1	39.4	
Required Staff	SNCT	SNCT	Ward Review
RNs required/ratio	36.7	33.4	39.87
HCAs required/ratio	24.5	22.2	27.4
Total FTE required	**61.1**	**55.6**	**67.27**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Nov 14
Nursing Care Indicators			
Staffing Levels	100	100	
Patient Observations	98	96	100
Pain Management	100	90	
Man Hand/Falls Assessment	100	92	50
Falls Assessment			100
Tissue Viability Assessment	100	82	100
Nutritional Assessment	100	97	100
Fluid Balance Management	93	79	94
Medication Assessment	100	99	96
Infection Control	100	94	
Think Glucose	100	100	
Documentation	100	95	
Bowels	98	55	
Minor Incidents	8	4	-
Moderate Incidents	0	1	-
Major/Tragic Incidents	0	0	-
Complaints	0	0	0

Commentary: C8 works as an extension to the Emergency and EAU Departments, having to assess and discharge patients quickly, so, as with the surgical assessment units and wards, the fact that the ward review has a higher FTE than the SNCT studies is probably due to the SNCT not taking into consideration the workload that comes from high numbers/turnover of admissions and discharges. Occupancy remains high with the use of the flex beds. Dependency has improved slightly. NSIs have deteriorated and a documentation review is being undertaken to ensure that the standards within the Nursing Care Indicators are achievable in this acute area. The ward is on escalation stage 1 for the NCIs.

Conclusion: No action required other than continue closely monitoring NSIs.

7. Conclusion

It can be seen that even with the difficulties in comparing different methods of formulating how many staff are required on a ward that not too dissimilar results occur. From the analysis that can be undertaken on both the results of the establishment calculations and on the Nursing Sensitive Indicators, it would seem that the situation as it stands is reasonable across all areas, although some areas for action have been noted. While the present establishments seem to conform with the requirements of an 'objective' measure, it is still necessary to monitor what occurs on a day to day basis with such variables as staff sickness and vacancies affecting the staff available. The latest results of this monitoring for November follows in Part 2 below.

With regards to the quality indicators, this is the first time they have been made available in this report. As already stated due to changes in some of the criteria of the NCIs in September it has not been possible to make historical comparisons on all criteria after this date. Prior to the next six monthly report an attempt will be made to find alternative quality measures that can be used. It also needs to be noted that due to the changes in ward specialities and bed numbers that occurred in October and any future similar changes will also make it difficult to make clear historical staffing comparisons in the future.

PART 2 Monthly Nurse/Midwife Staffing Position

November 2014

One of the requirements set out in the National Quality Board Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information.

The paper endeavours to give the Board a view of the frequency when Registered Nurse to patient ratios do not meet the recommended ratio on general wards of 1:8 on day shifts and also the number of occurrences when staffing levels have fallen below the optimum levels for both registered and unregistered staff. It should be noted that these occurrences will not necessarily have a negative impact on patient care

In line with the recently published NICE (2014) guideline on safe staffing:

1) An establishment (an allocated number of registered and care support workers) is calculated for each ward based on a combination of the results of the six monthly Safer Nursing Care Tool exercise and senior nurse professional judgement both based on the number and types of patients on that ward (with the Board receiving a six monthly paper on this). The establishment forms a planned number of registered and care support workers each shift.
2) Each six weeks the Lead Nurse draws up a duty rota aimed at achieving those planned numbers.
3) Each shift the nurse in charge assesses if the staff available meet the patients' nursing needs.

Following the shift, the nurse in charge completes a monthly form indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed for the patients on that day. Each month the completed form for every ward is sent to the Nursing Directorate where they are analysed and the attached chart compiled.

It can be seen from the chart that the staffing available met the patients' nursing needs in the majority of cases (green squares). In a number of instances, despite attempts through the use of deployment of staff or the use of bank/agency staff, the number of planned staff for the patients on that shift were not reached.

When there is an unregistered staff shortfall the shift is marked in blue and when there is a registered staff shortfall this is marked in amber. If the shift is reported as unsafe, this will be marked as red. In all instances of shortfalls, the planned and actual numbers are indicated.

The number of shifts identified as amber or blue has decreased for November to 38 from the October figure of 53 (there were 33 in September). There have been no incidents of any shifts assessed as red and unsafe.

When shortfalls in the 1:8 RN to patient ratio for day shifts on general wards or when shifts have been identified as below optimum; the reasons for the gaps and the actions being taken to address these in the future are outlined below.

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

Nice (2014) Safe Staffing for nursing in adult in-patient wards in acute hospitals (London: July 2014)

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS NOVEMBER 2014

WARD	No.	RN/ Unreg	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	2 1	RN Unreg	Vacancy	Escalated to Matron, out to bank and agency – both unable to fill. Unqualified staff found to fill the registered nurse shifts which were both at night and day staff remained to assist to 22.00 and 23.00. When there was an Unregistered nurse short on days, lead nurse worked clinically to assist.
A2	3 1	RN Unreg	Vacancy	Requested staff from bank and agency but both unable to fill. For the RN shortfalls, assistance occurred from an unqualified staff assisted on one occasion, on another the night site co-ordinator and adjacent ward staff assisted and on the third the nurse in On the Unreg shortfall occasion, assistance was given by the adjacent ward and the site co-ordinator.
A3	1	RN	Short term sickness	Unfilled by bank and agency and the workload redistributed the workload more effectively.
B1	6	RN	Vacancy and sickness	Unfilled by bank. On two occasions new international nurses in attendance, on one occasion the ward took minor patients only and for the other three shifts work was prioritised more effectively.
B4	8	RN	Maternity Leave Short term sickness Vacancy	Unfilled by bank and agency. On one occasion at night two Unreg staff assisted and on the seven day shifts the ratio was 1:9 patients and the workload was redistributed more effectively.
B6	1	RN	Vacancy	Shift filled by bank nurse who was taken poorly on arrival. The ward was closed to admissions.
C1	3	RN	Short term sickness	Unfilled by bank and agency and the workload redistributed the workload more effectively.
C5	1	RN	Sickness	Unfilled by bank and agency. Patient dependency assessed and was such that no action required.
C6	3	RN	Vacancy	Unfilled by bank and agency. Patient dependency assessed and was such that no action required.
C7	3 2	RN Unreg	Short term sickness Vacancy Additional support required	Bank unable to fill shifts. On one RN shortfall occasion two newly qualified supernumerary staff available and on the other two patient needs assessed and safety maintained. The two Unreg shortfall shifts were due to additional support being required but not available but safety maintained.
Maternity	3	RM	Unanticipated absence High maternity leave Sickness	Bank unable to fill. Escalation process enacted. Staff redeployed to area of need. Elective work delayed after risk assessment. On one occasion, community midwives and on-call Supervisor of Midwives assisted.

Nov-14

SHIFT

WARD	STAFF	1 D	1 N	2 D	2 N	3 D	3 N	4 D	4 N	5 D	5 N	6 D	6 N	7 D	7 N	8 D	8 N	9 D	9 N	10 D	10 N	11 D	11 N	12 D	12 N	13 D	13 N	14 D	14 N	15 D	15 N	16 D	16 N	17 D	17 N	18 D	18 N	19 D	19 N	20 D	20 N	21 D	21 N	22 D	22 N	23 D	23 N	24 D	24 N	25 D	25 N	26 D	26 N	27 D	27 N	28 D	28 N	29 D	29 N	30 D	30 N	31 D	31 N
WARD A1	Reg		2/1		2/1																																																										
	Unreg	4/3																																																											
WARD A2	Reg		5/3		4/2																																																	6/5									
	Unreg				4/2																																																										
WARD A3	Reg																																																									4/3					
	Unreg																																																													
WARD A4	Reg																																																													
	Unreg																																																													
WARD B1	Reg					4/2																		4/3				4/3						4/3												4/2										4/3							
	Unreg																																																													
WARD B2 HIP	Reg																																																														
	Unreg																																																													
WARD B2 TRAUMA	Reg																																																														
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WARD B3	Reg																																																														
	Unreg																																																													
WARD B4	Reg	6/5		6/5											5/3											6/5						6/5		6/5				6/5																						6/5			
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WARD B5	Reg																																																														
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WARD B6	Reg																																																			2/1										
	Unreg																																																													
WARD C1	Reg																															6/5												6/5													4/3						
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WARD C2***	Reg																																																														
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	Unreg																																																					6/5	5/4								
WARD C8	Reg																																																														
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CCU	Reg																																																														
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PCCU	Reg																																																														
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EAU	Reg																																																														
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MHDU	Reg																																																														
	Unreg																																																													
CRITICAL CARE*	Reg																																																														
	Unreg																																																													
NEONATAL**	Reg																																																														
MATERNITY ****	Reg																				15/11		15/11																																	15/10							
	Unreg																																																													

Key — Unsafe staffing (red) — Registered nurse shortfal (amber) — Care Support Worker short (blue)

* Critical Care has 6 ITU beds and 8 HDU beds

** Neonatal Unit has 3 ITU cots, 2 HDU cots and 18 Special care cots. Ratios reflect BAPM guidance and include a single figure for registered and non registered stat

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

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

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors Meeting on Thursday 8th January 2015

TITLE:	Moving Patients Out of Hours		
AUTHOR:	Karen Hanson Divisional Manager – Patient Flow	**PRESENTER**	Jon Scott Chief Operating Advisor
CORPORATE OBJECTIVE: SG01, SG02, SG06			
SUMMARY OF KEY ISSUES: This is a briefing paper providing information and subsequently assurance as to the progress made around patient flow and the management of patient moves out of hours.			

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details:**
	NHSLA	**Y/N**	**Details:**
	Monitor	**Y/N**	**Details:**
	Equality Assured	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE COMMITTEE:

This a briefing paper to provide assurance that processes are being adhered too and that there is a performance management structure in place.

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 Dudley Group NHS
NHS Foundation Trust

Report to: - Board of Directors – January 2015

Report Title: - Moving Patients Out of Hours

Report Author: - Jon Scott – Chief Operating Advisor

Date: - 2nd January 2015

Introduction

Further to the briefing paper in November 2014, this information is an update to provide assurance to the Board that the Trust has taken steps to minimise unnecessary/avoidable moves as part of improving patient experience.

The issue of moving patients out of hours is taken very seriously. To support the management of the overall process a new system of reporting has been developed with the aim of allowing for daily action to be taken to avoid or investigate out of hours movements. It is therefore suggested that the need for a clinical audit has been superseded and that the Board support the suggested alternative management approach as identified within this paper.

Background

The original request for the briefing paper came from Board following a letter from Sir Bruce Keogh on the matter. It was noted at the time that there are instances where it is clinically or operationally appropriate to transfer patients between clinical areas out of hours. However the Board of Directors requested assurance that the hospital processes employed are appropriate. It was requested that an audit be undertaken to review the processes and provide assurance.

Exclusions to the Moves

Areas which are agreed to be excluded from reporting as 'out of hours' moves are:

- Assessment units within medicine and surgery
- Ambulatory Emergency Care unit
- Maternity Unit.

The Dudley Group NHS
NHS Foundation Trust

Improvement to Patient Flow

As discussed in the November briefing paper to the Trust Board a number of actions have been undertaken since June 2014, as follows:

- A daily increase in the use of the Discharge Lounge which supports early discharge and increased capacity out of hours.
- A clinically led 'bed manager' team for Medicine has been implemented which includes the Medical Matron of the Day, a Directorate and Senior Manager who work alongside the Clinical Site Co-ordinator to maintain an emphasis on flow. The Matron specifically works with the medical wards, in the challenge around discharge and use of the lounge. The Matron works closely with the Head of Nursing for Medicine in terms of practice and flow and issues are identified as appropriate.
- Twice daily meeting with the medical Lead Nurses to "check and challenge" the reports of definite discharges, potential discharges and the use of the Discharge Lounge.
- The "Home for Lunch" action plan was reinvigorated and has been successfully piloted on C5.
- From December to March additional transport arrangements have been put in place from the Red Cross which is aimed at supporting the Emergency Department, Clinical Decisions Unit, Emergency Assessment Unit and Discharge Lounge.
- Twice daily board meetings with Emergency Assessment Unit (EAU). These meetings are at 14:30 and 21.00 to ensure that the unit is aware of bed availability and that there are actions in place for early transfer.
- The 18:00 daily capacity meeting ensures that an evening action plan is in place.

Patient Moves

A clinical audit request has been submitted to undertake a case by case review of those moves highlighted by Datix and the Information report. The Clinical Audit team have received a request for this audit, to date this remains outstanding. However, actions have been taken to ensure that there is greater visibility on a daily basis to manage this which should supersede the need for clinical audit intervention.

In December an automated report was implemented that is generated by the Clinical Site Co-ordinators who identify all moves and input the reasons why. This report is produced daily for the Heads of Nursing for Medicine and Surgery and used in daily capacity meetings and regular formal performance meetings. There is a daily performance meeting for validation of performance.

Since its implementation was planned it is suggested that the outstanding clinical audit of out of hours moves is now superfluous to requirements.

Table 1: provides a snapshot for week commencing 20.12.14 to 26.12.14.

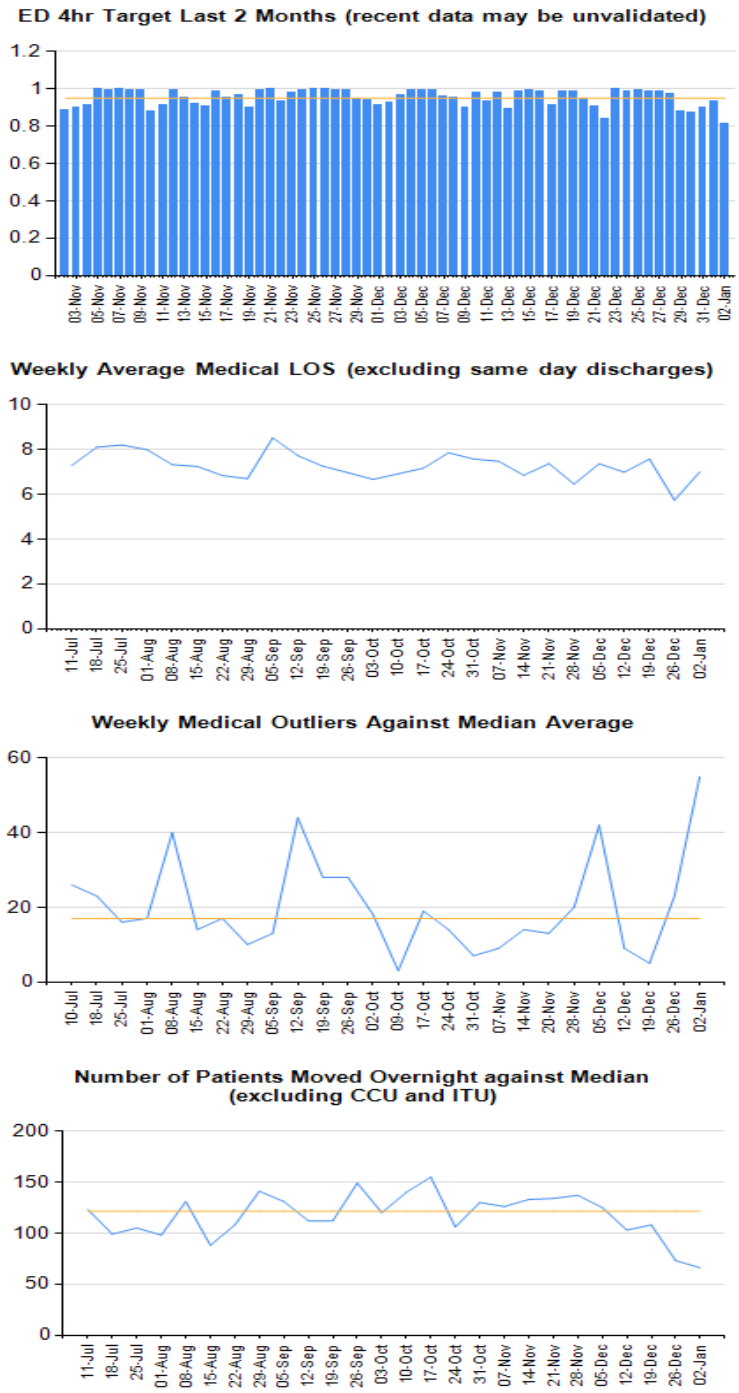
Table 1:

DATE	HOUR MOVED	WARD FROM	WARD TO	AGE	NHS NUMBER	Total
20.12.14	6	Maternity Unit (Moms)	Maternity Delivery Suite (Moms)	31	6062283788	
	1	Surgical Assessment Unit	Emergency Assessment Unit	44	6105019041	
	4	Midwifery Led Unit (Moms)	Maternity Delivery Suite (Moms)	21	6103966558	3
21.12.14	3	Maternity Unit (Moms)	Maternity Delivery Suite (Moms)	25	6103743907	
	1	Emergency Assessment Unit	POST CCU	89	4886117392	
	4	Emergency Assessment Unit	West A4 - Acute Stroke Unit	58	4487699932	3
22.12.14	0	Emergency Assessment Unit	EAST A2 - AMU	96	4902662450	
	3	Emergency Assessment Unit	CCU	76	4749267422	2
23.12.14	3	Surgical Assessment Unit	West B4	47	6069218205	
	1	Maternity Unit (Moms)	Maternity Delivery Suite (Moms)	30	6062900884	
	0	Maternity Triage (Moms)	Maternity Delivery Suite (Moms)	33	6062810826	
	4	Emergency Assessment Unit	POST CCU	85	4903856097	4
24.12.14	2	Emergency Assessment Unit	East C1	92	4902796678	1
25.12.14	0	0	0	0	0	0
26.12.14	0	0	0	0	0	0

Performance Management

As discussed in the November briefing paper a performance dashboard was being developed for discussion at the weekly operations meeting, chaired by the Chief Operating Advisor and attended by the Divisional Directors and Deputy Directors of Operations (Diagram 1).

Diagram 1: Performance Dashboard



Recommendations

The Board of Directors is asked to note the content of this report and the continuing improvement in the management of patient flow and the minimising of moves out of hours.

The Board of Directors are also asked to support the use of the automated daily report and exception reports at the performance meetings as the agreed method of managing this important issue.

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors – 9th December 2014

TITLE:	Quarterly Complaints report – Q2, July to September 2014		
AUTHOR:	Maria Smith (Complaints & litigation manager)	**PRESENTER:**	Julie Cotterill Associate Director of Governance/Board Secretary

CORPORATE OBJECTIVE: SG02 - To provide the best possible patient experience

SUMMARY OF KEY ISSUES:

Complaints report for quarter ending 30 September 2014:

- **46%** more complaints were received than during the previous quarter ending 31 March 2014
- **100%** of complaints received were acknowledged within 3 working days
- **50%** of complaints received and closed during the quarter were answered within 30 working days
- **57%** of complaints received and closed during the quarter were upheld/partially upheld.
- **6 (6%)** of complainants expressed dissatisfaction with their response
- **23** meetings were held with complainants during the quarter
- **0** rule 28 (formerly rule 43) reports on 'Action to Prevent Future Deaths' were received from the Senior/Assistant Coroner
- **1 inquest conclusion-** held that the deceased had died from 'accident as a result of neglect'

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** **Outcome 01: Respecting and involving people who use our services** **Outcome 17: Complaints**
	NHSLA	**Y**	**Details: Standard 2 – concerns and complaints and claims management**
	Monitor	**N**	**Details:**
	Equality Assured	**Y**	**Details: Better health outcomes** **Improved patient access and experience**
	Other **Ombudsman**	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309** **3 complaints accepted for investigation by Ombudsman during the quarter**

ACTION REQUIRED OF THE BOARD:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS:

To receive the complaint manager's quarterly report and note the increase in complaints received (46% more than during the previous quarter).

Key Facts – complaints & inquests

Key facts	Qtr 4 ending 31 March 2014	Year ending 31 Mar 2014	Qtr 1 ending 30 June 2014	Qtr 2 ending 30 Sept 2014
Total number of complaints received -	**72** 7 - high 43 - mod 22 - low	**330** 17 - high 190 - mod 123 - low	**63** 2 - high 34 - mod 27 - low	**92** 4 - high 58 - mod 30 - low
% Complaints acknowledged within 3 working days	100%	99%	100%	100%
% Complaints received during qtr and answered within 30 working days	46%	46% (data coll comm'd in 4th qtr)	80%	50%
Number of upheld/partially upheld complaints received & closed during quarter	**64 (60%)**	**252 (66%)**	**20 (50%)**	**33 (36%)**
Complaints accepted for investigation by Ombudsman	2	5 (2 upheld and compensation paid)	3	3
Privacy/dignity included as a concern in complaint	1	2	1	1
Complaints referring to shared accommodation	0	0	0	0
Number of meetings held with complainants	20	87 (26% of complaints rec'd)	14	23
Total number of dissatisfied complaints received	14	51 (15% of complaints rec'd)	5	6
Total CCG/CSU led complaints received in the qtr	1	6	2	2
New Coroner's cases opened during quarter	3	25	2	3
Coroner's Inquests held/closed during quarter	6	13	5	7
Coroner's Rule 28 (was rule 43) received in quarter	0	0	1	0
Complaints received where safeguarding concern raised	1	0	0	1
Compliments and thanks received (incl on-line feedback)	**1129**	**2108**	**1746**	**1764**

Complaints by category

Category	Qtr 4 ending 31/03/14	Year ending 31/03/14	Qtr 1 Ending 30/06/14	Qtr 2 Ending 30/9/14
Clinical Care (Assessment/Monitoring)	*22 (31%)*	*93 (28%)*	*30 (47%)*	*34 (37%)*
Diagnosis & Tests	*19 (26%)*	*76 (23%)*	*3 (4%)*	*25 (27%)*
Records, Communication & Information	*13 (18%)*	*53 (16%)*	*7 (11%)*	*3 (3%)*
Appointments, discharge & Transfers	*8 (11%)*	*53 (16%)*	*8 (13%)*	*9 (10%)*
Staff attitude, (previously included in Records, communication & information)	-	-	*3 (4%)*	*8 (9%)*
Obstetrics	*2 (3%)*	*17 (5%)*	*3 (4%)*	*3 (3%)*
Nursing care (District Nurses)	*0*	*0*	*2 (3%)*	*0*
Medication	*2 (3%)*	*15 (4%)*	*1 (2%)*	*5 (6%)*
Patient Falls, Injuries or Accidents	*2 (3%)*	*15 (4%)*	*0*	*1 (1%)*
Equipment	*2 (3%)*	*5 (1%)*	*1 (2%)*	*1 (1%)*
Safeguarding	*1 (1%)*	*1 (1%)*	*0*	*1 (1%)*
Theatres	*0*	*1 (1%)*	*1 (2%)*	*0*
Privacy & dignity	*0*		*1 (2%)*	*1 (1%)*
Pressure Sore	*1 (1%)*	*1 (1%)*	*1 (2%)*	*1 (1%)*
Violence, aggression	*0*		*1 (2%)*	*0*
Other (security)	*0*		*1 (2%)*	*0*
Total:	***72*** *(100%)*	***330*** *(100%)*	***63*** *(100%)*	***92*** ***(100%)***

Complaints by team responsible

The chart below displays the number of complaints received during the quarter by ward or department.

Where a number of complaints have been received for one ward or department, the issues raised are summarised below.

Emergency Department (10 complaints)

- Delays seeing a doctor
- Regular medication not given
- CT scan not performed
- Dislocated shoulder injury not diagnosed
- Fracture(s) not diagnosed
- Failure to diagnose condition
- Inappropriate discharge

Ward B2

- Concerns relating to care and treatment received (included in three complaints)
- Delays in being seen by a doctor
- Claimed patient's belongings given to another patient (not upheld)
- Questioned number of clips used during surgery
- Delay in answering nurse call buzzer
- Questions relating to discharge

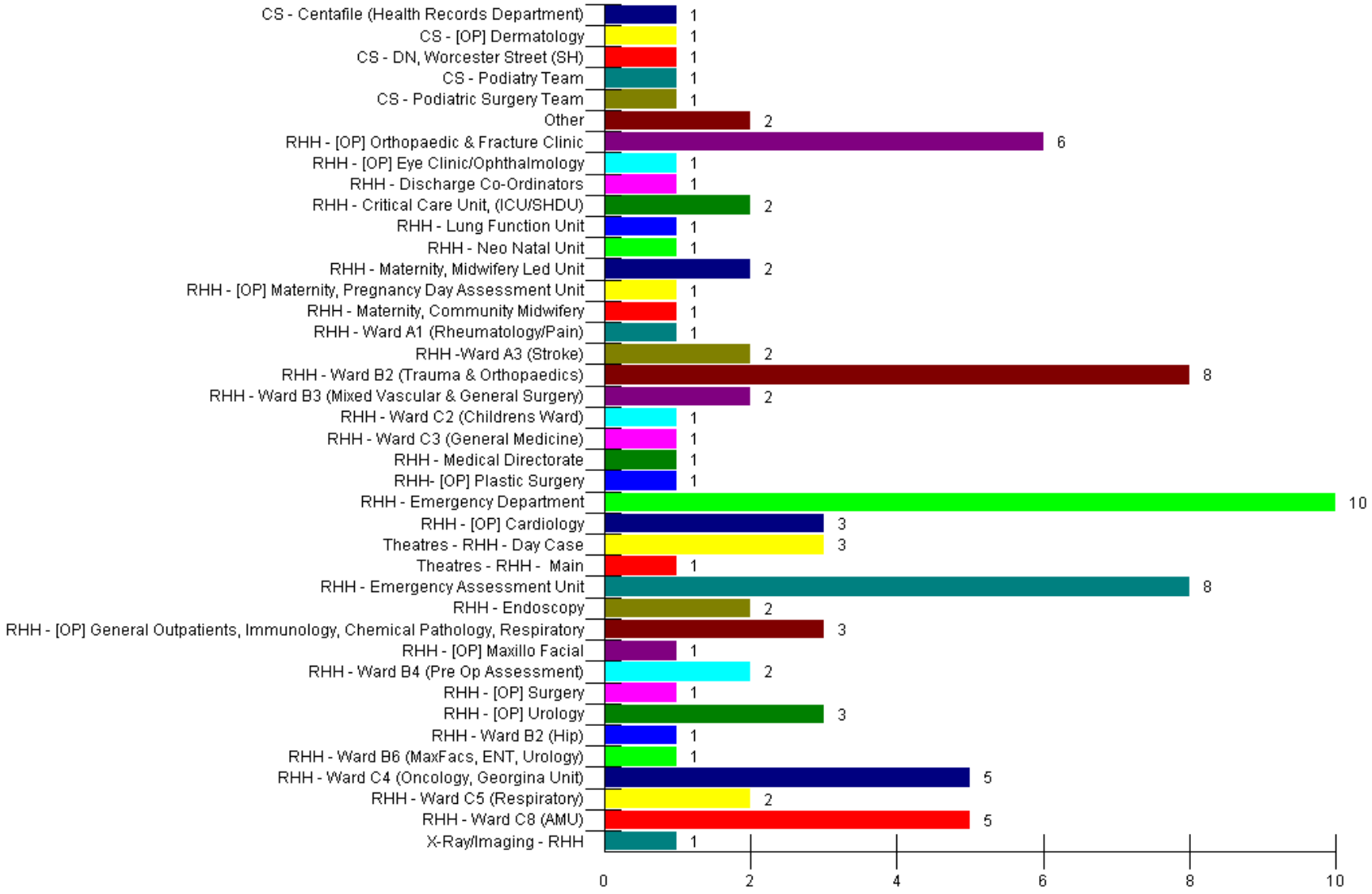
EAU

- Questions investigations undertaken prior to relative's death
- Relative felt incorrect treatment was given for symptoms displayed
- Number of complaints related to care and treatment provided in the department
- Complainant suggested stroke diagnosis was missed
- Suggested diagnosis was delayed
- Patient prone to fainting attacks was left alone and sustained a fall, hitting face
- Relative told investigations for overdose were ongoing but suggested was not given any information

Orthopaedic OPD & Fracture clinic

- Complaint about attitude of staff
- Questioned why condition unresolved despite surgery
- Complained that treatment for fracture was inappropriate
- Unhappy with lack of treatment
- Concerns raised regarding care and treatment
- Complained that fracture was not diagnosed
- Unhappy with treatment provided

Complaints by Team Responsible 1 July to 30 Sept 2014



Percentage of complaints against activity

ACTIVITY	Total Qtr 2 ending 30/09/13	Total Qtr 3 ending 31/12/13	Total Qtr 4 ending 31/03/14	Total Year ending 31/3/2014	Total Qtr 1 ending 30/06/14	Total Qtr 2 ending 30/09/14
Total patient activity	181,539	186,084	181,503	734,239	181,132	187,117
% Complaints against activity	0.04%	0.04%	0.04%	0.04%	0.03%	0.05%

Senior Coroner – Accident as a result of neglect - conclusion

Although seven inquests were held during the quarter, the senior coroner raised no concerns about treatment provided to the deceased prior to death in six of the inquests.

However there was one inquest where the senior coroner concluded the patient had died as a 'result of an accident due to neglect'. This related to a failure to arrange a scan or ask the GP to arrange a scan for a patient who attended with history of rectal bleeding, back pain and diarrhoea. Although a doctor queried the possibility of performing an ultrasound examination, this was not performed and the patient was discharged to the care of the GP; the discharge letter did not suggest an ultrasound scan should be performed, nor was one arranged for the patient.

The patient collapsed some days later and despite surgery became unstable post operatively and needed further surgery but sadly died.

Review of Actions taken
Appropriate action was taken with the member of staff concerned.

Complaint themes for quarter ending 30 September 2014

Since November 2013, complaint numbers each month have remained consistently low but in August and September 2014 there was a big increase, which is difficult to explain, as no themes were noted in the complaint letters.

Complaints continue to be complex, requiring extensive investigations; complainants are always offered a meeting to discuss their concerns with senior staff involved in their care. This quarter has seen an increase too, in the number of meetings held and in some cases, a second meeting is also offered.

‘High’ risk categories

Three of the four complaints received during the quarter and assessed as ‘high risk’ upon receipt are still open and investigations are ongoing.

One of the high risk categorised complaints received during the quarter has been investigated and closed. This related to a breach of patient confidentiality where the machinery used for folding and placing letters in an envelope failed and some patients received letters addressed to other patients. Incorrectly mailed letters were identified and new letters sent to correct recipients.

Action taken
Regular checks of the folding/envelope machine are now undertaken and staff have been asked to undertake audits on outgoing post.

Ombudsman reports

The summary shown at the beginning of this report confirms that the Parliamentary and Health Service Ombudsman accepted three complaints for further investigation. These investigations are ongoing and a final report is awaited for these three cases.

The following two Ombudsman cases were investigated and a final report was received for each investigation during this quarter.

Complaint number 1828

Communication of death. Explanation and apology offered. RIP.

19/08/14: Final report issued by the Ombudsman. **Decision:** HSO found failings in the actions of the Trust and evidence that relevant guidance was not followed - **Upheld**

Recommendations: (a) The Trust reviews the policy on certifying the death of patients to include the steps that need to be taken and recorded to certify death and the way in which this is communicated to relatives. (b) The Trust should review complaints handling procedures to ensure responses are clear, accurately reflect the events that took place and openly and honestly accept where things could have been handled better. (c) The Trust reviews policy on actions taken when patients are clearly approaching the end of their life to ensure GMC guidance is followed.

All actions completed.

Out of time complaint number 1987

Patient complained that comments and actions taken by a consultant 14 years earlier had caused her distress and anxiety. Several offers of a meeting were made but all were refused.

04/08/14: Final report issued by the Ombudsman

Decision: Trust responded reasonably to the complaint. Nothing else the Trust could have done to resolve things at this stage. **Not upheld.**

Examples of the Action taken as a result of complaints

Patient Access Division

- Failure to return telephone calls was investigated by the manager, who discussed this concern with the staff involved. An apology was given for the mixed messages receiving regarding the availability of a wheelchair and for any confusion caused.

Emergency Medicine

- Nutrition needs to be discussed during staff meetings and via the huddle boards to ensure nutrition needs are met.
- Nursing staff asked to respond to nurse call buzzer in a timely manner
- Additional substantive staff recruited to minimise requirement for agency staff.
- Need for accurate record keeping and good communication reinforced with staff.
- Lead nurse to work a late shift every week to speak to relatives/patients to ask if they have any concerns they would like to discuss with her.
- Staff reminded of the importance of providing the correct information to patients and relatives regarding their ongoing care, including discharge arrangements.

Orthopaedic and Speciality surgery

- Apology offered to a patient, who was misinformed about the availability of results and a further review appointment was arranged to discuss these.

Surgery, Urology and Vascular

- New system in place during night shift, with two 'floating' clinical workers now available to offer assistance with discharge arrangements
- The testicular torsion pathway is to be revised to ensure prompt escalation and appropriate management of cases. The pathway to be published on the Trust intranet site (hub). Junior doctors to be educated on the pathway during induction to ensure they know where to access this on the hub. Compliance with the pathway is to be audited and non-compliance will be addressed
- A business case to increase urology medical staffing establishment was approved and an additional consultant, registrar grade and SHO grade doctors were appointed.

Diagnostics

- All staff working in imaging briefed regarding the need to ensure doors and locks to the scanning rooms are properly secured. Additional notices have been placed on doors and radiation levels in the waiting area immediately checked (ongoing standard checks are already in place).
- Patients to be advised of the nearest toilets if department toilet is 'out of order'.

Acute Medicine

- Deputy matron recruited to older people's mental health team to implement and train new patient support team.

- There is now a medicines management link nurse for each ward, who attends regular meetings/training sessions with pharmacy leads. Training and information to be disseminated to all trained staff.

- An RCA to be completed for all missed doses of medication. Gaps in training/education for staff to be managed on an individual basis.

- Nurse care indicator audits will include a regular review of Datix incident reports and any actions required to be escalated through Trust escalation policies in areas associated with any medicine management performance concerns.

- Huddle boards to be used to reinforce messages on a daily basis.

- A fluid bundle audit to be completed monthly, with areas of poor performance to be escalated through Trust audit escalation process.

- Lead nurse/shift lead will meet and greet all new patients/families within 24 hours of admission to the ward and to be asked to complete a 'time the time out' questionnaire to establish patients' likes and dislikes, eg food and drink choices, bed time/sleep routines, etc.

- Extra training for ward staff re importance of nutrition in the elderly and supportive action to aid nutrition and escalate concerns regarding poor intake.

- 'You said we did' action plans to be developed following patient experience questionnaire results.

Catering department

- Improvement in quality of cooked meals and increased number of choices at each main meal, to include more soft and traditional food.

- Fruit provided at and in between meals.

- Improvement in nutritional quality of soup.

- Improvement in quality of bread used.

Ambulatory and Community care

1. A number of band 6 nursing staff have visited Mary Stevens Hospice to discuss care for the terminal patient. More nursing staff will go in November, as staff rotas permit. This will be rolled out to other wards, including elderly care wards.

In addition, a number of individual staff members were reminded of the importance of communication and/ or asked to reflect on care/treatment provided.

Paper for submission to the Board of Directors on 8th January 2015

TITLE:	**Board Assurance Framework – as at December 2014**		
AUTHOR:	**Julie Cotterill Associate Director of Governance and Board Secretary**	**PRESENTER**	**Julie Cotterill Associate Director of Governance and Board Secretary**

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 Annual Governance Statement.

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 the Risk and Assurance Group) the Directors are currently managing 16 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (6 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.

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 DECEMBER 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
COR072 **Director Lead: Medical Director** **Initial Risk Score 20** **Mitigated Risk Score 4**	The JAC, a medicines management system, since 2008, to generate an electronic discharge summary containing details of patients' diagnosis, and discharge medication. However a discharge summary is not always being sent to the GP or to Soarian and sometimes the messaging between systems is not processed correctly.	NHSLA - Standard 4 CQC Outcome 6	1.Users are trained to use both Soarian and JAC	1.Users trained to use Soarian & JAC before they are issued with a login	1.July 2014 new training programme now in place			Meet with JAC to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	2.An admission and discharge message is sent from OASIS to JAC when the patient is either admitted or discharged	2.The OASIS to JAC interface is monitored by Siemens.		2. It is not easy to monitor the JAC system for open episodes where a patient has been discharged in OASIS.	2. If the patient for any reason has an open episode in JAC the message will not be processed resulting in no discharge being created.	Meet with Indigo4 to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed.
						2. Because the system is not actively monitored the Trust is unaware when a discharge message is not sent and a GP does not receive the electronic discharge summary.	2.The JAC to Keystone interface is not actively monitored. The Keystone system is used to send discharge summaries to GPs.	Create a new set of processes to actively monitor JAC and Keystone error messages
			3.The Trust is able to generate the current bed state from OASIS and is then able to manually match this to the ward list in JAC in order to be able to close open episodes which would prevent an OASIS admission message being processed			3. This is not actively monitored, therefore discharge summaries that have failed the automated messaging are not sent to the GP and Soarian. Often the GP telephones the Trust to request a discharge letter, this is often not reported.	3. This requires resources from the Trust to actively match patients across both systems.	Develop Joint Audit between the CCG and The Dudley Group NHSFT

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	4. In order for discharge summaries to appear in Soarian a folder in the Keystone system is searched and documents copied to Soarian.	4.Documents in the Keystone folder appear in Soarian	.	4.Documents belonging to incompatible GPs are not created in the Keystone folder and are not sent to GPs or Soarian However delays in updating the national spine continue to cause some issues updating the files where GPs have changed.	4. There are a number of incompatible GP practices in Keystone, therefore these do not generate a discharge summary document and as such will not appear in Soarian	Reference files across the Trust to be updated.
			5. Admission and discharge on OASIS does not always correspond to admission and discharge on JAC. This happens very frequently in some areas with high throughput, such as EAU or day case units	5. Staff should reclose the admission so that any future admissions are generated correctly.	5.Display warning message on Soarian front page 5. Display warning message on doctors App	5. Staff do not close reopened admission spells on JAC until the patient is readmitted. By closing the original spell a new summary will be created and sent electronically which is now out of date	5. Staff are able to override the closed admission in JAC by manually opening a spell previously closed by OASIS	Create a new set of processes that only permit a select group of users to reopen correctly closed spells
			6. Multiple individuals complete the TTO letter, with no clear final sign-off process.	6. A new sign-off procedure is needed for TTOs. Letters should be signed and clearly identified by the discharging doctor	6. Fully addressed through Sign and Stamp campaign. Pharmacy will no longer accept letters not correctly and clearly signed.			
			7.Not all drugs can be included on JAC from the pick list				7. The drug list on JAC has not been updated for 7 years, meaning not all drugs can be picked accurately.	7. Display urgent message on the Hub. Trust data base and drug list on the JAC to be updated with the local formulary

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	8. TTO's are sometimes completed and sent to pharmacy when the patient is medically fit but before the patient is ready for discharge and then the TTO drugs are kept on the ward, sometimes for many days.	8. There needed to be a expiry date on TTOs – approx 48 hours.	8. Sign and Stamp Campaign has addressed this. A three way check is now in place	8. Nursing staff currently only check the TTOs against the TTO letter, not the patient's drug chart. This misses an opportunity to cross-check for accuracy	8. Patient's medication and diagnosis may change during that time, but this will not be included on the TTO.	
			9.There are many prescribing errors on TTOs which have to be corrected in pharmacy		9. Sign and Stamp Campaign has addressed this. A three way check is now in place		9.When pharmacy updates a TTO, there is no process for a further sign-off by the prescribing doctor	Review TTO process to ensure it is clinically safe
			10. The GP list of emails on Keystone is not up to date				10.Letters are not sent electronically to GP. A copy of the letter is not stored for future reference	Gen Practitioner email address to be updated Develop a framework that ensures incompatible letters are saved
			11.Dudley CCG monitors receipt of discharge summaries twice yearly, to monitor contract standard target	11.There must be a robust audit process around discharge letters	11.Joint audit with CCG under development	Dudley CCG has raised a contract query and want to investigate further Sandwell CCG has reported problems with the Trust discharge summaries – to be investigated		

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
COR071 **Director Lead: Director Operations** **Initial Risk Score 20** **Mitigated Risk Score 15**	The ED 4 hour standard is at risk if: • the level of emergency attendance or admission activity is higher than contracted activity or • there is an increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input resulting in high numbers of 4 hour breaches within ED, a below 95% performance and the implementation of fines.	CQC Outcome 6	1.Live capacity monitoring	1. Four times daily multi divisional capacity meeting. 1.Daily information reports 1.Performance Review meetings 1.Finance and Performance meeting	1. Key Performance Target Report to F & P Committee A&E 4 Hour Waits: Strong performance for July at 96.9%. Aug 2014 Quarter 2 remained above target at 97%. A&E target was achieved in November with a performance of 95.6%. As at 15th December. Quarter 3 target was 94.67%	Trust's governance risk rating is *Under review*		

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR071		CQC Outcome 6	2. Capacity meetings with CCG 3. Daily reviews of delayed discharges 4. Length of Stay monitoring	2. Urgent Care Working Group 2.Winter Plan 3. Delayed discharge reporting 3.Delayed discharge meetings 3.Capacity team monitoring and escalation 3.Policies on delays including Choice 4. Ward and speciality reporting. Review against peers. 4.Length of Stay working group 4.Winter plan 4. Previous pilot of Frail Elderly Unit	2. Director of Operations letter to CCG re high level of demand for emergency services and requesting the CCGs plan to manage demand to contract 2014 4.Winter planning report to F&P 30th October 2014 Frail Elderly Unit now open	2.Delivery of UCWG plans in past 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand	2. CCG implemented plan (including Better Care Fund) to manage activity Lack of on-site Urgent Care Centre 3. Adherence to agreement on numbers of accepted delayed discharges Activation of fining protocol	Establish actions by CCG to reduce attendances and admissions at DGH in line with contract and BCF plans Open commissioned Urgent Care Centre Agree Frail Elderly Unit plan to reduce LOS and create capacity Implement Winter Plan internally and gain action from partners for wider Winter Plan Agree response by partners to delayed discharge pressure and implement section 2 & 5 sanctions Activation of fines for delayed discharges as per protocol

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**	**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	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								

Enabling objectives	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	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								

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
COR059 **Director Lead:** **Director of Strategy and Performance** **Initial Risk Score 16** Mitigated Risk Score 10	The capital development costs of the UCC exceed that available to the Trust. The financial consequence of the planned reduction in ED activity causes financial pressure.		1. Urgent Care Project Group (Involves senior staff from DCCG as equal partners in planning the development and its finances).	1. Urgent Care Project Group Minutes discuss key financial issues. 1. DCCG Board Minutes support project. 1. 2-year operational plans (DCCG and DGFT) support project. 1. Project Board re-focus jointly project managed by external organisation. 1. Finance and Performance Committee Minutes.	Update from Director of Strategy and Performance on UCC at the F&P Committee on 27th Nov 2014	No agreed budget and cost	1. No final agreement in place.	1/2. Contract negotiation with DCCG including consideration of risk share arrangement and/or local tariff on both ED attendance and AEC/SAU/EAU assessment activity, better reflecting re-designed service.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR059 **Director Lead:** **Director of Strategy and Transformation** **Initial Risk Score 16** Mitigated Risk Score 10			2. Project group examining 4 different estates options and will plan that client brief for new facility can be economically met within capital envelope set aside. Variation process has begun under PFI project agreement rules. Consistent capital development fees will be applied. 3. Completion of Business Case for capital and revenue elements to be developed.	2. DGFT investment committee notes. 2. Contract variation audit trail and Project plan and milestones includes Summit discussions. 3. DGFT investment committee minutes. 3. Project Board Minutes. 3. Business Case.		OBC incomplete 3. Business Case is delayed.	2. Approval process by Summit Healthcare not within DGFT control. 3. Business Case not yet produced for approval.	Production of OBC Presentation of business case for capital revenue. 3. Agreement of capital and revenue consequences of UCC provisions on DGFT with DCCG

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR061 **Director Lead: Director of Finance and Information** **Initial Risk Score 20** Mitigated Risk Score 12	The Trust must ensure that it remains financially viable over a 5 year time period. At present, there is no indication that either growth, exit or redesign of our major service lines over the next 5 years, will deliver the financial efficiencies required to mitigate the projected financial deficit over that time period. This means we are currently at risk of being put into "special measures" by Monitor, and the administration of the Trust taken out of its hand	CQC Outcome 26 Monitor	1.Beyond the initial 7 specialities examined, conduct a service line options appraisal for all services, to ensure optimum service mix is recommended to the Board of Directors 2. Formal monthly monitoring at F&P Committee and Board	1. Board workshop and private board papers on 5 year plan. 2. F&P and Board Reports and associated minutes of meetings.	Turnround Plan presented to the Board for approval and signed off 05/06/14 5 Year Strategic Plan presented to the Board and not signed off 05/06/14 Outpatient focus on 5 specialties. Ownership of outpatients and length of stay targets within new Divisional structure. Launch of Black Country Alliance meetings with Walsall and Sandwell & West Birmingham Monthly Turnround progress reports to Board Summary of Financial position to F&P Committee monthly report – December report confirmed "The forecast year deficit has been reduced as a consequence of another "good" month to a forecast of £8.0m (an improvement in a month of £0.6m)."	1.Time pressure means the depth of review, analysis and engagement for the remaining specialities won't be as deep as those done for the initial major services. Plan to complete the more in depth review as part of new Divisional arrangements during Q2 and Q3 2014/15, in advance of detailed APR scrutiny from Monitor		1. Revise the approach to the Cost Improvement Programme 2015-16 and 2016-17 to include a greater emphasis on cost reduction not income growth. Scheme to be worked up in detail as part of the Operational Planning 2015-16 process in conjunction with Divisions. Black Country Trust Finance Directors to arrange facilitated planning session(s) with respect to radical, sub-regional service configuration options and associated financial monitoring

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR065 **Director Lead: Director of Finance and Information** **Initial Risk Score 20** Mitigated Risk Score 12	The current Trust plan of a £6.7m deficit is predicated on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to deliver this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years.	CQC Outcome 26 Monitor	1. Development of rigid PMO structure to properly assess each saving opportunity, requiring completion of PID with key milestones and a QIA. 1.Weekly/Bi-Weekly PAR meetings held with Performance Director/Operations Director and Chief Executive to offer significant challenge to project leads. Further escalation where necessary. 2. Monthly report to F&P Committee 2.Development of a Turnaround programme designed to ensure that saving/efficiency opportunities are maximised without detriment to quality/patient care. Wider debate with Monitor/CCG Area Team at round table sessions. New vacancy control process developed including weekly executive led Approval Panels	Bi-weekly meetings with managers to run through key milestones. Completion of CIP tracker showing PID and QIA. CIP update report to Directors, F&P, Board. Escalation meetings now include Director of Ops/Chief Executive; Dashboard available on Hub; Reports to F&P 2.Turnaround plan/reports to Directors, F&P, TME and Board. Reports continue to be presented on a monthly basis; however, Month 7 position shows an adverse variance of £1.981m and projected year-end forecast of £8.705m Workforce Work stream commenced with robust vacancy controls and scoping of workforce reductions over coming years	Improved QIA process Monthly progress reports to Board and F&P PMO processes have been implemented across all projects in line with policy, ongoing monitoring of compliance is underway The forecast year deficit has been reduced as a consequence of another “good” month to a forecast of £8.0m (an improvement in a month of £0.6m). Weekly Turnround exception reports to Directors	1. Some central schemes not fully owned by Directorates 2. Poor detail presented to QIA panels - requiring deferral of support by MD/DN.		Focus on saving cost schemes reinforced through PAR meeting and escalation processes Board require sign-off of 2015/16 Plan by December.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
		CQC Outcome 26 Monitor	3.Increased budget manager accountability to ensure rectification plans are prepared for overspending budgets	3. Development of controls framework. Relaunch of Budget Manager responsibility policy. Discussions held with budget managers. Rectification plans for overspends in excess of £50k expected		3. New management structure has resulted in doubts about accountability for overspends.		
			4. Devolution of income to directorates to create greater ownership and accountability.	4. Discussion with CCG at CLT around re-patriation options. Income currently exceeding plan. 4.Monitoring of income levels	Increased revenue in elective activity			
			5. Drive to reduce run rate including medical staffing exercise and formal announcement of reduction of 400 posts over 2 years. Stricter control on vacancies in lieu of this	5. Chief Executive address to staff on importance of financial balance to clinical sustainability. 5. Additional winter pressure income received to provide finances to keep beds open.	75% of consultant workforce attendance at C Exec / MD briefing		5. Inability to achieve required savings due to other pressures, i.e. increased emergency activity resulting in inability to close beds.	5. Workforce Efficiencies (medical staff), agency reduction and programme to look at post 5. Increased drive on reduction efficiency for outpatient involving specific specialties of greatest impact.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR076 **Director Lead: Director of Nursing** **Initial Risk Score 20** Mitigated Risk Score 15	The Registered Nursing (RN) staffing levels do not meet Safe Staffing for Nursing in Adult Patient Wards in Acute Hospitals NICE/Guidance		1. Identified nurse rostering system across all wards (Allocate). 2. Process embedded to monitor staffing levels daily, includes: - Daily review by Lead Nurses - Staff ratios displayed on Huddle Boards and discussed at Huddle Board Meetings 3. Process embedded for managing prospective staff levels short and long term. 4. Trust has an integral Staff Bank to provide staffing cover. 4. Agency framework used if Bank cannot supply.	2. Daily e-mails of Lead Nurses review of staffing levels - requesting Bank. 2. Monthly report to the Board of Directors. 2. Weekly Agency Stats report. 2. Report to Finance and Performance. 3. Monthly report to the Board of Directors. 3. Weekly Agency Stats report. 3. Report to Finance and Performance. 4. Monthly report to the Board of Directors. 4. Report to Finance and Performance.	Monthly Board reports F&P Report Presentation from Director of Nursing to F& P (Nov 2014)			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR076 **Director Lead: Director of Nursing** **Initial Risk Score 20** Mitigated Risk Score 15			5. Monthly report to the Board of Directors and to Finance and Performance of Trust compliance to Safe Staffing Ratios (NICE). 6. Framework for graduate nurse and intermittent recruitment of nurses to achieve NICE staffing ratio,	5. Monthly report to the Board of Directors. 5. Report to Finance and Performance. 6. 6-monthly AUKUH nursing staffing assessment.	Monthly Nurse/Midwife Staffing Position (Nov and December Board)		6. Shortfall in the number of nurses to recruit within the catchment area.	6. To scope continued overseas recruitment internationally in Europe and potentially wider.

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors – 8th January 2014

TITLE:	**Corporate Risk Register**		
AUTHOR:	Sharon Phillips Risk and Standards Manager	**PRESENTER:**	Julie Cotterill Associate Director of Governance and Board Secretary

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
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

SUMMARY OF KEY ISSUES:

In addition to the operational risk registers (reported to Risk and Assurance Group) the Directors are currently managing 16 corporate risks, of which 6 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified.

4 new risks have been added to the register since the previous report and 4 risks have been mitigated to their lowest level and have been archived or superseded.

IMPLICATIONS OF PAPER:

RISKS	**Risk Register Y**	**Risk Score ALL**	**Details:** Refer to paper attached
COMPLIANCE	**CQC**	**Y**	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**	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 THE BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD:

To receive and approve the Corporate Risk Register, noting the assurance received to date on key risks and current gaps in assurance and control.

CORPORATE RISK REGISTER

In addition to the operational risk registers (reported to the Risk and Assurance Group) the Directors are currently managing 16 corporate risks, of which 6 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified. The risk scores are as follows:

Risk Score	Number of Risks
20	6
16	3
15	3
12	2
10	2

Action plans are in place, or being developed to address any gaps in control or assurance identified at this time.

RISK REGISTER MOVEMENT

4 new risks were added to the Corporate Risk Register between September and December 2014 (these are indicated in the table commencing on page 3).

4 risks have been removed from the Corporate Risk Register (archived or moved to Directorate Risk Registers) since the previous report (September 2014) and summarised below:

Director lead	Risk Summary	Date
Mr Richard Cattell	Potential compromise of clinical care due to the non-availability of clinical information at time of consultation	09/09/14
Mr Jon Scott	Cancellation of elective surgical patients due to excessive emergency admissions from Medicine, Trauma or Surgery	09/09/14
Ms Denise McMahon	Delay in response from Children's and/or Adults Social services Emergency Duty Team (EDT) due to staffing issues during July and August 2014. This could result in a delay in the Trust receiving safeguarding information timely or a response from EDT; leading to a delay in discharge or an admission to hospital	09/09/14
Mr Paul Assinder	The Trust spent £7.1m on agency staff in 13/14 despite an increase in employed staff of 170 WTE. The current budgets require a significant reduction in agency spend in order to deliver a plan of a £6.7m deficit. This is because agency costs are at a premium rate and are being used in excess of approved budgets	09/09/14

PENDING NEW RISKS

Presently there are no known pending risks to be added to the Corporate Risk Register. These risks are identified at Board Committee/groups or may arise from an incident, complaint, claim, internal or external review.

Corporate Risk Register – December 2014

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR061 **Director Lead: Director of Finance** **Initial Risk Score 20**	The Trust must ensure that it remains financially viable over a 5 year time period. At present, there is no indication that either growth, exit or redesign of our major service lines over the next 5 years, will deliver the financial efficiencies required to mitigate the projected financial deficit over that time period. This means we are currently at risk of being put into "special measures" by Monitor, and the administration of the Trust taken out of its hand	16/05/2014 **Last Review Date: December 2014**	6. To deliver an infrastructure that supports delivery.	1. Beyond the initial 7 specialities examined, conduct a service line options appraisal for all services, to ensure optimum service mix is recommended to the Board of Directors. 2. Formal monthly monitoring at F&P Committee and Board	4	5	20	1. Board Workshop and Private Board papers on 5-year plan. 2. F&P and Board reports	1. Time pressure means the depth of review; analysis and engagement for the remaining specialities won't be as deep as those done for the initial major services. Plan to complete the more in-depth review as part of new Divisional arrangements during Q2 and Q3 2014/15, in advance of detailed APR scrutiny from Monitor.		1. Revise the approach to the Cost Improvement Programme 2015-16 and 2016-17 to include a greater emphasis on cost reduction not income growth. Scheme to be worked up in detail as part of the Operational Planning 2015-16 process in conjunction with Divisions. 1. Black Country Trust Finance Directors to arrange facilitated planning session(s) with respect to radical, sub-regional service configuration options and associated financial monitoring	31/03/2015	4	3	12

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR065 **Director Lead: Director of Finance** **Initial Risk Score 20**	The current Trust plan of a £6.7m deficit is predicated on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to deliver this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years	27/05/2014 **Last Review Date: November 2014**	6. To deliver an infrastructure that supports delivery.	1. Development of rigid PMO structure to properly assess each saving opportunity, requiring completion of PID with key milestones and a QIA. 1. Weekly/Bi-Weekly PAR meetings held with Performance Director /Operations Director and Chief Executive to offer significant challenge to project leads. Further escalation where necessary. 2. Development of a Turnaround Programme designed to ensure that saving/efficiency opportunities are maximised without detriment to quality/patient care. Wider debate with Monitor/CCG/Area Team at round table sessions. 3. Increased budget manager accountability to ensure rectification plans are prepared for overspending budgets. 4. Devolution of income to directorates to create greater ownership and accountability. 5. Drive to reduce run rate including medical staffing exercise and formal announcement of reduction of 400 posts over 2 years. Stricter control on vacancies in lieu of this.	4	5	20	1. Bi-weekly meetings with managers to run through key milestones. Completion of CIP tracker showing PID and QIA. CIP Update report to Directors, F&P, Board. 1. Escalation meetings now include Director of Ops/Chief Executive; Dashboard available on Hub. 1. F&P Committee and Board reports 2. Turnaround plan/reports to Directors, F&P, TME and Board. 2. Reports continue to be presented to above on a monthly basis; however, Month 7 position shows an adverse variance of £1.981m and projected year-end forecast of £8.705m. 3. Development of controls framework. 3. Re-launch of Budget Manager responsibility policy. 3. Discussions held with Budget Managers. 3. Rectification plans for overspends in excess of £50k. 4.Monitoing of income levels 5. Additional winter pressure income received to provide finances to keep beds open.	5. Inability to achieve required savings due to other pressures, i.e. increased emergency activity resulting in inability to close beds.	1. Some central schemes not fully owned by Directorates. 2. Poor detail presented to QIA panels - requiring deferral of support by MD/DN. 3. New management structure has resulted in doubts about accountability for overspends.	1. Focus on saving cost schemes reinforced through PAR meeting and escalation processes. 2. Board require sign-off of 2015/16 Plan by December. Workforce Efficiencies medical staff - agency reduction and programme to look at post. Increased drive on outpatient efficiency involving specific specialties of greatest impact.	31/12/2014	3	4	12

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR072 [FI002 (IT009)] **Director Lead: Medical Director** **Initial Risk Score 20**	The JAC, a medicines management system, since 2008, to generate an electronic discharge summary containing details of patients' diagnosis and discharge medication. However, a discharge summary is not always being sent to the GP or to Soarian and sometimes the messaging between systems is not processed correctly	12/06/2014 **Last Review Date: September 2014**	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Users are trained to use both Soarian and JAC. 2. An admission and discharge message is sent from OASIS to JAC when the patient is either admitted or discharged. 3. The Trust is able to generate the current bed state from OASIS and is then able to manually match this to the ward list in JAC in order to be able to close open episodes which would prevent an OASIS admission message being processed. 4. In order for discharge summaries to appear in Soarian, a folder in the Keystone system is searched and documents copied to Soarian. 5. Admission and discharge on OASIS does not always correspond to admission and discharge on JAC. This happens very frequently in some areas with high throughput, such as EAU or Day Case Units.	4	5	20	1. Users must be trained to use Soarian and JAC before they are issued with a log-in. 2. The OASIS to JAC interface is monitored by Siemens. 4. Documents in the Keystone folder appear in Soarian. 5. Staff should then reclose the admission so that any future admissions are generated correctly.	1. If the patient has an open episode in JAC, the message will not be processed resulting in no discharge being created 2. The JAC to Keystone interface is not actively monitored. The Keystone system is used to send discharge summaries to GPs 3. This requires resources from the Trust to match patients across both systems 4. There are a number of incompatible GP practices in Keystone, therefore these do not generate a discharge summary document and such will not appear in Soarian 5. Staff are able to override the closed admission in JAC by manually opening a spell previously closed by OASIS	1. It is not easy to monitor the JAC system for open episodes where a patient has been discharged in OASIS. 2. Because the system is not actively monitored, the Trust is unaware when a discharge message is not sent and a GP does not receive the electronic discharge summary 3. This is not actively monitored, therefore discharge summaries that have failed the automated messaging are not sent to the GP and Soarian. Often the GP telephones the Trust to request a discharge letter, this is often not reported. 4. Documents belonging to Incompatible GPs are not created in the Keystone folder and are not sent to GPs or Soarian, however, delays in updating the national spine continue to cause some issues where GPs have changed 5. Staff do not close reopened admission spells on JAC until the patient is readmitted. By closing the original spell a new summary will be created and sent electronically which is now out of date.	1. Meet with JAC to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed 2. Meet with Indigo4 to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed 3. Create a new set of processes to actively monitor JAC and Keystone error messages 4. Develop of Joint Audit between the CCG and The Dudley Group NHSF Trust 5. Reference files across the Trust to be updated	**30/06/2014**	4	1	4

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
				6. Multiple individuals complete the TTO letter, with no clear final sign-off process. 7. Not all drugs can be included on JAC from the picklist. 8. TTO's are sometimes completed and sent to Pharmacy TTO's are sometimes completed and sent to pharmacy when the patient is medically fit but before the patient is ready for discharge and then the TTO drugs are kept on the ward, sometimes for many days. 9. There are many prescribing errors on TTOs which have to be corrected in Pharmacy. 10. The GP list of emails on Keystone is not up to date. 11. Dudley CCG monitors receipt of discharge summaries twice yearly, to monitor contract standard target.				6. A new sign-off procedure is needed for TTOs. Letters should be signed and clearly identified by the discharging doctor 9. There needed to be an expiry date on TTOs – approx 48 hours. 11. There must be a robust audit process around discharge letters	7. The drug list on JAC has not been updated for 7 years, meaning not all drugs can be picked accurately 8. Patient's medication and diagnosis may change during that time, but this will not be included on the TTO 9. When Pharmacy updates a TTO, there is no process for a further sign-off by the doctor 10. Letters not sent electronically to GP. A copy of the letter is not stored for future reference	6. Nursing staff currently only check the TTOs against TTO letter, not the patient's drug chart. This misses an opportunity to cross check for accuracy.	6. Create a new set of processes that only permit a select group of users to reopen correctly closed spells 7. Display urgent message on the Hub 7. Trust database and drug list on the JAC to be updated with the local formulary 8/9. Review TTO process to ensure it is clinically safe 10. Gen Practitioner email address to be updated 11. Develop a framework that ensures incompatible letters are saved				

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR059 **Director Lead: Director of Strategy & performance** **Initial Risk Score 16**	The capital development cost of the UCC exceed that available to the Trust. The financial consequence of the planned reduction in ED activity causes financial pressure	15/05/2014 **Last Review Date: November 2014**	6. To deliver an infrastructure that supports delivery.	1. Urgent Care Project Group (Involves senior staff from DCCG as equal partners in planning the development and its finances). 2. Project group examining 4 different estates options and will plan that client brief for new facility can be economically met within capital envelope set aside. Variation process has begun under PFI project agreement rules. Consistent capital development fees will be applied. 3. Completion of Business Case for capital and revenue elements to be developed.	5	4	20	1. Urgent Care Project Group Minutes discuss key financial issues. 1. DCCG Board Minutes support project. 1. 2-year operational plans (DCCG and DGFT) support project. 1. Project Board re-focus jointly project managed by external organisation. 1. Finance and Performance Committee Minutes. 2. DGFT investment committee notes. 2. Contract variation audit trail. And Project plan and milestones includes Summit discussions. 3. DGFT investment committee minutes. 3. Project Board Minutes. 3. Business Case.	1. No final agreement in place. 2. Approval process by Summit Healthcare not within DGFT control. 3. Business Case not yet produced for approval.	1/2. No agreed budget and cost 2. OBC incomplete 3. Business Case is delayed.	1/2. Contract negotiation with DCCG including consideration of risk share arrangement and/or local tariff on both ED attendance and AEC/SAU/EAU assessment activity, better reflecting re-designed service. 2. Production of OBC 3. Presentation of business case for capital revenue. 3. Agreement of capital and revenue consequences of UCC provisions on DGFT with DCCG.	31/01/2015	5	2	10

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR071 **Director Lead: Director of Operations** **Initial Risk Score 20**	The ED 4 hour standard is at risk if: the level of emergency attendance or admission activity is higher than contracted activity or; there is an increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input, resulting in high numbers of 4 hour breaches within ED, a below 95% performance and the implementation of fines	31/08/2014 **Last Review Date: December 2014**	2. To provide the best possible patient experience	1. Live capacity monitoring. 2. Capacity meetings with CCG. 3. Daily reviews of delayed discharges. 4. Length of Stay monitoring.	5	4	20	1. Four times daily multi divisional capacity meeting. 1. Daily information reports 1. Performance Review meetings 1. Finance and Performance meeting 2. Urgent Care Working Group 2. Winter Plan 3. Delayed discharge reporting 3. Delayed discharge meetings 3. Capacity team monitoring and escalation 3. Policies on delays including Choice 4. Ward and specialty reporting 4. Review against peers 4. Length of Stay working group 4. Previous pilot of Frail Elderly Unit	1. None. 2. CCG implemented plan (including Better Care Fund) to manage activity. 2. Lack of on-site Urgent Care Centre. 3. Adherence to agreement on numbers of accepted delayed discharges. 3. Activation of fining protocol. 4. None.	1. None. 2. Delivery of UCWG plans in past. 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand. 4. Accepted and agreed plan for sustained Frail Elderly Unit.	2. Establish actions by CCG to reduce attendances and admissions at DGH in line with contract and BCF plans 2. Open commissioned Urgent Care Centre 3. Agree Frail Elderly Unit plan to reduce LOS and create capacity 3. Implement Winter Plan internally and gain action from partners for wider Winter Plan 3. Agree response by partners to delayed discharge pressure and implement section 2 & 5 sanctions 3. Activation of fines for delayed discharges as per protocol	30/04/2015	5	3	15

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR076 **Director Lead: Director of Nursing** **Initial Risk Score 20**	The Registered Nursing (RN) staffing levels do not meet Safe Staffing for Nursing in Adult Patient Wards in Acute Hospitals NICE/Guidance	28/11/2014 **NEW RISK**	6. To deliver an infrastructure that supports delivery.	1. Identified nurse rostering system across all wards (Allocate). 2. Process embedded to monitor staffing levels daily, includes: - Daily review by Lead Nurses - Staff ratios displayed on Huddle Boards and discussed at Huddle Board Meetings. 3. Process embedded for managing prospective staff levels short and long term. 4. Trust has an integral Staff Bank to provide staffing cover. 4. Agency framework used if Bank cannot supply. 5. Monthly report to the Board of Directors and to Finance and Performance of Trust compliance to Safe Staffing Ratios (NICE). 6. Framework for graduate nurse and intermittent recruitment of nurses to achieve NICE staffing ratio.	5	4	20	2. Daily e-mails of Lead Nurses review of staffing levels - requesting Bank. 2. Monthly report to the Board of Directors. 2. Weekly Agency Stats report. 2. Report to Finance and Performance. 3. Monthly report to the Board of Directors. 3. Weekly Agency Stats report. 3. Report to Finance and Performance. 4. Monthly report to the Board of Directors. 4. Report to Finance and Performance. 5. Monthly report to the Board of Directors. 5. Report to Finance and Performance. 6. 6-monthly AUKUH nursing staffing assessment.	6. Shortfall in the number of nurses to recruit within the catchment area.		6. To scope continued overseas recruitment internationally in Europe and potentially wider.	30/04/2015	5	3	15

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR069 **Director Lead: Director of Operations** **Initial Risk Score 25**	The Diagnostic standard is at risk if: the demand rises to a level above capacity, resulting in breaches to the Diagnostic standard	31/08/2014 **Last Review Date: November 2014**	2. To provide the best possible patient experience	1. Daily monitoring. 2. Divisional Plan to increase capacity to meet current demand.	4	4	16	1. Daily information reports. 1. Performance Review Meetings. 1. Finance and Performance Meeting. 2. Finance and Assurance Committee paper.	1. None. 2. None.	1. None. 2. None.	2. Plan to ensure recruitment of sufficient qualified staff. 2. Capacity and Demand review to establish future demand and required capacity. 2. Plan to replace or expand equipment needed based on Capacity and Demand review.	**30/11/2014**	4	3	12
COR073 **Director Lead: Director of Strategy and Trans** **Initial Risk Score 16**	The Black Country Review of acute services does not deliver a solution that supports the future clinical and financial sustainability of the Trust	05/11/2014 **NEW RISK**	6. To deliver an infrastructure that supports delivery.	1. The Review has been raised with Monitor who have agreed the facilitate discussions. 2. Informal discussion have taken place between three of the Chief Executives. 3. This is on the Board of Directors Agenda and discussed during reviews of the strategic objectives for implementation in 2016/17.	4	4	16	1/2/3. Progress reported at the Board of Directors.	1. No formal project/discussions have been launched. 2. No agreement on the process of timeframe has been reached.		1/2. Dialogue with CCG, Area Team and other providers to get agreement and initiate a formal project.	31/03/2015	4	3	12
COR075 **Director Lead: Director of Strategy and Trans** **Initial Risk Score 16**	The Black Country Alliance does not deliver solutions that supports the future clinical and financial sustainability of the Trust -	05/11/2014 **NEW RISK**	6. To deliver an infrastructure that supports delivery.	1. The review has been raised with Monitor who have agreed to facilitate discussions. 2. Informal discussions have taken place between three of the Chief Executives. 3. This is on the Board of Directors Agenda and discussed during reviewed of the strategic objectives for implementation in 2016/17.	4	4	16	1/2/3. Progress reported at the Board of Directors.	1. No formal project/discussions have been launched. 2. No agreement on the process or timeframe has been reached.		1/2. Dialogue with CCG, Area Team and other providers to get agreement and initiate a formal project.	31/03/2015	4	3	12

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR063 **Director Lead: Director of Finance** **Initial Risk Score 15**	The current NHS contract enables the Trust to earn additional income up to 2.5% (£6.1m) to meet specified quality targets. The Trust budget assumes that the quality targets will be achieved in full. Hence, any shortfall against any of the schemes will result in a real financial consequence to the Trust's income position which could seriously compromise financial plans	27/05/2014 **Last Review Date: November 2014**	6. To deliver an infrastructure that supports delivery.	1. Separate CQUIN Exception Report scheduled in for quarterly discussion at F&P Committee. 2. CQUIN report incorporated into monthly reporting dashboard and covered in Directorate Performance Review Meetings. 3. All CQUIN schemes have a Lead Manager and nominated Executive Lead. Progress reports reviewed monthly with the Director of Operations with Exception Reports required for red rated schemes. 4. Exceptions flagged in CQUIN report and responsible officer required to report to F&P Committee. 5. Letter to CCG requesting current CQUIN for electronic discharge letters be set aside due to problems with JAC and need to revert to paper referrals.	3	5	15	1. Reports F&P Committee. 2. Dashboards and Performance Review Meetings. 3. Progress report collected on a monthly basis from Lead Manager. Exception Reports for red rated schemes. 4. August F&P Committee received exception reports for Pressure Ulcers, Dementia and Discharge Letters. 4. August financial position assumes risk of 10% (£0.6m). October financial position assumes risk of 15% (£0.9m).	5. Some CQUIN targets/milestones not fully agreed or remain unclear.	5. Awaiting CCG response to Trust proposal to set aside discharge summary CQUIN.	5. Agreement being sought to set aside discharge letter CQUIN.	31/12/2014	2	5	10

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR064 **Director Lead: Director of Finance** **Initial Risk Score 15**	The current NHS contract allows the CCG to invoke penalties for sub-standard performance/failure to meet key targets. The Trust budget makes no allowance for any deduction. Hence, if contract penalties are enacted, there is real financial consequence to the Trust's income position which could seriously compromise financial plans	27/05/2014 **Last Review Date: November 2014**	6. To deliver an infrastructure that supports delivery.	1. Regular monthly monitoring of Performance Reports and exposure to penalties to Directors, F&P Committee and Board. 2. Corporate and Departmental dashboards in place for monitoring. 3. Breach analysis and Directorate reporting regime in place for investigation of target failures giving rise to penalties. 4. Letter from Director of Operations setting out Trust stance that fines cannot be invoked due to CCG failure to manage demand.	3	5	15	1. Reports to Directors, F&P Committee and Board. 2. Dashboards. 3. Action plans reported to F&P with reasons for failure and action to improve. Issues debated at Directorate Performance Reviews. ED 4-hour target achieved in July/August. RTT overall 90% target achieved throughout the year but currently being fined on individual specialties. Ambulance turnaround find reduced to £40K in July. 4. CCG are to discuss Director of Operations letter at their September F&P Committee. Likely outcome is that CCG will maintain contractual requirement to enact fines but will seek to agree a reimbursement mechanism linked to behavioral "strings". Outcome remains that the CCG reject the Trust argument regarding fines but maintain willingness to agree reinvestment based on behavioral incentives.	4. Seek to negotiate repatriation of contract penalties with CCG.	4. CCG invoiced for Q1 fines totaling £464K, split £219K ambulance handover, £130K A&E, £115K RTT. 4. CCG also questioning reimbursement of 13/14 fines, stipulating that Trust did not deliver on all of requirements amounting to £275K. The 2 specific issues have been challenged (Discharge by 1pm and twice daily consultant ward rounds) by the Trust. This will be discussed at the September CCG F&P Committee. CCG have requested discussion between Medical Director and counterpart at Area Team to agree issue. Trust view is that this has occurred with a favorable outcome.	4. Agree with CCG mitigating reasons for not invoking fines or alternatively agree acceptable rationale for the payback of imposed contract penalties. 5. Trust to ensure that no fines are invoked for RTT from July - November in line with national guidance and linked to reduction of backlogs.	31/12/2014	3	5	15

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR032 (OP097) **Director Lead: Director of Operations** **Initial Risk Score 15**	The Trust is required to have an up to date plan to manage major incidents and business continuity so that the Trust can deliver care to patients when a major incident is declared and continue to deliver patient care in the event of a serious outage or disruption to key services - (RISK LEAD: Karen Hanson)	01/12/2011 **Last Review Date: November 2014**	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Business Continuity Plan in place developed with PFI Partners. 2. BCP Group including PFI Partners. (Established to review potential incidents and agree Mitigating Actions. This work has commenced to strengthen the Estates and FM Contingency Plans).	5	3	15	1. IFM Reports and business continuity. 1. RCA Reports following business continuity incidents. 2. Clinical Quality and Patient Experience Committee Reports.	1. There are gaps in the BCP especially in relation to IT failure. 2. Delivery of actions.	1. There is no established group to oversee the completion of the Business Continuity Plan. 2. The recent IT failure demonstrated a significant lack of assurance in the ability of the Trust to manage business continuity.	1. Provide training and undertake exercise to improve response. FM response tested December 2013 and was favourable. 2. Implement recommendations following HV incident July 2013. 3. The management of Major Incident and Business Continuity has passed to the Capacity Directorate who will review the plan and the governance arrangements.	**30/11/2014**	5	2	10
COR074 **Director Lead: Director of Strategy and Trans** **Initial Risk Score 12**	The inability to release the Guest Hospital to enable its lease for other healthcase uses to bring income into the Trust, in line with the agreed actions within the 5-year strategic plan - (RISK LEAD: Karen Morrey; DIRECTOR LEAD: Anne Baines)	05/11/2014 **NEW RISK**	6. To deliver an infrastructure that supports delivery.	1. The principle has been agreed by the Board of Directors.	3	4	12	1. The progress of the objectives of the 5-year plan are reviewed by the Board of Directors.	1. No details of the remit have been worked up. No defined actions have been agreed. 2. This work has not yet started. Without it we are not able to respond to any enquiries. 3. No formal project plan in place. 4. A detailed assessment of the potential rental value has not been undertaken.	1. There is no expected income stream built into the financial plan until 2016/17.	2/3/4. Implementation of a project team to review details and the remit and identify actions to be taken forward. 1/3. Development of a project plan following identification of a project team and further actions to be taken.	30/04/2015	3	3	9

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR067 **Director Lead: Director of Finance** **Initial Risk Score 12**	The current Trust plans assume the receipt of £4m transitional support from Dudley CCG. Whilst this has now been approved by the CCG Board, payment is linked to compliance with certain conditions and is therefore not guaranteed. The four conditions focus on greater transparency, implementation of the Service Delivery & Implementation Plan (SDIP), improving referral practice and establishing a comprehensive elderly care pathway)	22/08/2014 **Last Review Date: November 2014**	6. To deliver an infrastructure that supports delivery.	1. Joint funded post across Trust/CCG and regular SDIP Steering Group Meetings. 2. CCG letter discussed at CLT and agreed that meetings would occur by the end of September to agree the scope of each requirement to enable the release of the first tranche of £1m. The second tranche of £1.5m will be released in December subject to the agreement of actions arising from the scoping meetings.	4	3	12	1. Update of SDIP presented at monthly contract review. Separate SDIP Steering Group Meetings on a monthly basis. 2. Of the first tranche of money, £900k has been agreed and paid. The outstanding £100k is subject to the outcome of a Capita report setting out the progress made on the Urgent Care Centre. The second tranche linked to actions is not due until December.	1. Need to ensure that actions are agreed for each area between October and December, 2. System to manage delivery of the four conditions to enable quarterly progress reports to be submitted to the CCG and ensure full payment of £4m.	1. Scoping meetings need to occur by the end of September for each of the requirements: SDIP, CAB, Elderly Care pathways and greater transparency (Finance, Estates, Workforce and Patient Experience). 2. Final tranche of £1.5m will be released in March, subject to delivery of actions.	1/2. Schedule to be prepared setting out what needs to happen for each item in order to increase the likelihood of achieving the agreed actions. A Director lead will be allocated to each item to ensure these are progressed.	**30/11/2014**	2	2	4

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR068 **Director Lead: Director of Operations** **Initial Risk Score 20**	The RTT standard is at risk if: the level of emergency attendance or admission activity rises or; the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or; the theatre capacity and productivity is insufficient to meet demands, resulting in cancelled elective patients, breaches to the RTT standard and reduced income.	31/08/2014 **Last Review Date: November 2014**	2. To provide the best possible patient experience	1. Live capacity monitoring 2. Capacity meetings with CCG 3. Daily reviews of delayed discharges 4. Length of Stay monitoring 5. Monitoring of patients on inpatient lists 6. Theatre productivity 7. Continued delivery of performance above required level	5	2	10	1. Four times daily multi divisional capacity meeting. 1. Daily information reports 1. Performance Review meetings 1. Finance and Performance meeting 2. Urgent Care Working Group 2. Winter Plan 3. Delayed discharge reporting 3. Delayed discharge meetings 3. Capacity team monitoring and escalation 3. Policies on delays including Choice 4. Ward and specialty reporting 4. Review against peers 4. Length of Stay working group 4. Winter plan 4. Previous pilot of Frail Elderly Unit 5. Weekly PTL meetings 5. Monitoring reports 5. Performance Review meetings 5. Finance and Performance Meeting 5. Review of waiting list management 6. Theatre productivity reports 6. Theatre productivity meetings 6. Consultant leave policy 7. Trust Board Performance Report	1. None 2. CCG plan to manage activity 2. Lack of on-site Urgent Care Centre 3. Adherence to agreement on numbers of accepted delayed discharges	1. None 2. Delivery of UCWG plans in past 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand 4. Accepted and agreed plan for sustained Frail Elderly Unit 5. None 6. Consultant leave planning and impact on theatre activity management 7. None	1. Agree Frail Elderly Unit plan to reduce LOS and create capacity 2. Implement Winter Plan internally and gain action from partners for wider Winter Plan 3. Agree response by partners to delayed discharge pressure and implement section 2 & 5 sanctions 4. Establish actions by CCG to reduce attendances and admissions at DGH 5. Open commissioned Urgent Care Centre 6. Ensure priority of elective patients is kept high within Capacity meetings 7. Agree plan for annual activity including managing consultant leave appropriately	30/04/2015	5	2	10

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR070 **Director Lead: Director of Operations** **Initial Risk Score 20**	The Cancer standard is at risk if: the level of emergency attendance or admission activity rises or; the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or; the theatre capacity is insufficient to meet demands, resulting in breaches to the cancer standard	31/08/2014 **Last Review Date: November 2014**	2. To provide the best possible patient experience	1. Live capacity monitoring. 2. Capacity Meetings with CCG. 3. Daily reviews of delayed discharges. 4. Length of Stay monitoring. 5. Monitoring of patients on inpatient lists. 6. Theatre productivity. 7. Continued delivery of performance above required level show that mitigating actions are mitigating risk.	5	2	10	1. Four times daily multi divisional capacity meeting. 1. Daily information reports. 1. Performance Review meetings. 1. Finance and Performance meeting. 2. Urgent Care Working Group. 2. Winter Plan. 3. Delayed discharge reporting. 3. Delayed discharge meetings. 3. Capacity team monitoring and escalation. 4. Ward and specialty reporting. 4. Review against peers. 4. Length of Stay working group. 4. Winter plan. 4. Previous pilot of Frail Elderly Unit. 5. Weekly PTL meetings. 5. Monitoring reports. 5. Performance Review meetings. 5. Finance and Performance Meeting. 5. Review of waiting list management. 6. Theatre productivity reports. 6. Theatre productivity meetings. 6. Consultant leave policy. 7. Trust Board Performance Report.	1. None. 2. CCG plan to manage activity. 2. Lack of on-site Urgent Care Centre. 3. Adherence to agreement on numbers of accepted delayed discharges.	1. None. 2. Delivery of UCWG plans in past. 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand. 4. Accepted and agreed plan for sustained Frail Elderly Unit. 5. None. 6. Consultant leave planning and impact on theatre activity management. 7. None.	1. Agree Frail Elderly Unit plan to reduce LOS and create capacity. 2. Implement Winter Plan internally and gain action from partners for wider Winter Plan. 3. Agree response by partners to delayed discharge pressure and implement Section 2 & 5 sanctions. 4. Establish actions by CCG to reduce attendances and admissions at DGH. 5. Open commissioned Urgent Care Centre. 6. Ensure priority of cancer patients is kept high within Capacity Meetings. 7. Agree plan for annual activity including managing consultant leave appropriately.	30/04/2015	5	2	10

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 8th January 2015

TITLE:	**CQC Inspection Report – Update and Closure Report**		
AUTHOR:	**Paula Clark**	**PRESENTER**	**Paula Clark**

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

The Trust was inspected by the Care Quality Commission in March 2014. A number of areas for improvement were highlighted and it would be usual practice to provide an action plan.

However, the Trust asked for a review of the ratings during the summer and as a result there has been a considerable time lag from the point at which the Inspectors visited to the publication of the final report. As a result, the majority of areas for improvement have already been addressed and completed. Those which remain open are monitored by the Board and its Committees as areas of work on which the organisation was already sighted.

This paper therefore takes the Board through each of the areas of concern raised by the CQC in March and provides information about the actions already taken. In those areas which remain open it signposts Board members to the where progress is being monitored.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To agree contents of the paper for the CQC inspection report response and discuss issues of importance to the Board

The Dudley Group NHS
NHS Foundation Trust

Care Quality Commission Inspection Report – Areas for Improvement Response

The Trust was inspected by the Care Quality Commission in March 2014. A number of areas for improvement were highlighted and it would be usual practice to provide an action plan.

However, the Trust asked for a review of the ratings during the summer and as a result there has been a considerable time lag from the point at which the Inspectors visited to the publication of the final report. As a result the majority of areas for improvement have already been addressed and completed. Those which remain open are monitored by the Board and its Committees as areas of work on which the organisation was already sighted.

This paper therefore takes the Board through each of the areas of concern raised by the CQC in March and provides information about the actions already taken. In those areas which remain open it signposts Board members to the where progress is being monitored.

Although the Trust was awarded a Requires Improvement rating, 30 out of 38 areas were rated Good. The actions taken, and those in hand, address the RI areas and the Areas for Improvement/Compliance Actions.

Do Not Attempt Resuscitation Policy: Adherence, Training and Audit:

Although the Inspectors found good adherence to the policy on the wards they found two out of 17 notes with which they had concerns. Therefore the Trust has reacted by improving processes to provide full compliance.

DNAR is on the new ward round checklist/bundle that has been developed with Dr Matt Banks. Ward clerks have been asked to ensure there is a copy in each patient's notes, and Matrons agreed to take on this responsibility. The completion and audit of process is in medical responsibility. For patients with an active DNAR in place where there are concerns about capacity, each ward sends a list on a daily basis to the Mental Health team to check and challenge as appropriate.

Training has been provided for medical staff by the Trust's legal advisors on 27th June and 13th November to ensure they are up to date with the latest legal guidance and advice. Further sessions are planned.

Emergency Department Flow:

At the time of the visit in March the Trust was failing the 4 hour ED target and had done so for two successive quarters. Concerns were raised by the Inspectors about the responsiveness of the service given the delays being experienced by patients.

The Trust also failed Q1 but management arrangements have since been changed and performance has improved to be one of the best in the region and nationally. Focus on "pull" from the ED and improved processes on the wards has resulted in achievement of Q2 and being very close to the target on Q3 in the face of huge pressure in the wider system.

The Trust has continued to participate in ECIST and the development of the frail elderly service with the CCG. Plans are also underway to host the Urgent Care Centre on site from April 15 which will ensure patients are streamed appropriately thereby easing pressure on the main ED relieving capacity.

Performance of ED is monitored via both the Finance and Performance Committee and the Divisional Performance meetings.

Ophthalmology Clinic Provision:

The pressure on the ophthalmology service is long standing. This has been for two reasons; firstly national shortage of consultants and secondly because of increasing demand as the population ages.

Work was already underway to address this prior to the Inspection and has continued since. Additional senior medical staff have been secured from overseas recruitment and a new Consultant has now been appointed who will start in March 15.

The team are introducing three session days to create more capacity with the extended team. However as capacity comes on stream it is being taken up by increased demand. The Divisional team see the pressures continuing until the new Consultant starts in March.

Performance of this service is monitored by Finance and Performance in terms of slot availability and by the Divisional Performance meetings held monthly.

Phlebotomy Capacity:

The Inspectors witnessed crowded clinics with patients waiting long periods and in some cases having to stand. This was unusual as most patients are seen quickly within a few minutes. However demand on the service continues to increase.

An additional waiting area has been provided at Corbett so that patients can be accommodated more comfortably if they do need to wait.

The recent decision to house the interim solution for the Urgent Care Centre in Outpatients on the Russells Hall site has created an opportunity to review the service there. Phlebotomy services will be moved to ensure outpatient and anticoagulant patients can be accommodated at RHH but a new additional service will be opened at the Guest Hospital for other patients. This will provide a convenient service off the main site and expand capacity. It is envisaged that this change will take place during March.

Documentation for the Use of Compression Stockings:

During the inspection it came to light that the forms used for VTE assessment could be confusing for staff who were not familiar with them. The Inspectors were concerned that this could lead to patients who may need compression stockings not be given them potentially putting them at risk.

After the inspection all critical care patients were checked and they had all received either compression stockings or the appropriate VTE prevention treatment.

As a result of the Inspection findings the forms were changed during the summer.

Incident Recording and Reporting:

The inspection found that in many areas this was good but there was some inconsistency. Although the Trust is one of the highest reporting trusts nationally it is recognised we can always do better. Therefore the governance team at both a corporate level and at a Divisional level have been working to embed best practice at all levels and in all areas.

Staffing Level Reporting and Recording in Maternity:

This was an issue of reporting midwife to birth ratios rather than concerns about staffing levels. The Inspection team wanted to ensure clarity by the reporting of one measure in the unit so that there was good understanding of staffing levels on a daily basis. This has been actioned.

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NHS Foundation Trust

Staffing Levels and Cover for Vacant Shifts:

The Inspection team were content that the Trust had the appropriate staffing levels in place but concerns were raised about the reliance on bank staff, many of whom were Trust staff, to fill vacant shifts.

In a difficult recruitment climate for qualified nurses, the Trust has continued to recruit and has undertaken another successful round of recruitment in Portugal. The latest round of recruitment has brought the Trust close to full establishment for qualified nurses. We are still actively recruiting to ensure that we are we are able to meet new vacancies as they arise through natural turnover.

The Trust plays a leading role in the Black Country Education and Training Council and the CE has a seat on the West Midlands Health Education Board. Therefore we are in a good position to influence training and education and have been successful in getting increased training numbers and courses for sonographers and ODPs in addition to more nurse training places. Although this strategy will take three years to come to fruition with the new graduates, the Trust will continue its policy of recruiting abroad and in trying to make Dudley Group the best place to work to attract local candidates in a difficult market.

Ward staffing levels are monitored daily and reported to the Board on a monthly basis under the Safer Staffing initiative.

Paula Clark
23.12.14

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 8th January 2015

TITLE:	**Quality Priorities for 2015/16 Quality Metrics for Quality Account 2014/15**		
AUTHOR:	D Eaves, Quality Manager	**PRESENTER:**	D McMahon, Nursing Director

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.

SUMMARY OF KEY ISSUES:

The present Quality Account Priorities (2014-15) cover the following six topics:

Patient Experience **Infection Control** **Pressure Ulcers**
Nutrition **Hydration** **Mortality**

The first five topics were initially agreed by the Board of Directors for the 2012-13 year on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Indicators) and a national perspective (e.g. reports from national bodies e.g. Age Concern, general CQC findings). They were endorsed by a Listening in Action event on the Quality Account, hosted by the Chief Executive and Director of Nursing, attended by fifty five people (a mix of staff, governors, FT members and representatives from local statutory and voluntary bodies). Following discussions with the Governors, it was agreed to retain these topics for both the following year (2013-14) and this year when also Mortality was added due a recommendation from the Keogh Review.

Each year the Trust has to agree the Quality Priority topics and then specific targets for each of the priorities. A decision on these specific measureable targets for each of the priority topics will have to wait to late in the financial year (c. March/April 2015) as many of these will depend on the Trust's end of year (2014/15) position. The attached paper discusses proposals for the topics for 2015-16. Governors were asked for their views on this at their December meeting and it was agreed that if any individual had ideas other than a roll-over of the present topics they should inform the Nursing Director before the end of the month. The Board of Directors is asked to either agree with the roll-over of all the existing topics or agree an alternative list of topics.

As well as agreeing on next year's Quality Priority topics, the Board of Directors also needs to agree what three quality metrics will be publicised in the Quality Account for each of the three area of quality: Patient Experience, Patient Safety and Clinical Effectiveness.

Both decisions need to be minuted as this will be reviewed as part of the external audit of the Quality Account. The attached paper also indicates Monitor's requirements with regards to the metrics, the metrics used last year (2013/14) and it also includes a suggestion for this year. The Board of Directors are asked to either agree with the suggestion or agree an alternative.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details**:
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Quality Account requirements
	Equality Assured:	**Y**	**Details:** Better Health Outcomes Improved Patient Access and Experience
	Other	**Y**	**Details**: DoH Quality Account requirements

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
√		√	

RECOMMENDATIONS FOR THE BOARD:

To agree the Quality Priority topics for next year and the quality metrics to be used in the Quality Account 2014/15.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Suggestions regarding Quality Account Priorities for 2015-16

This paper proposes that the six existing topics are again retained, primarily because of their continuing importance. A positive Patient experience is at the core of why the Trust exists, the reduction and maintenance of low infection rates are a key commissioner and national requirement and there is a national campaign of zero tolerance to pressure ulcers. Good Nutrition and Hydration care are fundamental basic requirements for health, patient recovery and, if gaps occur, result in increased morbidity and patient dissatisfaction. The need to review patient deaths in hospital is an essential part of ensuring learning occurs in those cases when practice can be improved.

On September 11th at this year's Annual Members Meeting, a questionnaire was distributed to the attendees and 38 were returned. When asked if each priority topic was suitable the following answers were given:

	YES	NO	UNSURE	NO ANSWER
Patient Experience	38			
Pressure Ulcer	33		5	
Infection Control	37		1	
Nutrition	37		1	
Hydration	37		1	
Mortality	31		6	1

It can be seen there is a general agreement with the topics. The participants were also asked about ideas for quality priority topics in the future. Answers included:

End of Life Care
Mental Health Care
Dementia Care
Elderly Care
Waiting times for appointments
Spiritual care availability
Relative Care
Fluid checks to be more often
Communication on discharge
Physical Exercise (weight control)
Waiting time to reach ward from EAU/ED
Time between consultant appointments for children
Waiting time from discharge to being given prescribed medication by pharmacy
Type 1 diabetes management on children's ward
Communication in ED and with relatives
The provision to care for patients with hip problems on a gynaecology ward
Ability to provide OT equipment, an audit could be provided
Routine screening for EDS/Hypermobility by physiotherapists

Although they were asked to bear in mind that the topics need to have measurable targets and the data has to be easily collectable this is not the case with many of these suggestions (e.g. Spiritual Care). This is quite a varied list with some of the topics being quite specific, suggesting they come from individual patient experience.

The Board of Directors is asked to agree whether:

a) We should roll over the existing 6 priority topics or
b) We should omit one of the existing topics and add a new one, if so which ones bearing in mind the need for any new topic to be measurable and the data easily collectable

Preliminary Timetable

Sept/Nov 2014	Ask for views on topics via Trust website, at AGM and at CCG CQRM
11th Dec 2014	Discussion regarding above proposals with Governors
8th Jan 2015	Board of Directors agree priority topics
2nd April 2015	Board of Directors agree priority specific measureable targets

Quality Metrics for Quality Account

A. Introduction

As well as the requirement to have at least three quality priorities in the Quality Account (the Trust has 6 for 2014/15), Monitor mandates that in Part Three of the Account, Trusts should include three quality metrics for each of the three domains of quality. The Trust Board should agree these each year.

Monitor says that for those indicators selected by the Trust: ' *the report should refer to historical data and benchmarked data when available, to enable readers to understand progress over time and performance compared to other providers. References of the data sources for the indicators should be stated, including whether the data is governed by standard national definitions. Where these indicators have changed from the indicators used in the previous year's report, the Trust should outline the rationale for why these indicators have changed. Where the quality indicators are the same as those used in the previous year's report and refer to historical data, the data reported should be checked to ensure consistency with the previous year's report. Where inconsistencies exist, the Trust is required to include an explanatory note on any changes in the basis of calculation*.'

B. Decision made for 2013/14

The Board will recollect that last year an agreement was reached to continue with the metrics introduced in the previous year. This was because it was noted that following the reviews he undertook Sir Bruce Keogh said in his National Overview Report (dated 16th July 2013):

'I will ensure that the requirements for Quality Accounts for the 2014-15 round begin to provide a more comprehensive and balanced assessment of quality'.

Due to these implied changes for 2014/15, it was agreed not make any changes last year so for 2013/14 the following metrics were included in the Quality Account.

Patient Experience Domain

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

Inpatient survey question
Patients who agreed that the hospital room or ward was clean
Rating of overall experience of care
Patients who felt they were treated with dignity and respect

Patient Safety Domain

The three metrics were:

Patients with MRSA infection/1,000 bed days
Number of cases of venous thromboembolism (VTE) presenting within three months of hospital admission
Never Events – events that should not happen whilst in hospital

Clinical Effectiveness Domain

The three metrics were:

Readmission rate for Surgery
Number of cardiac arrests
% of elective admissions where planned procedure not carried out (not patient decision)

C. For this year 2014/15

As the quote from Monitor above indicates, the Board needs to decide whether to continue using the above metrics or make any amendments.

It has now been announced that the expected changes to the Quality Accounts announced by Sir Bruce Keogh will not now occur for this year's report but in the near future. If the national changes to Quality Accounts occur next year it is suggested that the Board agrees that last year's metrics are used again in 2014/15. This also allows easy access to historical comparative data.

D. Eaves. December 2014

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 8th January 2015

TITLE:	**RESEARCH & DEVELOPMENT REPORT**		
AUTHOR:	**M Marriott, R Storey, R&D Facilitators/ J R Neilson, Head of R&D**	**PRESENTER**	**Jeffrey Neilson, Head of Research & Development**

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

SUMMARY OF KEY ISSUES: Update on research funding, recruitment, training, activity, staffing

IMPLICATIONS OF PAPER:

RISKS	**Risk Register** **No**	**Risk Score**	**Details:**
COMPLIANCE	**CQC**	**Y**	**Details:** Evidence to support compliance with Essential standards of Quality & Safety Outcome 16 – Assessing and monitoring the quality of service provision.
	NHSLA	**Y**	**Details:** Staff working on approved studies will be covered by normal NHS indemnity arrangements.
	Monitor	**Y**	**Details:** R&D activity included in the Annual Report.
	Other MHRA	**Y**	**Details:** SAEs for all drug/device studies are reported on study by study basis to MHRA by study sponsor

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE COMMITTEE:

The Board of Directors is asked to receive the report, and note and approve its contents.

The Dudley Group NHS
NHS Foundation Trust

REPORT OF THE MEDICAL DIRECTOR'S DIRECTORATE TO THE BOARD OF DIRECTORS ON 8TH JANUARY 2015

RESEARCH & DEVELOPMENT REPORT

Summary

Finance

R&D's core funding allocation granted by the Clinical Research Network West Midlands (CRN(WM)) was **£536,716.00.** We have also been successful in gaining an additional **£76,948.00** in strategic funding bids to further develop our research capabilities. Our final WMCRN funding total for the year 2014/2015 is **£613,634.00.**

The CRN West Midlands have already indicated that our funding for 2015/2016 will be **£571,730.00**. We are one of the few Trusts with an increase in funding. Strategic funding bids are currently being developed and we expect to have a decision from CRN(WM) on our final funding allocation, plus any bids made, by early March 2015. Details of this year's core funding awards plus indicative funding for next year for all Trusts within the CRN(WM) boundary can be found at appendix 1.

Recruitment

Recruitment activity has been successful so far this year and we are just about meeting the agreed NIHR target. Appendix 2 is derived from the CRN December report and our performance to date is illustrated together with how specialties contribute to this. Our performance compares favourably with neighbouring Trusts; the table in appendix 3 illustrates this and is again taken from the December CRN report. We are confident that we will achieve our target of 1861 patients recruited to research by the end of March 2015.

Activity

National Institute for Health Research portfolio studies only:

Number of recruiting studies as at 12/12/2014:	129 comprising of 109 academic (a) and 20 commercial (c).
Closed studies still collecting data:	73 (A) 23 (C).
Recruiting non NIHR studies:	14 academic; 4 commercial
Publications for 2014 calendar year:	132 – this figure includes conference posters and articles

Education and Training:

The Trust continues to host National Institute for Health Research (NIHR) accredited Good Clinical Practice (GCP) training. An R&D Facilitator (Margaret Marriott) has now completed the Facilitator Training Programme and will begin to deliver GCP training in January 2015 across CRN (West Midlands). The online training package provided by NIHR is also used.

Research Governance Implementation:

A total of **56** studies were assessed by the Protocol Review Sub-committee between 01/04/2014 and 01/12/2014.

Reported Serious Adverse Events as of 09/12/2014:

Oncology: 72
Haematology: 26
Cardiology: 17
Chemical Pathology: 18
Rheumatology: 5.

The large number of Oncology events is due to a backlog of SAEs that were reported in a timely fashion to the study centre, but not copied to the R&D Office. 17 of these SAEs are thought to be drug related (16 in Oncology).

Staffing:

1. CRN strategic funds granted in August 2014 have been used to:

    - Extend the contract of our 0.60 WTE band 7 Lead Generic Research Nurse (not tied into a specific discipline)
    - Increase Generic Research Nurse support by 1 WTE.

2. CRN strategic funds granted in December 2014 have been used to:

    - Further increase Generic Research Nurse support by 0.5 WTE
    - Further increase Maternity Research Midwife support by 0.2 WTE
    - Introduce support for Anaesthetic Research 0.3 WTE
    - Further support Pharmacy clinical trials dispensary team in view of the growing research taking place within the Trust - 1WTE
    - Increase data manager support across Oncology and Haematology Trials - 1WTE.

3. Commercial Research funds:

    - Increased Research Laboratory BMS staff by 0.5 WTE to broaden the capacity of the unit
    - Employed a band 2 0.4WTE Cardiology Research Administrative Officer
    - Employed a band 6 1WTE Research Nurse to provide maternity cover for Cardiology commercial trials.

MHRA Inspection: The report was published in May 2014 and was complimentary about the Rheumatology research team.

Issues: A couple of minor findings were found and have been addressed.

Good Clinical Laboratory Practice Inspection: The inspection in May 2014 was successful and the Research Lab was afforded full accreditation. We look forward to re-inspection in May 2015.

Issues: None reported.

Recommendations

The Board of Directors is asked to receive the report, and note and approve its contents.

Appendix 1

Partner Organisation	2014/15 Allocation (£)	2015/16 ABF Allocation with +/- 15% capping applied (£)
Birmingham and Solihull Mental Health NHS Foundation Trust	322,718	267,453
Birmingham Children's Hospital NHS Foundation Trust	641,968	560,865
Birmingham Community Healthcare NHS Trust	98,702	110,670
Birmingham Women's NHS Foundation Trust	592,498	617,755
Black Country Partnership NHS Foundation Trust	39,345	38,466
Burton Hospitals NHS Foundation Trust	571,907	473,968
Coventry and Warwickshire Partnership NHS Trust	307,109	333,914
Dudley and Walsall Mental Health Partnership NHS Trust	46,985	38,939
George Eliot Hospital NHS Trust	119,033	110,337
Heart of England NHS Foundation Trust	1,427,601	1,600,698
Mid Staffordshire NHS Foundation Trust	672,345	557,206
North Staffordshire Combined Healthcare NHS Trust	163,893	135,826
Sandwell and West Birmingham Hospitals NHS Trust	752,307	623,491
Shrewsbury and Telford Hospital NHS Trust	765,475	634,387
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	184,954	158,454
South Warwickshire NHS Foundation Trust	180,103	149,260
Staffordshire and Stoke On Trent Partnership NHS Trust	270,000	223,763
The Dudley Group NHS Foundation Trust	536,716	571,730
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundatio	308,519	255,685
The Royal Orthopaedic Hospital NHS Foundation Trust	289,920	261,098
The Royal Wolverhampton NHS Trust	1,540,856	1,276,984
University Hospital of North Staffordshire NHS Trust	1,957,284	1,622,099
University Hospitals Birmingham NHS Foundation Trust	1,998,727	1,656,445
University Hospitals Coventry and Warwickshire NHS Trust	1,948,615	1,614,915
Walsall Healthcare NHS Trust	211,258	175,080
West Midlands Ambulance Service NHS Foundation Trust	Excluded	0
Worcestershire Acute Hospitals NHS Trust	481,220	398,811
Worcestershire Health and Care NHS Trust	111,812	92,664
Wye Valley NHS Trust	279,738	231,833
Primary Care - Central	1,096,134	1,229,040
Primary Care - North	836,178	937,565
Primary Care - South	683,950	766,879
(non NHS e.g. private healthcare or recruitment at Universities etc)	Excluded	
TOTAL	19,437,870	17,726,280

Strategic Funding **1,711,590**

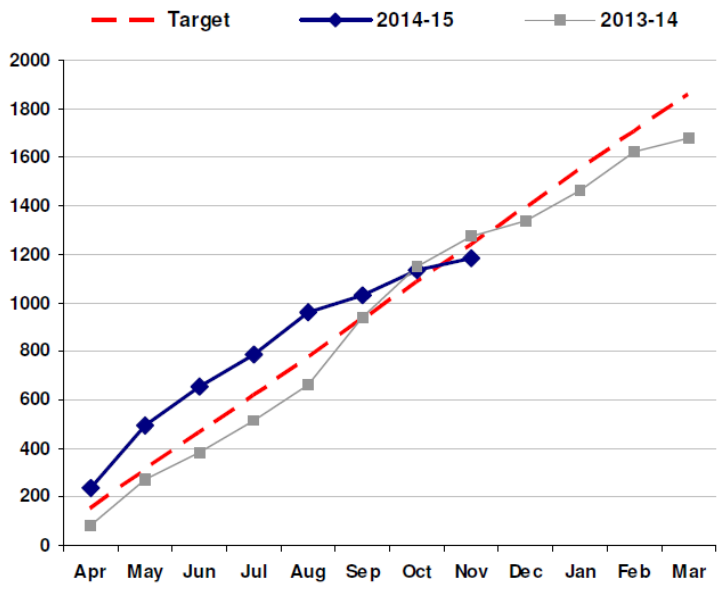
Total Allocation **19,437,870**

NOTE - ACTIVITY for Ambulance & Non NHS Excluded

Appendix 2

Recruitment data as provided by CRN Coordinating Centre on 12/12/2014

	This year		Last year
	Target	Recruitment	
Apr	155	234	84
May	310	498	275
Jun	465	655	383
Jul	620	788	513
Aug	775	959	663
Sep	931	1033	941
Oct	1086	1134	1148
Nov	1241	1187	1277
Dec	1396		1335
Jan	1551		1466
Feb	1706		1627
Mar	1861		1676



Due to the average delay in studies uploading data, it is recommended to look back 1-2 months for a more accurate picture.

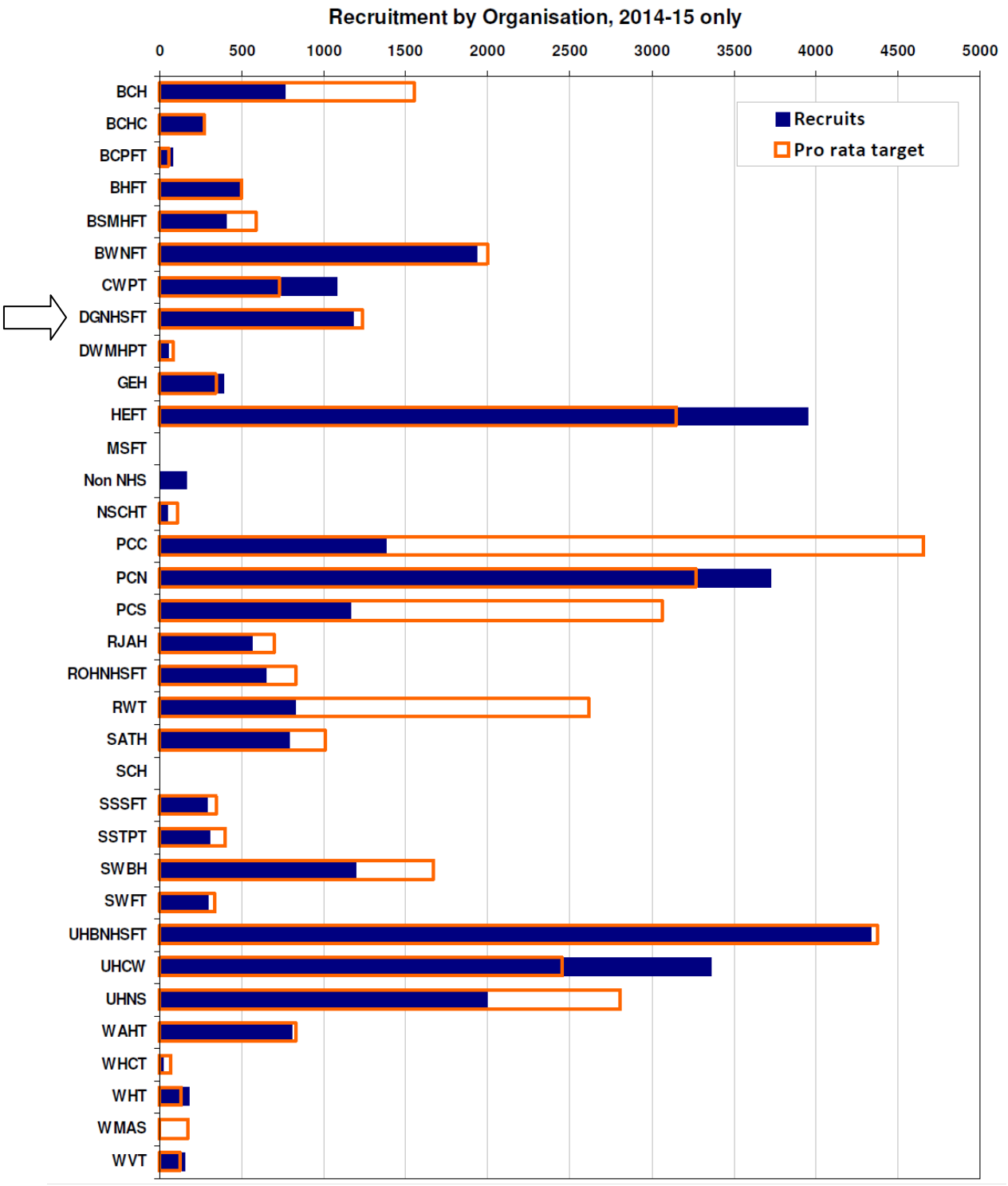
Recruitment by Specialty compared with Targets FY 2014-15, up to end of last month

Recruitment data as provided by CRN Coordinating Centre on 12/12/2014

The Dudley Group NHS Foundation Trust only

Specialty	Target		Recruits	*Variance*
	Full year	Pro rata		
Anaesthesia, perioperative medicine and pain management	20	13	82	*69*
Cancer	345	230	130	*-100*
Cardiovascular disease	383	255	95	*-160*
Children	2	1		*-1*
Critical care	1	1	2	*1*
Dermatology	105	70	30	*-40*
Diabetes	80	53	34	*-19*
Gastroenterology	17	11	1	*-10*
Genetics	22	15		*-15*
Haematology	100	67	63	*-4*
Hepatology	6	4		*-4*
Infectious Diseases and Microbiology	21	14	51	*37*
Musculoskeletal disorders	157	105	562	*457*
Neurological Disorders	50	33	16	*-17*
Primary Care	1	1	1	*0*
Reproductive health and childbirth	11	7	14	*7*
Stroke	20	13	30	*17*
Surgery	20	13	76	*63*
xx Additional xx (for Trust Targets)	500	333		*-333*
	1861	**1241**	**1187**	*-54*

Appendix 3


Recruitment by Organisation, 2014-15 only
0
500
1000
1500
2000
2500
3000
3500
4000
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BCH
BCHC
BCPFT
BHFT
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RJAH
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UHCW
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WAHT
WHCT
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WMAS
WVT
Recruits
Pro rata target

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 8th Jan 2015

TITLE:	**Listening into Action Report**		
AUTHOR:	**Jackie Dietrich Communications Manager**	**PRESENTER**	**Jackie Dietrich Communications Manager**

CORPORATE OBJECTIVE:
SGO5 staff commitment
SGO6 enabling

SUMMARY OF KEY ISSUES:

This report updates the Board on plans to re-launch the Listening into Action (LiA) staff engagement programme. It is proposed that we run a CIP 2015/16 LiA to re-launch LiA.

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

RISK	**NO**		**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:** **Outcome 1:** Respecting and involving people who use the service. **Outcome 14:** Supporting workers. **Outcome 16**: Assessing and monitoring service provision.
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N**	**Details:** Better health access for all. Improved patient access and experience
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
√		√	

RECOMMENDATIONS FOR THE BOARD

It is recommended that the Board of Directors:

i. **Notes the re-launch of Listening into Action at the Dudley Group.**

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

1 Introduction

This report updates the Board on the plans to re-launch the Listening into Action (LiA) staff engagement programme within the Trust in 2015.

LiA is a systematic approach to widespread staff engagement designed to empower leaders and staff around any change or challenge. It was developed by a company called Optimise Limited and is outcome orientated designed to mobilise the full capability of the workforce to improve outcomes for patients and staff.

LiA launched in September 2010 with a series of five 'big conversations' hosted by the Chief Executive. Some 40 teams, ranging from front line staff on wards to office staff in support functions, have been empowered by LiA to make changes to the way they work to improve patient care and patient experience.

Teams from cancer services to critical care, and from medical secretaries to main outpatients, adopted LiA to make service changes and improvements.

1.1 Achievements – departmental LiAs

Community Services:
Mission: to create a seamless integration of Dudley Adult Community Services teams with The Dudley Group.

Outcomes: mandatory training standardised and a clear training programme was developed; communication was improved with the development of a shared Hub and community staff attended customer care promises LiA.

Cancer Services:
Mission: to agree an acute oncology service coordinator utilising existing staff in order to demonstrate the benefits of administrative support on this new initiative.

Outcomes: a medical secretary from within the cancer services team took on this role which saw a reduction in length of stay for patients admitted with a condition related to cancer diagnoses; a reduction in inappropriate admissions and enhanced communication between healthcare professionals.

Clinical Audit
Mission: to raise the profile of clinical audit across the organisation, working with staff to review standards and capture changes in practice giving improved patient care.

Outcomes: improved communication by raising awareness on how to request clinical audit support; improved motivation and ownership of clinical audit across all levels of staff via regular directorate meetings; wide promotion of clinical audit via a monthly newsletter that received positive feedback.

Surgical HDU
Mission: to improve flow through SHDU to a ward to free up spaces for critical care and also improve team work and staff morale.

Outcomes: medical staffing CT/SHO level presence agreed to be in SHDU am and pre-assessment pm; improved communication i.e. plans of care disseminated to nursing team throughout the day; SHDU in charge guidelines being re-written to include team briefing sessions throughout the day. Use of electronic handover completed.

Finance
Mission: to improve the way finance staff communicated the financial position to the Trust to increase cost awareness.

Outcomes: policy on escalation of IT issues written; training guidance written; meeting structure and communication reviewed.

Maternity OPD
Mission: to reduce waiting times in the antenatal clinic.

Outcomes: appointments were spread out in the pre-op assessment clinic so that women did not all arrive at the same time; stamp used on appointment cards advising women of their standard appointment slots; big efforts were made to ensure clinics started on time to eradicate variation in obstetric management. Consultants encouraged to reduce unnecessary follow up appointments and discharge to the community midwife instead.

1.2 Achievements – Trust-wide LiAs

A number of Trust-wide LiA conversations followed to help implement a major bed re-designation, improve IT and embed customer care. LiA has also been used to help set the Trust's quality priorities and to help improve the complaints handling process following feedback from the Keogh Review.

1.3 Re-launch

It is proposed that LiA is re-launched in the New Year 2015. The timing of the launch will follow further discussion to find the most appropriate date given workforce changes. Actions to facilitate re-launch: promotional artwork to be refreshed; LiA Hub page to be created and former adopters invited to present at re-launch event. See action plan (appendix 1)

Listening into Action Re-launch Plan

Action	By when	Owner	Status	Explanatory notes
Refresh launch material	End of Jan 2015			
Create LiA Hub page	End of Jan 2015	Staff Engagement Officer		
Invite two/three former adopters to present at launch	End of Jan 2015	Communications Manager		■ To talk about the benefits of holding an LiA to make improvements and service changes.
CE presents to directors & senior managers at TME	End of Jan 2015	Chief Executive		■ To explain what LiA is (especially to new directors) & the aim of re-launching it, the importance of their commitment to it and their role as executive sponsors. ■ Could broaden this out to divisional directors
CE LiA launch message to leaders		Communications Manager		
CE LiA launch letter to all staff		Communications Manager		
Invite staff to re-launch event		Staff Engagement Officer		
Hold re-launch event	TBC	Communications Manager		■ Timing of launch will follow further discussion to find the most appropriate date given forthcoming workforce changes.
Invite staff to submit mission idea and suggested sponsor groups	Following re-launch event	Communications Manager		
Directors select LiA adopters	Following mission idea submissions	Executive team		
Inform successful adopters & invite to briefing LiA teams session	Following directors' selection of LiA adopters			
Hold LiA teams briefing sessions	Following informing adopters of successful submission	Communications Manager		■ To guide LiA adopter leads on creating an achievable mission with measurable outcomes that benefit staff and/or patients. ■ To guide LiA adopter leads on forming an effective sponsor group
Approve LiA missions & proposed sponsor groups	Following submission of refined mission	Executive team		
Create & maintain LiA matrix of	Following approval of	Staff Engagement Officer		■ At a glance list of teams, missions, sponsor group members and executive sponsor designated to

teams & missions	missions & sponsor group members			support them.
Assign exec sponsors to LiA teams		Communications Manager / Chief Executive		■ To offer executive support to LiA teams to help them achieve their missions
Hold weekly LiA face-face & virtual 'Surgeries'		Communications Manager / Staff Engagement Officer		■ To help and support teams as they set up their LiA conversations
Teams report LiA actions & outcomes	Timeframe and process to be agreed	LiA teams/ directorate managers		
Monitor progress		Communications Manager / Staff Engagement Officer		

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 8th January 2015

TITLE:	**Transform End of Life Project**		
AUTHOR:	**Dr Joanne Bowen Palliative Medicine Consultant**	**PRESENTER**	**Dr Joanne Bowen Palliative Medicine Consultant**

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

SUMMARY OF KEY ISSUES:

- Economy wide engagement continues to support the workstreams in the development & roll out of improvements. An economy wide steering group is due to meet for the first time in January 2015.
- Robust governance arrangements support the workstreams to monitor their actions & timelines & provides reporting mechanisms both internal & external to the Trust
- Successful application to become one of only six national innovation sites to look at improving the way palliative care & end of life services are provided to patients with cancer & other long term conditions at home or closer to home
- Capacity within the team to deliver care, provide education & training and undertake service improvement continues to be an issue. However we have successfully recruited to two new consultant posts(1.2wte) – part funded by Macmillan pilot & match funded by Dudley CCG.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:** ACC003: Insufficient resource within the Specialist Care Team to support professionals & patients with their palliative care needs & deliver service improvements. ACC004: The Dudley Group NHSFT, failed to achieve 6 of the 7 Organisational KPIs when audited (The National care of the dying audit for hospitals) (NCDAH).
	Risk Register: Yes		**Risk Score:** **ACC003 – 20** **ACC004 – 20**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details: Outcome 1, Outcome 4 & Outcome 6**
	NHSLA	**No**	**Details:**
	Monitor	**No**	**Details:**

	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

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

Decision	**Approval**	**Discussion**	**Other**
			For information

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP: *delete as appropriate*

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

Specialist Palliative & End of Life Care

The Trust signed up to the Transforming End of Life Care in Acute Hospitals Program in April 2013. Denise McMahon is Executive Sponsor & Dr Jo Bowen is Clinical Lead.A steering group was formed & agreement reached that the project would look at transforming end of life care across the economy rather than just in the acute hospital.

The End of Life Project now reports to the Clinical, Quality, Safety & Patient Experience Committee & an economy wide steering group to be chaired by our Non Exec Lead for End of Life, David Badger, is due to meet in January 2015. A working group reporting to the steering group will be chaired by Dr Jo Bowen.

Transform uses the following 5 key enablers to transform care:

5 Priorities for Care – National guidance instructed the use of the LCP to cease & to replace it with individualised care plans. A workstream is underway reviewing the 44 recommendations from the review into the LCP, the recommendations from 'One Chance to Get it Right' & the results of the National Care of the Dying Audit in order to develop a way forward for Dudley to achieve the 5 Priorities for Care.

Advance Care Planning - develop & improve the current document & process to support individuals to express their wishes in the context of an anticipated deterioration & where they may not have the ability to communicate wishes to others. A workstream is underway developing a guideline, patient held document & patient information for launch in the New Year.

AMBER Care Bundle - a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the worst happen. A workstream is underway supported by an AMBER care facilitator for 12 months. A pilot commenced on wards C5 & C7 in December 2014.

Rapid Discharge home to die process - improvements to the current discharge process enabling patients to die in their preferred place of care. A workstream is underway to review the process for a rapid discharge within 24 hours of identification & for a more immediate turnaround for patients presenting in ED.

EPaCCs - Electronic palliative care coordination system which would provide a shared record for health & social care professionals. Dudley health economy has received a demonstration of the 'Co-ordinate My Care' system used across London. In addition Emisweb is also being considered following a move to this system by all Dudley GPs. Discussion's continue across the economy re the best solution & costs/funding arrangements.

In addition to the 5 enablers, the project also has the following additional workstreams:

Education – Underpinning all of the project is Education. A workstream is underway that has scoped the current training & education for End of Life and agreed areas for education & training by discipline and by topic. The group are currently working through an action plan to deliver the education & training required by all disciplines across the economy. This workstream works closely with all of the above workstreams to ensure they are aware of any education/training needs arising from the improvements being developed.

Macmillan Specialist Care at Home – A 2 year pilot in collaboration with Macmillan, Mary Stevens Hospice & Dudley CCG. The team in Dudley are one of six national innovation sites that are looking to improve the way palliative care & end of life services are provided to patients with cancer & other long term conditions at home or closer to home.

The pilot will :

- **Create a Specialist Palliative Care Hub at the hospice & introduce a Single Point of Access for professionals & patients requiring the support of the Specialist Palliative Care Team.**
- **Collaborative working with joint MDT & GSFs that maximise the benefits to patients & makes effective use of professional time.**
- **Scope palliative care workforce across the economy 7 days per week**
- **Scope the need for additional volunteers to support patients & carers**

Bereavement – An existing working group that was meeting to address the significant gaps in Bereavement Care across Dudley is also being brought under the governance of the End of Life project. The group met in November & are developing an action plan to support the improvements they will undertake.

Communications & Engagement -

- **Communications Strategy to support the promotion of the work underway with End of Life. This is currently being developed & will be shared with the End of Life working group in the New Year.**
- **Specialist Palliative Care website for all professionals & public to access. Currently under development & will provide access to information from Dudley Group, Community Services, Primary Care, Social Care, Mary Stevens Hospice & other providers of palliative care.**
- **VOICES Bereavement survey – locally adapted from a national survey, Dudley Group launched this survey via the Bereavement office in September 2014 to gather the views of bereaved relatives about the care their loved ones received in the last days of life. Feedback from the survey will feed into the work of the groups above.**
- **Patient engagement – individual workstreams are engaging with the public through a variety of forums to gather their views.**

Summary of key achievements to date:-

- **Economy wide engagement continues to support the workstreams in the development & roll out of improvements**
- **Robust governance arrangements support the workstreams to monitor their actions & timelines & provides reporting mechanisms both internal & external to the Trust**
- **Successful application to become one of only six national innovation sites to look at improving the way palliative care & end of life services are provided to patients with cancer & other long term conditions at home or closer to home**
- **Successfully recruited to two new consultant posts(1.2wte) – part funded by Macmillan pilot & match funded by Dudley CCG**

Specialist Palliative Care Services

Specialist palliative care teams are those with palliative care as their core daily work. They are multidisciplinary teams, have specialist skills and experience, and deliver palliative care both directly and indirectly: directly by providing care to patients and families, and indirectly by supporting other professionals to deliver such care.

Specialist Palliative care aims to improve quality of life for patients and their families who are facing life limiting illnesses. It encompasses pain & symptom relief, spiritual, psychological support and assistance with future care planning. Specialist palliative care is important from initial diagnosis right up to end of life care.

The hospital Specialist Palliative care team have worked with several specialities including Cardiology and Respiratory teams to improve the recognition with regards to the palliative care needs of patients with a non – cancer diagnosis. There is increasing evidence that patients with a non-cancer diagnosis require Specialist Palliative Care support and now the percentage of cancer and non-cancer referrals are almost 50:50. Three years ago the majority of patients referred had a cancer diagnosis (80%). Furthermore, referrals to the hospital Palliative Care team have increased from 400 per year to over 1000 per year.

Most people would prefer to die in their own home even though less than 20% do so, with a similar proportion of patients dying in care homes and very few patients dying in hospices. Public Health data collection has recently changed, as part of the 2011/12 NHS operating framework, the definition of 'at home' is now defined as 'usual place of residence' and this includes home, care homes (NHS and non-NHS) and religious establishments.

Results from audits within the Dudley community specialist palliative care team demonstrate that over 80% of patients known to the team die in their preferred place of care and for the majority of these patients this is home, care home or hospice.

Results from an audit carried out in 2012

Data was collected on patients under the care of the Dudley palliative care team between July and September 2012. Data was collected retrospectively on all patients that died over the three month period, resulting in a study size of 127 patients.

Standard	Result
80% of patients should have a documented preferred place of care	Preferred place of care was established in 87(84/97) of the cancer patients and 93% (28/30) of the non-cancer patients
80% of patients should die in their preferred place of care	Of those in whom a preferred place of care was established, 93% (78/84) of cancer patients died in their preferred place of care, and 86% (24/28) of the non-cancer patients died in their preferred place of care.

Patient Case for Board

VOICES Bereavement survey – locally adapted from a national survey, Dudley Group launched this survey via the Bereavement office in September 2014 to gather the views of bereaved relatives about the care their loved ones received in the last days of life. Feedback from the survey will feed into the work of the groups above.

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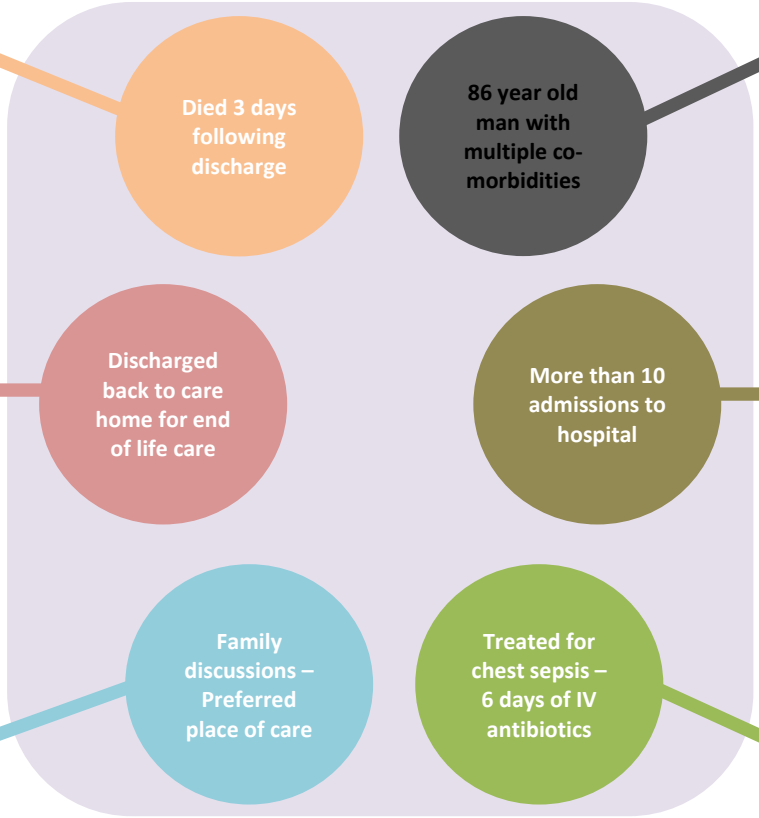

Advance Care Planning - Develop & improve the current document & process to support individuals to express their wishes in the context of an anticipated deterioration & where they may not have the ability to communicate wishes to others. A work stream is underway developing a guideline, patient held document & patient information for launch in the New Year.

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Education – Underpinning all of the project is Education. A workstream is underway that has scoped the current training & education for End of Life and agreed areas for education & training by discipline and by topic. The group are currently working through an action plan to deliver the education & training required by all disciplines across the economy. This workstream works closely with all of the above workstreams to ensure they are aware of any education/training needs arising from the improvements being developed.

Enclosure 15

Paper for submission to the Board on 8th January 2014

TITLE:	Non Executive Director Committee changes		
AUTHOR:	Julie Cotterill Associate Director of Governance / Board Secretary	**PRESENTER:**	David Badger (NED) Chairman

CORPORATE OBJECTIVES: SGO6:

SUMMARY OF KEY ISSUES

The Board of Directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the trust to enable them to discharge their respective duties and responsibilities effectively. To comply with the Standing Orders of the Trust (section 5.6); the Board must approve the appointments to each of the committees it has formally constituted.

Following the recent appointment of Mr Badger as Chairman of the Trust the following changes to the Non Executive Director membership and chairmanship of the Board Committees are proposed:

Committee	Chair	Membership (NED)
Audit	Richard Miner	Ann Becke Jonathan Fellows
Finance and Performance	Jonathan Fellows	David Bland Richard Miner
Workforce and Staff Engagement	Ann Becke	Richard Miner Clinical NED (vacant)
Clinical Quality Safety and Patient Experience	Clinical NED (vacant)	Ann Becke David Bland
Charitable Funds	David Bland	Jonathan Fellows Clinical NED (vacant)

To assist with Committee quoracy pending the recruitment to both Executive and Non Executive Director vacancies, the Board is also requested to consider an interim amendment to the quoracy requirements for the above Committees such that business shall be transacted if at least one Executive and one Non Executive Director are present. Normal quoracy requirements would resume when vacancies are filled.

IMPLICATIONS OF PAPER:

RISK	N		**Risk Description:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Governance Arrangements
	NHSLA	N	**Details:**
	Monitor	Y	**Details:** Governance Arrangements. Authorisation compliance
	Equality Assured	Y	**Details:**
	Other	N	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓		

RECOMMENDATIONS FOR THE BOARD:
To approve the changes to the Non Executive Director Board Committee membership
To approve an amendment (for an interim period) to the quoracy requirements for Board Committees.

Enclosure 16

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 8 January 2015

TITLE	**Performance Report April – November 2014**		
AUTHOR	**Paul Taylor Director of Finance and Information**	**PRESENTER**	**David Badger F & P Committee Chairman – Dec 14**
CORPORATE OBJECTIVE: SG06 Enabling Objective			
SUMMARY OF KEY ISSUES: • **Deficit of £0.4m in October (£1.2m better than plan)** • **Deficit of £5.1m for year to date, (£0.7m better than plan)** • **Deficit budget for 2014-15 of £6.7m still likely to be exceeded, with a £8.0m deficit now forecast – which is an improvement of £0.6m on the previous month's projection** • **A&E 4 Hours waiting time target met in November 2014 (95.6%), but quarter to date reported as 94.67% on 15th December 2014. The actual Q3 position will be reported verbally to the Board meeting** • **Some RTT waiting time pressures, but major RTT and Cancer targets being met**			

RISKS	**Risk Register**	**Risk Score Y**	**Details: Risk to achievement of the overall financial target for the year Financial deficit above Monitor plan now forecast**
COMPLIANCE	**CQC**	**Y**	**Details: CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.**
	NHSLA	**N**	

	Monitor	**Y**	**Details:** **The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS) at Q2, but 2 for Finance for the forthcoming 12 months. The Trust remains on monthly monitoring by Monitor.** **Monitor has notified the Trust that it is investigating A&E performance in the Trust and its long term business viability.** **Monitor expected to announce whether it intends to take regulatory action din January 2015**
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners**

ACTION REQUIRED OF COUNCIL

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report

The Dudley Group NHS
NHS Foundation Trust

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

Report on Finance and Performance for April to October 2014

1. Background

The Finance & Performance Committee of the Board met on 18th December 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.

Highlights of the discussion at the meeting are as follows:

2. Financial Performance for the 8 months period April to November 2014 (Appendix 1)

The Trust set itself the financial strategy from April 1st 2014 to get back to financial balance over a 2 year period, and as part of that strategy agreed a £6.7m deficit plan in 2014-15. Early months in 2014-15 were not as favourable as anticipated and the forecast year-end deficit exceeded £10m in August 2014. Since then spending has broadly stabilised and activity, and therefore income has exceeded expectations.

November 2014 was expected to be a difficult month financially, as it had a small number of working days in it affecting the likely level of clinical income.

In November 2014 the Trust posted an in-month deficit of £0.4m, which was £1.1m better than plan.

For the 8 months period to November 2014 a cumulative deficit of £5.1m is recorded. Key variances include income at +£5.3m (+2.5%); Non Pay -£3.0m (-4.0%); CIP not achieved -£2.6m.

These adverse trading trends are largely the result of the following factors:

- **Significant increases in emergency and other types of activity levels above plan**
- **Continued spending above budget on agency & locum front line medical & nursing staff**

- **Higher than anticipated spending on drugs and devices, which are recharged to commissioners under the terms of our healthcare contracts with them**
- **A slower than anticipated achievement of savings.**

The Trust is now forecasting a deficit of £8.0m for 2014-15 which is an improvement of £0.6m on the previous month.

At 30th November 2014 the Trust had cash reserves of £18.2m (£18.9m in October) and 10.5 days liquidity (10.8 previously).

Capital spending for the period was £5.6m (£0.8m Medical Equipment, £3.1m IT, £1.3m PFI Lifecycle), some £0.1m below plan.

3. Performance Targets and Standards (Appendix 2)

The Trust's non financial performance for the period remains relatively strong. Performance against the Monitor Governance KPI set is given at Appendix 2.

Highlights include:

a) A&E 4 Hour Waits

The November 2014 performance was 95.6% compared to the constitution target of 95%. This is a improvement on the October 2014 position, and the latest quarter to date position at the time of the meeting was 94.67%. Despite unprecedented levels of emergency and A&E activity levels in 2014-15, significant effort is being put into the achievement of the target in the reminder of the year. The actual Q3 position will be reported verbally to the Board.

b) Never Events

The Trust had no 'never events' in November 2014 or for the period to date.

c) Referral to Treatment Waiting Times

The RTT admitted waiting time standard of 90% of patients was just met again in November 2014 with 90.1% of patients being seen in time. There is confidence that this will continue to be achieved for the rest of the year. RTT non-admitted and incomplete pathways KPIs are both well within their thresholds, with performances of 98.6% and 95.7% respectively.

d) Diagnostic Waits

Diagnostic waits continue to underperform compared to targets, although there was some improvement in November 2014.

4. Divisional performance Review

The Committee considered the first performance presentation from the Division of Surgery regarding the financial performance of the maternity service. Under the new Divisional structure this clinical area has become the responsibility of the surgical division recently. The presentation looked at a range of potential improvements in coding and activity collection together with some expenditure reduction schemes, which could improve the trading position of by £1m if fully implemented.. The Committee asked for a report back on progress with implementation in March 2015.

5. Turnaround Progress Report

The Committee considered the extent of the progress being made to date on the Turnaround Programme, and in particular on the large scale cross-organisational schemes. £2m of Cost Improvement Schemes were s"signedoff" following the Quality Impact Assessment process following the meeting and so will be incorporated in future reports.

6. Summary of the Financial Implications of the Siemens Contract Termination.

The Committee considered a report into the financial arrangements with Siemens arising from the contract termination on 18th December 2014.

7. Overview of Financial Position and Next Steps.

The Committee were again pleased to note the improvement in the financial position of the Trust in November 2014 but recognised that more improvement was required to achieve the original deficit budget of £6.7m in 2014-15.

Progress on the new workforce reduction schemes was noted at that the target savings of 200 staff would be issued to budget holders before Christmas 2014, and would be discussed as part of the Operational Plan 2015-16 development process. A revised budget for 2015-16 would then be developed based on the latest view of income and expenditure.

P Taylor
Director of Finance & Information

THE DUDLEY GROUP NHS FOUNDATION TRUST

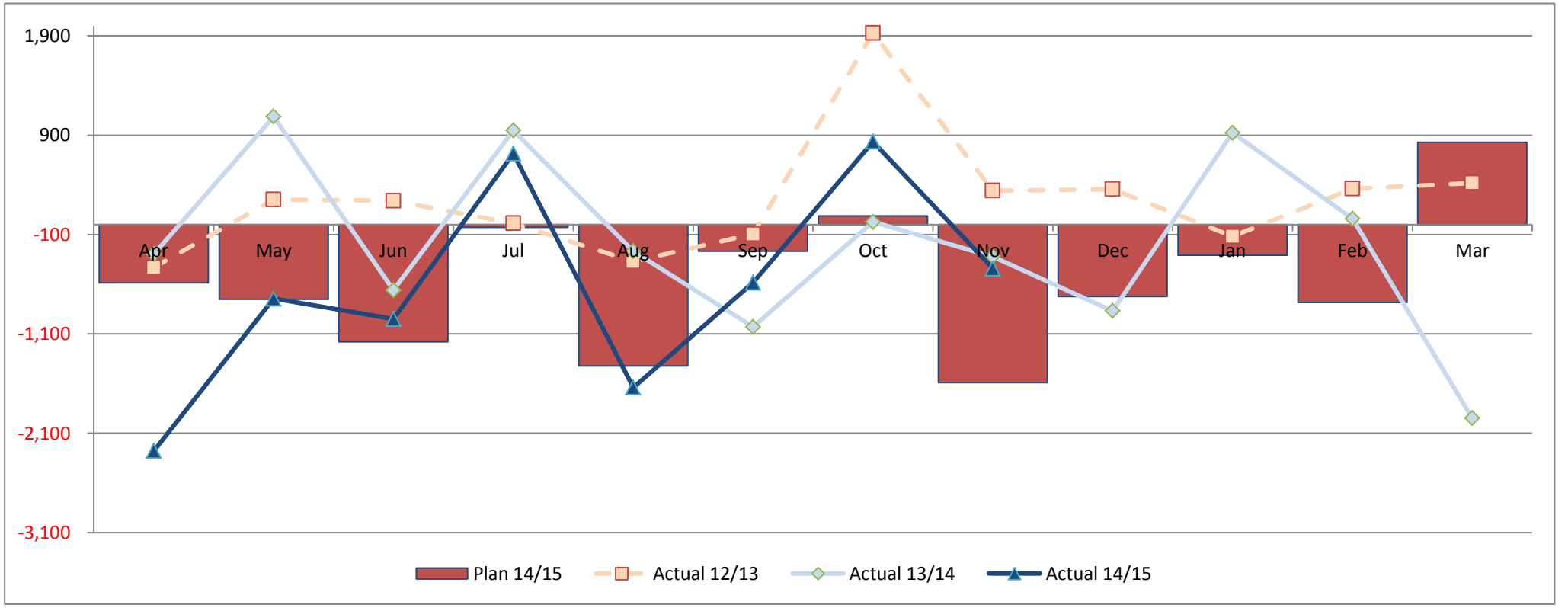
FINANCIAL SUMMARY **NOVEMBER 2014**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£25,659	£27,364	£1,705
PAY	-£16,494	-£15,973	£521
CIP	£651	£0	-£651
NON PAY	-£9,508	-£9,940	-£432
EBITDA	**£307**	**£1,451**	**£1,144**
OTHER	-£1,898	-£1,892	£6
NET	**-£1,591**	**-£442**	**£1,150**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£209,955	£215,292	£5,337
PAY	-£127,907	-£127,046	£861
CIP	£2,632	£0	-£2,632
NON PAY	-£75,213	-£78,221	-£3,009
EBITDA	**£9,467**	**£10,024**	**£557**
OTHER	-£15,207	-£15,111	£96
NET	**-£5,739**	**-£5,087**	**£652**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£314,975	£322,488	£7,512
PAY	-£193,170	-£192,054	£1,115
CIP	£5,913	£0	-£5,913
NON PAY	-£111,582	-£116,121	-£4,539
EBITDA	**£16,137**	**£14,313**	**-£1,824**
OTHER	-£22,865	-£22,322	£543
NET	**-£6,728**	**-£8,009**	**-£1,281**

NET SURPLUS/(DEFICIT) 14/15 PLAN & ACTUAL **NOVEMBER 2014**



Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold & Weighting		Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements							N/A
INFECTION CONTROL (SAFETY)							
HCAI - Clostridium Difficile - meeting the C Diff objective (+ *final figure for December not yet signed off)*	48	1.0	7	8	6+		**21**
HCAI - Clostridium Difficile - Avoidable Cases			5	6			**11**
CANCER WAIT TARGETS (QUALITY)							
Max waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	1.0	97.0	96.1	95.4*		**96.3**
Max waiting time of 2 weeks from urgent GP referral to date first seen for symptomatic breast patients.	93%		97.3	94.7	96.1*		**96.1**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	1.0	99.7	99.8	99.3*		**99.7**
Maximum waiting time of 31 days for second of subsequent treatments – Anti Cancer Drug Treatments	98%	1.0	100	100	100*		**100**
Maximum waiting time of 31 days for second of subsequent treatments – Surgery	94%		98.2	100	100*		**99.4**
Maximum waiting time of 31 days for second of subsequent treatments – Radiotherapy	94%		N/A	N/A	N/A	N/A	N/A
Maximum two month (62 days) wait from referral to treatment for all cancers – Urgent GP Referral to Treatment	85%	1.0	88.7	87.4	87.5*		**87.9**
Maximum two month (62 days) wait from referral to treatment for all cancers – From National Screening Service Referral	90%		100	100	95.2*		**99.4**
					** Does not include provisional data for November*		
A&E (QUALITY)							
% Patients Waiting Less than 4 hours in A&E	95%	1.0	92.1	96.1	94.5		**94.2**
REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)							
RTT – Admitted % Treated within 18 weeks	90%	1.0	90.1	90.6	91.5		N/A
RTT – Non-Admitted % Treated within 18 weeks	95%	1.0	99.2	99.1	98.8		N/A
RTT – Incomplete pathways % waiting within 18 weeks	92%	1.0	94.7	95.9	95.8		N/A

Community Services (Effectiveness)							
Referral to treatment information	50%	1.0	98.0	99.0	99.5		N/A
Referral information	50%		64.9	65.4	66.7		N/A
Treatment activity information	50%		99.5	100	100		N/A

Dudley Group FT

Governance Targets and Indicators

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Independent Regulator of NHS Foundation Trusts

	Threshold & Weighting	Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements						N/A
PATIENT EXPERIENCE						
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Yes/No 0.5	Yes	Yes	Yes		N/A
Risk of, or actual, failure to deliver mandatory services	Yes/No 4.0	No	No	No		N/A
CQC Compliance action outstanding	Yes/No 2.0	No	No	No		N/A
CQC enforcement notice currently in effect	Yes/No 4.0	No	No	No		N/A
Moderate CQC concerns regarding the safety of healthcare provision	Yes/No 1.0	No	No	No		N/A
Major CQC concerns regarding the safety of healthcare provision	Yes/No 2.0	No	No	No		N/A
Unable to maintain a minimum published CNST level 1.0 or have in place appropriate alternative arrangements	Yes/No 2.0	No	No	No		N/A