The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 2 July, 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**		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 4 June 2015	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 4 June 2015	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	Y O'Connor	To Note & Discuss	10.00
	7.2 Nursing Staffing Report	Enclosure 5	Y O'Connor	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	G Palethorpe	To Note & Discuss	10.20
	7.4 Workforce and Staff Engagement Committee Exception Report	Enclosure 7	A Becke	To Note & Discuss	10.30
	7.5 Approval of Standards of Business Conduct Policy	Enclosure 8	G Palethorpe	To Note & Approve	10.40
	7.6 Mortality Report	Enclosure 9	P Harrison	To Note	10.50
	7.7 Quality Accounts	Enclosure 10	Y O'Connor	To Note	11.00
	7.8 Corporate Risk Register and Board Assurance Framework Report	Enclosure 11	G Palethorpe	To Note	11.10
	7.9 Research and Development Report	Enclosure 12	J Neilson	To Note	11.20
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 13	J Fellows	To Note & Discuss	11.30

9.	**Any other Business**				11.40
10.	**Date of Next Board of Directors Meeting** 9.30am 3 September 2015, Clinical Education Centre		D Badger		11.45
11.	**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		11.45

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 4 June 2015, in the Clinical Education Centre

PRESENT:
Mr D Badger, Chairman
Mr J Fellows, Non-Executive Director
Mr R Miner, Non-Executive Director
Mr D Bland, Non-Executive Director
Mrs A Becke, Non-Executive Director
Dr D Wulff, Non-Executive Director
Ms P Clark, Chief Executive
Mr P Taylor, Director of Finance and Information
Mrs D Wardell, Chief Nurse
Mr P Bytheway, Chief Operating Officer

IN ATTENDANCE:
Mrs N Hough, Personal Assistant
Mrs L Abbiss, Head of Communications and Customer Relations
Mrs J Bacon, Chief HR Advisor
Mr G Palethorpe, Director of Governance/Board Secretary
Mrs O'Connor, Deputy Chief Nurse

15/056 Chairman's Welcome and Note of Apologies

Apologies were received from Anne Baines.

The Chairman welcomed Mrs Dawn Wardell, Chief Nurse and Mr Paul Bytheway, Chief Operating Officer to their first Board meeting in their respective roles.

15/057 Declarations of Interest

There were no declarations of interest.

15/058 Announcements

There were no announcements.

15/059 Minutes of the Meeting held on 7 May 2015 (Enclosure 1)

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

15/060 Action Sheet from the Meeting held on 7 May 2015 (Enclosure 2)

15/049.1 Nursing Staffing (Item 15/030.2)

Item 15/030.2 regarding nurse staffing reporting to be discussed further with the Nursing Director.

Mr Badger, the Chairman confirmed that he had written to the Director of Operations and Performance at NHS England National to ask if there will be a template for reporting to ensure consistency across all Trusts.

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

15/061 Patient Story

Liz Abbiss, Head of Communications and Patient Experience presented the patient story. The story related to a patient receiving care on the Children's Ward with breathing problems, the child and mother had commented that the nurses were very friendly. Discussions took place about food for children and that sandwiches could be presented better i.e. cut into small triangles rather than two large triangles picking up on a comment made by the mother within their story.

Mr Badger commented that it appeared to be that some sandwich fillings were not necessarily children friendly.

Mrs Abbiss commented that the patient himself thought the food was great.

Mr Badger noted that the presentation of the video was poor, with a lot of background noise and asked that the equipment be checked before the next meeting. It was noted that there were minor points around food but most importantly it appeared that the young patient and his parents were happy and comfortable with the care being provided.

The Chairman noted the patient story and that the Board was content that the appropriate issues were being addressed.

15/062 Chief Executive's Overview Report (Enclosure 3)

Ms P Clark, the Chief Executive presented her overview report, given as Enclosure 3. Ms Clark updated the Board on the following areas from the report:

Friends and Family Test Performance: The community and inpatient results remain good; there is still work to do in the Emergency Department. Maternity have scored 100% in a couple of months and there is a need to ensure that feedback is given to staff.

Mrs Becke advised that she attended the International Day of the Midwife and she had provided feedback to them on the high regard the Board has for their patient care and had said that staff themselves should be proud of this.

Junior Doctors: The Dudley Group had been recognised by Junior Doctors as a top performing Trust in the Country in respect of the development and support being provided. Andy Whallett's work was being recognised outside of the Trust and the Board asked for congratulations to be passed on.

Vanguard: The NHS Executive had visited the Trust for two days last month and they were looking at what we were doing in Dudley and how this could be shared across the Country.

7 Day Working: A paper is going to be presented to the Board in July regarding this but the Executive Team were pleased with the progress made so far.

Mr Badger enquired as to the likelihood of 7 day services happening in the NHS and Ms Clark replied that this was in the Bruce Keogh timeline.

Dr Harrison commented that there had been problems across the Country with regards to this and that the Black Country Alliance was helping the local Trusts work together and working better with Primary Care services. He added that there are some areas that we are doing really well and others not so well but this is the same across other Trusts.

The Chairman asked the Board to note the report, note that he would write Andy Whallet and the team. The Board was also asked to note the work being done on Vanguard and 7 Day Working.

The Chairman to write to Andy Whallet and the team.

15/063 Infection Prevention and Control Exception Report (Enclosure 4)

Mrs D Wardell, the Chief Nurse presented the Infection Prevention and Control Exception Report given as Enclosure 4. The Boards attention was drawn to the following kep pointes with the report:

MRSA: No cases to report

C.Diff - The trajectory figure for this year (2015/2016) is no more than 29 C.Diff. Work is being undertaken on avoidable or lapses of care to ensure that this target is acheived.

The Chairman noted that the Board was pleased to receive the positive report.

15/064 Nursing Staffing Report (Enclosure 5)

Mrs Y O'Connor, the Deputy Chief Nurse presented the Nursing Staffing Report given as Enclosure 5.

There were two sections to this month's report these being the results of the six monthly 'Safer Nursing Tool' exercise and routine monthly nurse/midwife staffing position (April 2015). The report also provided a review of all staffing shortfalls since commencement of data collection in June 2014.

Mrs O'Connor referred the Board to the breakdown by ward of required/actual staffing and advised that it didn't take into account admission/discharges. She added that since the last report that was presented to the Board there had been some ward changes which has proved some difficulty. She commented that it does not take into account 1:8 staffing ratio. She advised that the small wards like C6 and B6 stand out as they have small bed numbers.

Mrs Becke queried how the patient acuity influences the staffing levels required. Mr O'Connor replied that the results are in respect of patients in the ward at the time of the audit and does take into account their dependency levels. As part of the audit low level and high level of dependency double-checked by the Professional Development team so that comparability over time is not compromised.

Mr Badger asked if the Safer Nursing Tool was a National tool and Mrs Wardell replied that it was.

Mr Taylor commented that B3 appeared to be scoring worse to which Mrs Smith confirmed that Nursing are currently doing a 'deep dive' with B3. Mrs Wardell commented that in this area that Patient Experience feedback has not highlighted anything but the tool is to identify potential areas which warrant a review which is what is being done. Mrs O'Connor added that there was a rise in dependency in March in this ward. Ms Clark queried whether B3 was the vascular ward. Mrs O'Connor replied that yes it was and it fluctuates a little bit.

Mr Miner commented on the problems that were on C7 and asked if this was subject to active management. Mrs O'Connor replied that they had also undertaken a 'deep dive' in C7 as they are doing for B3, she explained that the Matron is working in the area with the lead nurse and is having staff meetings looking at Nursing Care Indicator results, Complaints, Incidents etc.

Mrs O'Connor then referred the Board to Part 2 of the report monthly nurse/midwife staffing report and added that it was down slightly from the previous month. She added that the report shows the Trust is maintaining safe staffing level and this is through the flexing of the deployment of staff on a shift by shift basis.

The Chairman noted the results from the 6 months Safer Nursing Tool' exercise and the Monthly nurse/midwife staffing position positive for April and that there were no issues that needed follow up by the Board given the actions being taken within the Nursing Directorate.

Mrs O'Connor left the meeting.

15/065 Clinical Quality, Safety and Pati ent Experience Committee Exception Report (Enclosure 6)

Dr Wulff, the Medical Non-Executive Director presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 6. The Board noted the assurances being provided by the Committee and the activity the committee continues to remain close to. The Board noted the actions being taken by the Committee in respect of the missing assurance and would see the outcome of this within the Committee's next report.

The Chairman noted the report and the Board's acceptance of the assurances provided.

15/066 Trust Response to the Lampard Report (Enclosure 7)

The Director of Governance/Board Secretary presented the Trust Response to the Lampard Report, given as Enclosure 7.

The Board noted that the detail of the response being made to Monitor had been reviewed by the Clinical Quality, Safety and Patient Experience Committee and had reported the Trust progress previously.

Mr Palethorpe said that in effect this response consolidates the information seen at the Clinical Quality, Safety and Patient Experience Committee and reported to the Board

The Board noted the report and the approved the Trust Response to the Lampard Report be submitted to Monitor in line with required timescale.

15/067 Annual Report – Doctors Appraisal and Revalidation (Enclosure 8)

Dr P Harrison, the Medical Director presented the Annual Report – Doctors Appraisal and Revalidation, given as Enclosure 8.

The Board noted that the format of the report is set and thus may not be as helpful as we would have liked. Dr Harrison took the Board through the headlines these being

- The Trust appraisal rate was sitting at 84%.
- Deferrals were at 16%. In the first year hospitals chose which Doctors were revalidated but that is not the case do deferral rates are likely to increase as they may not as prepared as the earlier cohort.
- All mandatory standards were being achieved.

Dr Harrison informed the Trust that the submission which would be reported next year was made one day late, but was unsure if this would be flagged by the GMC next year.

A discussion was held regarding the time this activity takes. Dr Harrison said that each appraisal takes approximately 6 hours for the appraiser on top of the actual appraisal itself and then corrective action plan monitoring is a further draw on resources. Dr Wulff queried whether support for investigations had been discussed across the network. Dr Harrison replied that yes it had and discussions continue to take place but no decision on wider support had been made.

Mr Badger commented that it was a very full report and noted the section where whilst the Trust was complaint with all the statutory standards improvement could be made on other core standards. Dr Harrison replied that the Trust was meeting all of the mandatory core standards and that in relation to the others it was prioritising workloads and increasing appraisers.

Mr Badger queried how the separation of the Responsible Officer role from the role as Medical Director was progressing.

Dr Harrison replied that whilst somebody had been identified other pressures on their time had meant that this had not been resolved as yet.

Ms Clark noted this important work and commented on the fact that the task has taken a lot of time of our Responsible Officer/Medical Director.

The Board noted that a quarterly report will be submitted to the Workforce and Engagement Committee.

15/068 Finance and Performance Exception Report (Enclosure 9)

Mr J Fellows, the Non-Executive Director/Committee Chair presented the Finance and Performance Exception Report, given as Enclosure 9. The Board noted the assurances being provided by the Committee and the activity the committee continues to remain close to.

The Board discussed the Trust's deficit position and agreed that the £3.718m deficit be submitted to Monitor and the resultant Continuity of Service rating of 3 this attracts.

Mr Taylor advised that he was expecting to receive the last months data next week in respect of activity income but said that the Trust continued to exercise good cost control contributing to confidence in the achievement of the deficit position.

The Board noted the continued strong ED performance. Mr Badger commented that it remained good news that the actions taken were embedded in the continued strong performance of the Trust in respect of ED and that such dedication to the cancer performance should see improvements flow there also

The Chairman noted the report and that the Board required no follow up other than the actions being taken by the Committee.

15/069 Audit Committee Exception Report (Enclosure 10)

Mr R Miner, the Non-Executive Director/Committee Chair presented the Audit Committee Exception Report, given as Enclosure 10. The Board noted the activity undertaken by the Board recognising that the Audit Committee meeting had dealt with the approval of the Trust's accounts. The Board were updated on the outcome of the debate with external auditors around their opinion on the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources and that the Committee were content with the wording now being used by the auditors. The Committee report updated the Board on the discussion at the meeting in respect of the lack of co-operation from Summit and Interserve with the Local Counter Fraud teams work into certain tendering activities.

Mr Badger advised that the last issue had been raised with Summit in the meeting he and the Chief Executive had with Summit on the preceding day. Assurance had been given by Summit that they had now put in more robust Governance arrangements to ensure this would not occur again. It was agreed that the outcome of this meeting would be communicated to the Counter Fraud team asking them to raise without delay if they encounter any reluctance to co-operate in the future.

The Committee Chair informed the Board that as in previous year an Internal Audit plan had been approved seeking assurance on those areas where more assurance is needed such as such as CIP, Safer Staffing. The full plan had been appended to the report.

The Chairman commented on the possible negative public perception of the external auditors comments on the efficient use of resources which would be particularly unfortunate given the extraordinary year of success as indicated by the many Trust achievements.

The Board noted the assurance the Chief Executive and Chairman had received in respect of the Governance arrangements that have been put in place by Summit and agreed with the Audit Committee that the best use of Internal Audit resource was to direct their attention to areas of greatest risk.

The Director of Finance to write to the LCFS to advise them of the assurances received from the Summit Board.

The Director of Finance to write to the LCFS to advise them of the assurances received from the Summit Board.

15/070 Charitable Funds Exception Report (Enclosure 11)

The Non-Executive Director/Committee Chair presented the Charitable Funds Exception Report, given as Enclosure 11. The Board noted the assurances this provided and the actions being followed up by the Committee namely the spending of the funds being donated.

The Chairman noted the report and the Board's view that further work was to be undertaken on inactive funds.

15/071 Monitor Certifications (Enclosure 12)

The Director of Governance/Board Secretary presented the Trust's Monitor Certification submissions, given as Enclosure 12.

The Board noted the declarations being made in respect of its License and agreed with their accuracy reflecting that they accord with information already seen with the Trust's annual report.

15/072 Any Other Business

15/072.1 CQC Inspection Action Plan (Enclosure 12a)

The Director of Governance/Board Secretary presented the CQC Inspection Action Plan, given as Enclosure 12a.

The Board agreed that it was appropriate for actions within two of the areas, Phlebotomy Service and the Trust's Ophthalmology provision to remain open to allow management to ensure that subsequent service improvements achieve their intended outcomes without disrupting the action taken after the original inspection.

The remaining areas the Board noted the assurance being provided by management as to the closure of the original issues.

The Chairman noted the report and the Board's agreement to the report's recommendation to keep the two actions open.

15/073 Date of Next Meeting

The next Board meeting will be held at 9.30am on the 2 July 2015, in the Clinical Education Centre

Signed as correct.....Chairman

Date.....

DB/NH/

Enclosure 2

The Dudley Group NHS
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Action Sheet
Minutes of the Board of Directors Public Session
Held on 4 June 2015

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
15/019.3	Estates Report on Emergency Planning and Business Continuity	Risk Committee to investigate assurance around Emergency Planning and Business Continuity in more detail.	JS	16/6/15	To June Risk Committee Meeting – Done
15/008.9	Research and Development Report	The hidden benefits of Research and Development, particularly around drug costs, to be included in future Research and Development Reports to Board.	PH	2/7/15	On Agenda
		Dr Neilson to consider presenting an update on the Trust's Research and Development activities to Dudley CCG.	JN	2/7/15	On Agenda
15/062	Chief Executive's Report – Junior Doctors	The Chairman to write to Andy Whallet and the team.	DB	2/7/15	
15/069	Audit Committee Exception Report	The Director of Finance and Information to write to LCFS to advise them of the assurances received from the Summit Board.	PT	2/7/15	

Enclosure 3

The Dudley Grou
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Paper for submission to the Public Board Meeting – 2nd July 2015

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Paul Taylor Director of Finance and Information**	**PRESENTER**	**Paula Clark, CEO**

CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6

SUMMARY OF KEY ISSUES:

- Friends and Family Tests
- Department of Health visit to the Emergency Department 23 June 2015
- Vanguard bid
- Black Country Alliance
- Carter Review of NHS Operational Productivity

IMPLICATIONS OF PAPER:

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

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

Decision	Approval	Discussion	Other

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

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

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

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

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Chief Executive's Report – Public Board – July 2015

Patient Friends and Family Test: Update July 2015 Board

Community (01.06.15 – 14.06.15 provisional)

It is pleasing to see that in June 2015 99% of respondents indicated they would be extremely likely or likely to recommend the service they had used to friends and family. The number of responses is still very small however, there has been a small increase and work is on-going with local managers to continue this trend. National benchmarking data is not available at this time.

Community Services	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Community Nursing Services – percentage recommended	90%	91%	97%	100%	100%	100%
No of responses	12	23	30	5	24	34
Rehab and Therapy services – percentage recommended	87%	100%	91%	100%	100%	100%
No of responses	31	7	22	9	11	8
Specialist Services – percentage recommended	90%	100%	95%	95%	95%	97%
No of responses	10	1	59	22	20	30
Combined score – percentage recommended	89%	93%	95%	97%	98%	99%
Total responses	53	31	111	36	55	72

Inpatient FFT (01.06.15 – 14.06.15 provisional)

The percentage of friends and family who would recommend the Trust's inpatient services (now includes children's and Day Case) has been maintained above the national average of 95% for April 2015 (the latest published NHS England figure) and show The Dudley Group scored higher than our neighbouring Trusts (Sandwell and West Birmingham, Walsall, Royal Wolverhampton) which we have held since April 2014.

The provisional inpatient response rate for June (01.06.15 – 14.06.15) is maintained at 33%.

Date range	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
	01.01.15	01.02.15	01.03.15	01.04.15	01.05.15	01.06.15
	31.01.15	28.02.15	31.03.15	30.04.15	31.05.15	14.06.15
Number of eligible inpatients**	1901	1717	1912	1368	2300	1053
Number of respondents	596	742	909	843	765	344
Ward FFT percentage recommended	97%	98%	98%	98%	97%	98%
Ward footfall	31%	43%*	38%*	34%	33%	33%

Key for inpatient RAG rating

% of footfall (response rate)	*<25%*	*25-30%*	*30-40% +*	*40%+* ★
FFT percentage recommended	*<95%*	*96%+*	*97%+*	
FFT scores based on Nov 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*	

A&E FFT (01.06.15 – 14.06.15 provisional)

The percentage of friends and family who would recommend the Trust's A&E during the period 1st – 14th June increased to 91% compared to 90% for April. The latest published NHS England figures are for April 2015 show The Dudley Group scored 90% compared to the national average of 88% which keeps us in the top 20% of trusts nationally. Locally, this puts us third behind Walsall with 93% and Worcester Acute with 94%.

The provisional response rate for June (01.06.15 – 14.06.15) shows a slight decrease to 12% compared to 15% for May 2015. The A&E information does not include the Urgent Care Centre; this is reported separately by Malling to NHS England.

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Date range	Jan 2015	Feb 2015	March 2015	April 2015	May 2015	June 2015 provisional
	01.01.15	01.02.15	01.03.15	01.04.15	01.05.15	01.06.15
	31.01.15	28.02.15	31.03.15	30.04.15	31.05.15	14.06.15
Number of eligible A&E patients	4023	3622	3804	3858	3851	1784
Number of respondents	587	1045	1011	326	589	208
A&E FFT recommended percentage	95%	98%	92%	90%	90%	91%
A&E response rate	15%	29%	27%	8%*	15%	12%

Key for A&E RAG rating

% of footfall (response rate)	*<15%*	*15-20%*	*20%+*
FFT percentage recommended	*<94%*	*94%*	*95%+*
FFT scores based on Nov 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*

Maternity FFT (01.06.15 – 15.06.15 is provisional)

The Trust continues to score well and remains in the top 20% of Trusts with those who say they are extremely likely or likely to recommend our maternity services to friends and family.

Maternity Area	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015 Provisional
Antenatal Score, percentage recommended	98%	99%	100%	95%	96%	98%
Response rate	19%	33%	30%	30%	39%	24%
Birth, percentage recommended	99%	97%	99%	100%	100%	100%
Response rate	18%	38%	31%	26%	20%	14%
Postnatal ward, percentage recommended	99%	99%	99%	100%	100%	98%
Response rate	18%	38%	31%	26%	20%	14%
Postnatal community, percentage recommended	100%	100%	100%	100%	100%	93%
Response rate	13%	11%	100%	8%	10%	12%

Key for maternity RAG rating

% of footfall (response rate)	*<15%*	*15%+*	
Antenatal	*80+*	*76-79*	*<76*
Birth	*89+*	*86-88*	*<86*
Postnatal ward	*81+*	*75-81*	*<75*
Postnatal community	*90+*	*84-89*	*<84*

FFT scores based on Mar 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*

Outpatients FFT (01.06.15 – 17.06.15 is provisional)

The first data submission commenced from April 2015. There is no national benchmarking available at this time. NHS England does not require the submission to include eligible population figures.

FFT Outpatients Services	Apr 2015	May 2015	June 2015
	01.04.15	01.05.15	01.06.15
	30.04.15	31.05.15	14.06.15
Number of respondents	49	93	38
Outpatients recommended percentage	84%	82%	88%

2. Department of Health visit to the Emergency Department 23 June 2015

A team from the policy unit of the Department of Health visited the Trust on 23rd June 2015 as part of an exercise to assist the NHS in managing emergency pressures.

The team were very complimentary about the visit noting the wide engagemenet of the whole trust in the issue.

Some specific comments included:

- Team working to deliver the EAS that was seen throughout the organisation – shared accountability
- Collaborative involvement with nursing / medical teams and external partners – felt very different from other Trusts they have visited
- Change in culture – Trust is supportive and engaging
- Palpable leadership and support of that from the staff – they felt supported and able to raise concerns
- Real pride in working for the Trust was apparent
- ‘ never been in a hospital where everyone is so smiley’

3. Vanguard submission

We are working actively with our partners in Dudley to develop a proposal for submission to the New Care Models team, which will show our plans to develop a multi-disciplinary primary and community care approach in 5 localities in Dudley.

This will involve changes in ways of working for our community staff, alongside similar changes for primary care, social care, community mental health and voluntary services for the benefit of patients locally.

It is the Trust’s ambition to be the lead provider for healthcare in the borough, and to build alliance partnerships with other Dudley providers to improve the outcome and health of patients locally. This isn’t to suggest a “take-over” of other providers where we have little or no experience, but to develop proper meaningful partnerships involving risk sharing and gain sharing agreements

We will endeavour to do this in collaboration with all of our partners, and in particular to build new relationships with GPs and other primary care staff, who are central to this new way of working.

More work is required for our vision of lead provider to be shared with our commissioners, Dudley CCG, who have so far preferred for larger practice groupings to form the lead provider role.

We have agreed to work collaboratively together on the development of the new care models, and to leave the resultant organisational form discussions for later in the process.

4. Black Country Alliance

Consideration is currently being given for a joint bid to be made to the New Care Models team under the Acute Care Collaboration initiative with our partners in the Black County Alliance. This initiative proposes to develop “chains” of NHS providers who can provide mutual clinical and administrative support, in order to maintain high quality healthcare for patients within constrained fiscal circumstances.

Whether or not this bid succeeds, work areas are currently being developed by our joint Programme Director to give some “early wins” and to cement confidence of the three partners in this collaborative approach

5. Review of Operational Efficiency in NHS providers

Lord Carter published this report recently as part of the NHS contribution to the £22bn of efficiency savings required to be found by 2020-21.

Whilst details for Trusts is currently limited, this will become an important initiative for us. Through the use of benchmarks Trusts will be able to identify areas where they appear to be more expensive than their peers and good practice guides will help implement new ways of spending less.

Further reports will be made to Trust Board from Finance and Performance Committee as details emerge later in 2015.

Enclosure 4

The Dudley Group NHS
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Paper for submission to the Board of Directors July 2015 - PUBLIC

TITLE:	**Infection Prevention and Control Forum**		
AUTHOR:	Dr E Rees, Director of Infection Prevention and Control	**PRESENTER**	Mrs D Wardell, Chief Nurse

CORPORATE OBJECTIVE:

SO1 – Deliver a great patient experience
SO2 – Safe and caring services
SO3 – Drive service improvements, innovation and transformation
SO4 – Be the place people chose to work
SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

- Almost at end of Q1 on trajectory for 29 cases of post 48 hr C. difficile (7 cases in this quarter to date).
- PII C. difficile on C8 – internal and multi-agency meetings held
- No norovirus
- No post 48 hr MRSA bacteraemia cases

IMPLICATIONS OF PAPER:

RISK	**Yes**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** Safe and effective care
	Monitor	**Yes**	**Details:** MRSA and C. difficile targets
	Other	**Yes**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF COMMITTEE

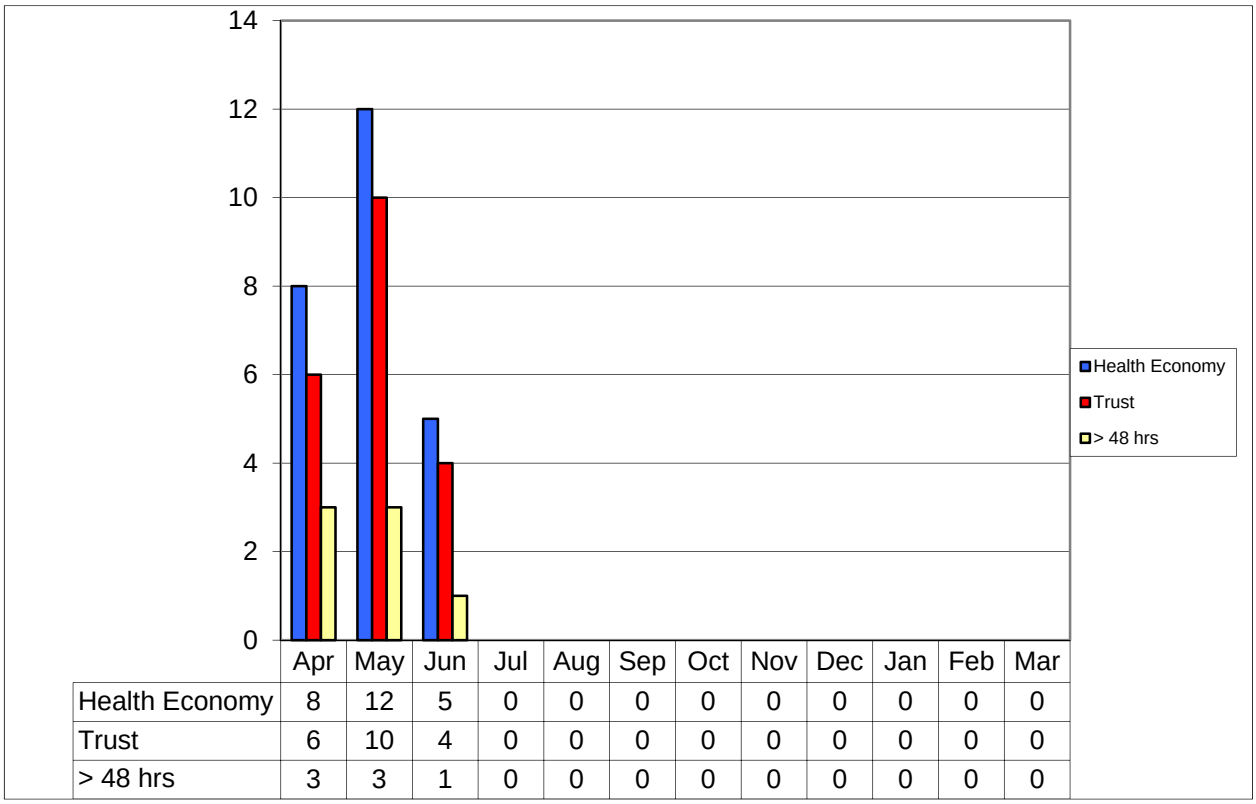
Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD: To receive the report and note the contents.

Summary:

Clostridium Difficile – The target for 2015/16 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. At the time of writing (24/6/15) we have 1 post 48 hour case recorded in June 2015.

C. DIFFICILE CASES 2015/16



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	12	5	0	0	0	0	0	0	0	0	0
Trust	6	10	4	0	0	0	0	0	0	0	0	0
> 48 hrs	3	3	1	0	0	0	0	0	0	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], continues. Of the 7 post 48 hour cases identified since 1st April 2015, 4 cases have so far been reviewed by the apportionment panel and all 4 were deemed as avoidable. The main themes identified are: delay in sending sample, delay in isolation, poor documentation and incomplete stool charts.

A period of increased incidence (PII) of C. difficile has occurred on C8 with 2 cases being identified within a 28 day period (20th May and 30th May) on the same ward. A 72 hour meeting was held on 3rd June with the PII Meeting being held on 5th June. Actions from the PII meeting included ribotyping requests, chlorcleaning to continue, repeat of environmental audits and antibiotic snap shot audit. A further meeting will be called, if necessary, when typing results are received or if further C. difficile is identified on this ward during the PII period.

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

Norovirus - no further cases.

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 2nd July 2015

TITLE:	**Monthly Nurse/Midwife Staffing Position – May 2015**		
AUTHOR:	Derek Eaves, Professional Lead for Quality; Yvonne O'Connor, Deputy Chief Nurse; Steph Mansell, Head of Midwifery	**PRESENTER:**	Yvonne O'Connor, Deputy Chief Nurse

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:

Attached is the monthly information on nurse/midwife staffing. 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. The format may evolve as time progresses but no changes have been made to the format since last month.

The paper indicates for the month of May 2015 when day and night shifts on all wards were (green) and 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. It also indicates when planned levels were reached of registered (amber) and unregistered (blue) staff but the dependency or number of patients was such that the extra staff needed were not available and when levels were unsafe (red). The total number of these shifts is 24 which is a reduction from the previous eight months. As seven of these shifts are in midwifery, a more detailed analysis of the situation is provided.

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.

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.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

May 2015

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 planned levels for both registered and unregistered staff. It should be noted that these occurrences will not necessarily have a negative impact on patient care

The attached chart follows the same format as last month. It indicates for this month when day and night shifts on all wards fell below the optimum, or when the 1:8 nurse to patient ratio for general wards on day shifts was not achieved.

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 a 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 Division where they are analysed and the attached chart compiled.

It can be seen from the accompanying spreadsheet that the number of shifts identified as amber (shortfall of registered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available), blue (shortfall of unregistered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available) are 24. This compares to 40 in April, 51 in March, 34 in February, 59 in January, 49 in December 2014, 38 in November 2014, 53 in October 2014 and 33 in September 2014. The number has decreased considerably this month with the number being small in terms of the overall shifts. This month no shift was assessed as red/unsafe. Overall the staffing available met the patients' nursing needs in the majority of cases but, in a number of instances, despite attempts through the use of deployment of staff or the use of bank/agency staff, the optimum number of staff for the patients on that shift were not reached. In all instances of shortfalls, the planned and actual numbers are indicated.

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.

As seven of the problem shifts have arisen in midwifery this month, a more detailed analysis of the situation is provided below.

The Midwife to Birth ratio in month is 1:30.6; this is against a BirthRate+ table top assessment recommendation of 1:29.1.

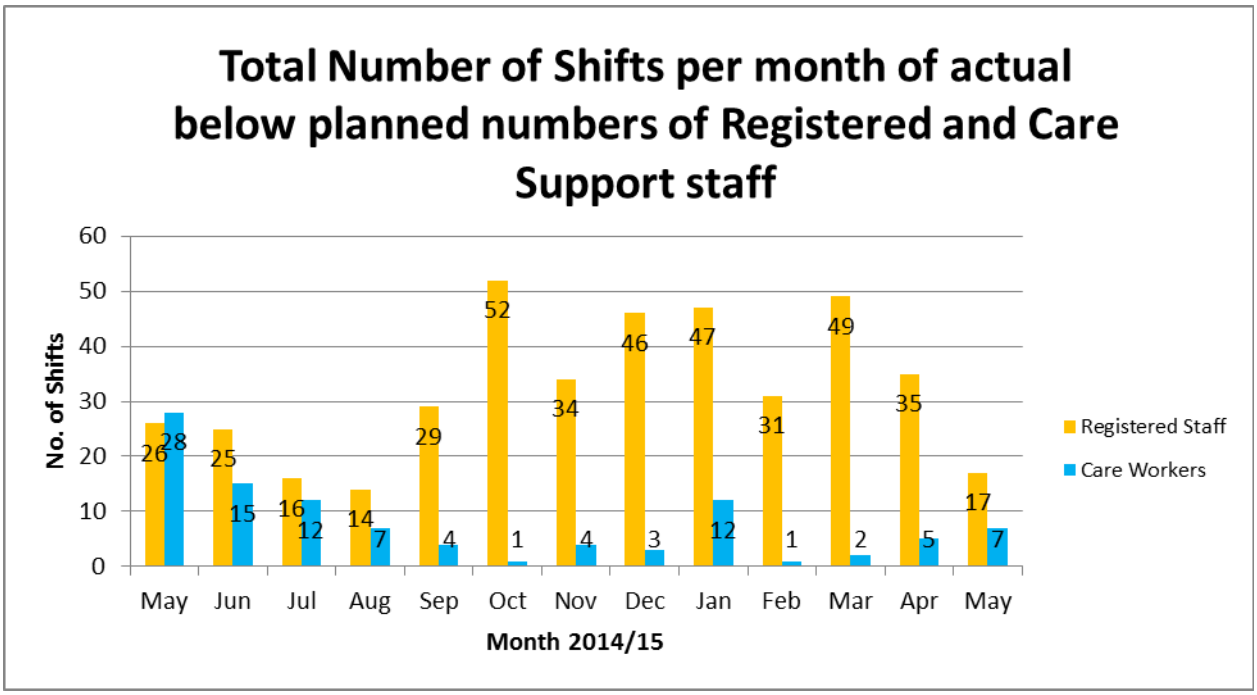
15 shifts (from 62) fell below the standard, of these, 7 required a DATIX report to be generated.

All staffing incidents have been managed using the agreed policy, escalation was actioned as required and any potential patient safety issue was managed effectively.

The use of agency midwives has been considered and agreed as a compromised option, however experience has shown agency midwives to lack the full range of skilled required and historically units with a high agency usage have reported increased incidents and poor outcomes e.g. Northwick Park

Midwifery vacancies have risen to around 19 WTE, analysis of the known reason for staff leaving has identified a number of themes: emigration, expanding clinical experience in tertiary, inner city units, relocating to original home area, joining specialist teams e.g. home birth team

Recruitment is progressing and there has just been recruitment of around 14 WTE midwives who are expected to be in post by September 2015. However, these midwives will not be fully autonomous until after induction. Realistically staffing shortages are expected until October /November, particularly as a high percentage of the recruited staff will be newly qualified midwives who will require additional support and preceptorship.



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 MAY 2015

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A3	1	RN	Vacancy	Bank nurse did not attend. Additional CSW on the shift assisted and safety maintained.
B2T	1	RN	Sickness	Agency nurse did not attend. Staff supported from another ward for 5 hours. Safety maintained
B3	2	RN	Maternity Leave x1 Long term sickness x1	Bank and agency were unable to fill. On the one occasion on Sunday bank holiday there were no patients in VASCU and on the other the lead nurse supported so both times the ratio was 1:9.5
B4	3	RN	Staff moved to other ward x1 Maternity leave x2	Bank and agency were unable to fill. On all occasions safety maintained with a ratio of 1:9.6
B5	1	CSW	Sickness	The bank CSW who attended was moved to another ward as the patient dependency was such that she was not needed. Patients remained safe.
B6	1	RN	Staff redeployed	A staff member was moved to another ward as there were empty beds and the dependency and numbers of patients was such that safety was maintained.
C1	4	CSW	Vacancy Sickness	Bank and agency were unable to fill. On all occasions, safety was maintained
C3	1 1	RN CSW	Sickness x2	Bank and agency were unable to fill. Substantive staff contacted but unable to help. Patient safety maintained.
C8	1	RN	Sickness	Patient acuity was such that safety maintained
EAU	1	CSW	-	Staffed to full complement but there were high dependent patients. Safety maintained.
Maternity	7	RM	High maternity leave and sickness absence	Bank unable to fill. Escalation process enacted. Staff moved to provide care to the areas of need. No patient safety issues occurred. On two occasions community and specialist midwives assisted and on one occasion there was a delayed induction of labour.

SHIFT

May-15		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
WARD	STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
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	Unreg																																																												
WARD A3	Reg																																			3/2																									
	Unreg																																																												
WARD A4	Reg																																																												
	Unreg																																																												
WARD B1	Reg																																																												
	Unreg																																																												
WARD B2 HIP	Reg																																																												
	Unreg																																																												
WARD B2 TRAUMA	Reg																																																										3/2			
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WARD B3	Reg					6/4																																																				6/4					
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WARD C3	Reg																																																										7/5			
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WARD C4	Reg																																																												
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MHDU	Reg																																																												
	Unreg																																																												
CRITICAL CARE*	Reg																																																												
	Unreg																																																												
NEONATAL**	Reg																																																												
MATERNITY ****	Reg		15/14	15/13				15/14							15/13																																									15/14					
	Unreg																																																												

Key Unsafe staffing | Registered nurse/midwife shortfall | Care Support Worker shortfall

* 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 sta

*** 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 ca

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

Any coloured shifts without numbers indicate that the planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board on 2nd July 2015

TITLE:	**Workforce and Staff Engagement Committee**		
AUTHOR:	**Julie Bacon; Chief HR Advisor**	**PRESENTER**	**Ann Becke; Non-Executive Director**
CORPORATE OBJECTIVE: SO4: Be the place people choose to work			

SUMMARY OF KEY ISSUES:

The Workforce and Staff Engagement Committee met on 26th May 2014.

Staff Health & Wellbeing Update
A Health and Wellbeing Group has been established that reports into the Workforce and Staff Engagement Committee. It will develop and monitor a Staff Health and Wellbeing Strategy.

The committee agreed to change the name of the Occupational Health Service to the Staff Health and Wellbeing Service. This service will have an accreditation assessment on 15th June for the Safe, Effective, Quality Occupational Health Service (SEQOHS) standard.

Trust People Plan
The Trust People Plan was approved. It combines the Trusts Workforce Strategy and key implementation work streams. Progress against targets will be monitored by the committee.

National Staff Survey Results / Staff Friends and Family Report
Our national staff survey results are very positive, placing the Trust in the best 20% of NHS organisations. A small number of areas for improvement include poor communication between staff and managers, work related stress and staff feeling pressured to come back to work with illnesses. The HSJ, in conjunction with the Nursing Times reported that the Trust could be in the “Top Ten places to work” in the NHS.

In the staff, Friends and Family Report, positive responses to the question ‘Would you recommend a friend or family member to work at the Dudley Group of Hospitals?’ fell by 20%, possibly as a result of workforce reductions. Regionally the Trust still compares very well.

Annual Appraisal Review
An annual review of appraisal compliance was received for the 2014/15 finance year. It was noted that the target of 85% had been exceeded. The target is 90% from 1 April 2015. Appraisals now require a performance rating to be given. Enough data should be available to analyse staff performance across the Trust by Autumn 2015. Appraisal compliance is currently monitored over a 14 month period but will be changed to yearly from 1 April 2015.

Deep Dive on Sickness
Sickness absence for the 2014/15 financial year was 3.8% against the 3.5% target. This cost the Trust over £4.7m but the Trust still compares well with other local and Acute Trusts. Nursing and Midwifery staff had the highest rate at 4.89%.

Musculoskeletal and back problems, mental health illness and gastro intestinal illness are the top three most common reasons for absence.

Mandatory Training - Annual Compliance Report
Mandatory Training compliance had increased by 2.7% over the year since March 2014 to 81.5%. This was 3.5% below the 85% target which has increased to 90% from 1 April 2015

Most subjects have improved in compliance with significant increases in Conflict Resolution, Diabetes Management, Mental Health Awareness and Safeguarding Children Intermediate. A small number of subjects still remain below 65%, these being Conflict Resolution, Blood Transfusion for Nurses and paediatric Resuscitation

Work continues to bring compliance up to target. This focuses around extending the e-learning options for training and raising the issue of non-compliant individuals with managers.

Mandatory Training Future Development Report
The committee received an update on the Trusts planned alignment of its mandatory training to the national Skills for Health "Core Skills Training Framework" (CSTF) and approved the proposal for the Trust to report its compliance only using the subjects set out in the (CSTF) with effect from 1 October 2015.

Progress with Regional streamlining work, the sharing of good practice and the continuing expansion of e-learning provision, access and recording was reported.

A report on funding for mandatory training provision will be presented to the next meeting. Mrs Bacon stated that at the next committee she will report on the funding of training.

Policies to be Ratified
No policies were presented to be ratified.

Terms of Reference – Local Education and Training Group (LETG)
The Committee approved the Terms of Reference for the LETG.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:** Mandatory Training links with CQC outcomes: SAFE & WELL LED
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF TRUST BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE TRUST BOARD

To receive the report

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Council of Board of Directors on 2 July 2015

TITLE:	**Standards of Business Conduct Policy**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary

CORPORATE OBJECTIVES ALL

The Trust has established a policy exists to assist staff in maintaining strict ethical standards in the conduct of NHS business. This Policy has been subject to its planned review and a small number of minor amendments have been made, these include:-

- Making the Director Governance supported by the Risk and Standards team responsible for maintaining the system in respect of capturing and reporting declarations of interest and for capturing and reporting of gifts, hospitality and sponsorship offered or received. Previously the PA to the Chief Executive and Chairman dealt with the register of interests and the Finance Department dealt with gifts and hospitality;
- Updating the forms to be used to record interests and gifts etc; and
- Clarifying that reports will be presented to the Audit Committee to enable them to support the Board being assured over the application of this policy and that compliance is being maintained.

The Policy retains the its linkages to other Trust relevant Polices in particular the Trust's Anti-Bribery Policy and Local Counter Fraud and Corruption Policy.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		

Action for the Board

To approve the updated Policy.

The Dudley Group NHS
NHS Foundation Trust

CONDUCT POLICY (STANDARDS OF BUSINESS) INCLUDING DECLARATION OF INTERESTS AND GIFTS AND HOSPITALITY		
	DOCUMENT TITLE:	**CONDUCT POLICY (STANDARDS OF BUSINESS) including DECLARATION OF INTERESTS and GIFTS AND HOSPITALITY**
	Originator/Author:	Director of Governance /Board Secretary
	Director Lead:	Chief Executive
	Target Audience:	All staff
	Version:	1.1
	Date of Final Ratification:	tbc
	Ratifying Committee:	Trust Board
	Review Date:	March 2018
	Expiry Date:	June 2018
	Registration Requirements Outcome Number(s) (CQC)	Well Led Domain Fit and Proper Person Requirement
	Relevant Documents /Legislation/Standards	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5: Fit and proper persons: directors
	Linked Procedural documents	Anti-Bribery Policy Anti-Bullying and Harassment Policy Disciplinary Policy Local Counter Fraud and Corruption Policy Managing Intellectual Property Policy Management of Private Patients Misconduct and Fraud Research Policy Policy and Procedure for the Standing Financial Instructions Whistleblowing Policy
	Contributors:	**Designation:** Deputy Director of Finance Chief HR Advisor
	Consulted:	**Designation:** Executive Team
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
1	July 2011	New policy
1.1	July 2015	Periodic review

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

Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

CONDUCT POLICY (STANDARDS OF BUSINESS) INCLUDING DECLARATION OF INTERESTS AND GIFTS AND HOSPITALITY

1. INTRODUCTION

1.1. The NHS has provided guidance to employing authorities concerning "Standards of Business Conduct for NHS Staff" (HSG(93) 5). Further guidance "Code of Conduct Code of Accountability in the NHS" (2004) has also been issued. This guidance required Trusts to implement a local "Standards of Business Conduct Policy". This policy is made known to all new starters and all Heads of Department, who have a responsibility for ensuring that the contents are brought to the attention of all staff on a regular basis.

1.2. It is recognised that many staff are members of professional bodies who also have established Standards of Conduct. These do not seek to replace those but set out the Trust's expectations which in the main are no more or less that those professional bodies expect of their members.

2. STATEMENT OF INTENT/PURPOSE

2.1. This policy exists to assist staff in maintaining strict ethical standards in the conduct of NHS business. The following information and guidance must be noted and adhered to by all staff. Recognising that statements of this nature cannot allude to every possible contingency, it is assumed that all staff are able to distinguish between acceptable and unacceptable behaviour in the conduct of their duties. If, however, staff are uncertain about the correctness or propriety of any proposed business transactions, or in relation to hospitality, declaration of interests and commercial sponsorship then they must seek guidance from a senior officer.

2.2. It is a long established principle that public sector bodies, which include the NHS, must be impartial and honest in the conduct of their business and their employees should remain beyond suspicion. It is an offence under the Bribery Act 2010 for an employee to give, promise or offer a bribe and to request, agree to receive or accept a bribe. A breach of the provisions of this Act renders them liable to prosecution and may also lead to loss of their employment and superannuation rights in the NHS.

2.3. Therefore this policy and procedure is intended to:

- Make all staff aware of the Trust's expectations of their conduct and behaviour in relation to business conduct
- Give staff the knowledge and information they need to protect themselves from situations that may draw criticism or even disciplinary action
- Enable members of staff to express their concerns in an open and unthreatening way

2.4. This policy applies to:

- Dudley Group NHS Foundation Trust executive directors
- Dudley Group NHS Foundation Trust non-executive directors

- Dudley Group NHS Foundation Trust employees (whether their remit is
- clinical or corporate
- committee members
- Members' Council representatives
- Third parties acting on behalf of the Dudley Group NHS Foundation Trust under a contract
- Students and trainees (including apprentices)
- Bank and agency staff engaged by the Dudley Group NHS Foundation Trust
- Volunteers acting on behalf of the Trust and secondees

3. DEFINITIONS

Business Conduct: Standards of behaviour expected when involved in commercial activity.

Interest: Involvement by an employee or a family member or associate in a business or secondary employment.

4. DUTIES (RESPONSIBILITIES)

4.1. The Trust Board

The Trust Board has reserved the power to approve this policy.

4.2. The Audit Committee

The Audit Committee will support the Board by undertaking periodic review of the interests declared and the gifts / hospitality / sponsorship received or given by staff.

4.3. The Director of Governance (Board Secretary)

The Director of Governance (Board Secretary) is the primary source of advice and guidance to staff on compliance with this policy. The Director of Governance has responsibility for maintenance of the register of interests and the register of gifts and hospitality.

4.4. All Staff

All staff whether directly employed, contracted or on secondment and all volunteers and students must abide by the relevant requirements of all parts of this document.

All are expected to:
i) Ensure that the interest of patients remains paramount at all times
ii) Be impartial and honest in the conduct of their official business
iii) Use the public funds entrusted to them to the best advantage of the service, ensuring value for money at all times.

It is also the responsibility of all to ensure that they do **not**:
iv) Abuse their official position for personal gain or to benefit their family, friends or associates
v) Seek to advantage or further private business or other interests, in the course of their official duties (**See Appendix 1 – Short Guide for Staff**)

5. UNDERLYING PRINCIPLES

5.1. Principles of Conduct in Public Life

5.1.1. The Nolan Committee was set up in 1994 to examine concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in arrangements which might be required to ensure the highest standards of propriety in public life. The Committee published "Seven Principles of Public Life" (in Ministerial Code 2010, Annex A) which it believes should apply to all those operating in the public service sector. These principles should be adopted by all working within the NHS and are:

- **Selflessness:** Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness:** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership:** Holders of public office should promote and support these principles by leadership and example.

5.1.2. All are expected to adopt these principles when conducting official business for and on behalf of the Trust so that appropriate ethical standards can be demonstrated at all times.

5.2. Fit and Proper Persons Requirements

5.2.1. New regulatory standards for the Fit & Proper Person (FPP) Requirements of Directors came into force for all NHS bodies from 27 November 2014, as a response to the Francis Report, and integrated into Care Quality Commission registration requirements. Guidance issued by the Care Quality Commission (2014) emphasises the importance of the Fit and Proper Person Requirements in ensuring the accountability of directors of NHS bodies. NHS bodies have a responsibility to ensure the Requirements are met with the Care Quality Commission's role being to monitor and assess how well this responsibility is discharged.

5.2.2. The scope of the FPP Requirements cover all NHS bodies - including NHS trusts, NHS foundation trusts and Special Health Authorities that are required to register with the Care Quality Commission (CQC). Under the Requirements, providers must not appoint to an executive director level post or to a non-executive post unless they are:

- Of good character
- Have the necessary qualifications, skills and experience
- Are able to perform the work they are employed for after reasonable adjustments are made
- Can provide information as set out in the regulations

5.2.3. The Care Quality Commissions definition of "good character" is not the objective test of having no criminal convictions but rather a judgement to be made as to whether a person's character is such that they can be relied upon to do the right thing under all circumstances. The regulations list categories of persons who are prevented from holding office and for whom there is no discretion. (CQC, 2014, Schedule 4, p.20)

5.2.4. There is an expectation of senior leaders to set the tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude. As such in making director appointments, Boards and Council of Governors take account of the values of the organisation and candidate fit to these values

5.2.5. Subject to NHS Foundation Trust authorisation, standard condition G4 of the provider license requires that a foundation trust must not appoint or allow an "unfit" person to remain in post without Monitor's permission. Monitor can use its enforcement powers to deal with a breach requiring the foundation trust concerned to remove the unfit person from office or by taking such action itself.

5.3. Declaration of Interests

5.3.1. It is a requirement that the Chair and all Board Directors should declare any conflict of interest that may arise in the course of conducting NHS business. All Board Members are therefore expected to declare any personal or business interests which may influence or may be perceived to influence their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner, or being employed by, a person with such an interest.

5.3.2. All staff, whether directly employed, contracted or on secondment and all volunteers and students, need to declare cases where either they or a close relative or associate has a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS body and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the Trust. Those interests of spouses, civil partners and cohabiting partners should be regarded as relevant.

5.3.3. All should therefore declare such interests either on commencement of employment or on acquisition of the interest, in order that it may be known to and in no way promoted to the detriment of either the trust or the patients it serves.

5.3.4. All employees of the Trust who hold a self- beneficial interest in private care homes or hospitals must declare this interest. The General Medical Council advises that when a doctor refers a patient to a private care home or hostel in which he or she has a private interest, the patient must be informed of that interest before the referral is made.(GMC Good Medical Practice, 2013)

5.3.5. Disciplinary action will always be taken in cases where an employee fails to declare a relevant interest, or is found to have abused his or her official position, or knowledge, for the purposes of self-benefit, or that of family and/or friends. Disciplinary action may lead to dismissal.

5.3.6. A declaration form with appropriate guidance will be sent to all Trust Board members annually. In signing their declaration of interests form they are also confirming their awareness of and adherence to the Code of Conduct: Code of Accountability in the NHS (2004).

5.3.7. A declaration form with appropriate guidance will be sent to all Management Forum members as well as all Consultant Staff, Associate Specialists/Staff Grade doctors and any staff considered to be able to influence purchasing decisions of the Trust.

5.3.8. All recipients of the declaration will be required to complete and return the form to confirm the accuracy of information they have previously provided and provide details of any changes to that information. The completed forms will effectively comprise the Register of Interests.

5.3.9. The declarations received from medical staff will be reviewed by the Medical Director (the Medical Director's will be reviewed by the Chief Executive) and all other staff declarations by the Director of Governance (the Director of Governance's return will be reviewed by the Chief Executive).

5.3.10. All other staff have a duty to self-declare any interests by submitting their declaration.

5.3.11. The Register of Interests will be held and maintained by the Director of Governance on behalf of the Chief Executive and will be subject to periodic review by the Audit Committee and may be reviewed by the Board. The register will also be made available for revalidation purposes for doctors.

5.3.12. Declaration of interests must include:

- Name, job title, division, department, base and contact number
- Name of organisation and nature of interest
- Details of who holds the interest, employee/associate/family member
- Date the interest was acquired
- Position held or Nature of Interest
- Work type – paid work or voluntary work
- Any other relevant information
- Details of the organisation's dealings (potential dealings) with the Trust
- Details of steps that have or need to be taken if a conflict of interest could occur

5.3.13. Relevant and material interest include:

- Directorships including non-executive directorships held in private companies or Public Limited Companies (PLCs) (with the exception of those of dormant companies).
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary organisation in the field of health and social care.
- Any connection with a voluntary or other organisation contracting for NHS services.
- Private Practice
- Other Employment
- Other Material Interest/Paid or Sponsored Activities (i.e. grants or payments received from other organisations including pharmaceutical, medical devices and medico-legal activity)
- Care provided to patients where this care is funded by the NHS but the income is not received by the Trust.

This list is not exhaustive and constitutes the key examples; if there is any doubt with regard to declaration of interests these should be discussed with the Director of Governance, Chief Executive or in the case of Board Members with the Chairman. Those interests of spouses, civil partners and cohabiting partners should also be regarded as relevant when making any declaration.

5.3.14. Declarations should be made by to the Risk and Standards Team, Corporate Governance Department, Trust HQ, Block C, Russells Hall Hospital. When submitted, declaration will be reviewed, logged and actioned appropriately. Where the person has been specifically requested to make a declaration and has no interest to declare a 'Nil Return' must be made. (**See Appendix 2- Declaration of Interests Form**).

5.4. Hospitality / Gifts

5.4.1. Modest hospitality, provided it is normal and reasonable in the circumstances - e.g. lunches in the course of working visits, may be acceptable. Hospitality must be secondary to the purpose of the meeting. The level of hospitality offered must not exceed that level which the recipients would normally adopt when paying for themselves or that which could be reciprocated by the NHS. It should not extend beyond those whose role makes it appropriate for them to attend the meeting.

5.4.2. Where meetings are sponsored by external sources, that fact must be disclosed in the minutes of the meeting and in any published proceedings.

5.4.3. Gifts can be accepted by staff if they are of low intrinsic value for example, calendars, post it pads, pens as well as small tokens of appreciation from patients or their relatives, (e.g. chocolates, flowers, toiletries etc).

5.4.4. Guidance should be sought from senior management in all other cases as to whether or not the gifts can be accepted and whether or not they need to be declared. Gifts with a value in excess of £25.00 should always be declared, however gifts should also be declared if several low value gifts worth a total of over £100.00 are received from the same or a closely related source in a twelve month period. Also cases whereby several members of staff receive individually

from the same source at the same time gifts / hospitality that has a total value in excess of £100.00 must be declared.

5.4.5. For the avoidance of doubt, staff may not accept any gift of money (including gift vouchers and other such monetary equivalents) for personal gain. All gifts of money to wards or departments, without exception, must be treated as a charitable donation to the Trust and should be accepted in accordance with established endowment arrangements and paid into the relevant charitable account / fund.

5.4.6. A register of all gifts and hospitality will be held by the Director of Governance / Trust Board Secretary on behalf of the Chief Executive and will be subject to periodic review by the Audit Committee who will report to the Board.

5.4.7. The register is to be used for the recording of gifts and hospitality offered to all Directors and staff members of the Trust even where the gift of hospitality is subsequently declined.

5.4.8. All staff should discuss any gifts/hospitality offered with their managers. Acceptance of gifts/hospitality should be authorised by a senior manager.

5.4.9. Declarations of gifts/hospitality must be made in writing immediately to the Corporate Governance Team for recording in the register.
The details should include:

- The name and position of the person within the organisation offering the gift/hospitality.
- Details of the gift/hospitality including the date offered and approximate value.
- The name and nature of the business offering the gift/hospitality (including relationship with the trust)
- Note whether or not the gift/hospitality is accepted or declined
- Name and position of the senior manager authorising acceptance
- Name and position of the person/persons accepting the gift/hospitality.

(**See Appendix 3- Declaration of Hospitality / Gifts / Sponsorship Form**).

5.5. Outside Employment/Private Practice

5.5.1. Trust employees are not allowed to engage in outside employment which may conflict with, or be detrimental to their Trust work. Staff should advise their manager about any secondary employment in which they are engaged. Working for a secondary employer whilst absent from work due to being medically certified unfit is not permitted, unless under the direction of medical advice. Where an employee is suspected of secondary employment whilst absent due to sickness, these matters will be investigated in accordance with the Trust Anti-Bribery Policy and Disciplinary Policy.

5.5.2. Consultants and associate specialists employed under the Terms and Conditions of Service of Hospital Medical and Dental Staff are permitted to carry out private practice or other work for the private sector, providing they do not do so within the time they are contracted to the Trust. Doing so could result in conduct and disciplinary action. Specific queries relating to individual contracts of employment should be clarified with the Trust's Medical Staffing department. Any work should be subject to the conditions outlined in "A Guide to the Management of Private Practice in the NHS". Consultants who have signed new contracts with the Trust

will be subject to the terms applied to private practice in those contracts. Policy and Procedure for the Management of Private Patients.

5.6. Preferential Treatment in Private Transactions

5.6.1. Individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessionary agreements negotiated with Companies, or by recognised staff interests, on behalf of all staff, for example staff benefits schemes.

5.6.2. All staff who are in contact with suppliers and contractors, including external consultants, and in particular those who are authorised to sign purchase orders, or place contracts for goods, materials or services, are expected to apply the principles outlined. Guidance relating to levels of authorisation is set out in the Trust's Standing Financial Instructions.

5.7. Commercial Sponsorship

5.7.1. Commercial sponsorship is defined as funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, training, provision of pharmaceutical, equipment, provision of meeting rooms, cost associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services, buildings or premises.

5.7.2. When entering into commercial sponsorships of the types outlined above employees need to be aware of the possibility of bias generated through sponsorship, where this might impinge on professional judgement and impartiality.

5.7.3. Where such collaborative partnerships involve a pharmaceutical company, the proposed arrangements must comply fully with the Communications Act 2003 (Amendment of the Medicines (Monitoring of Advertising) Regulations 1994) Order 2003 (Footnote 1).

5.7.4. All collaborative partnerships or joint working projects involving pharmaceutical companies and associated materials must comply with the current Association of British Pharmaceutical Industry (ABPI) code of practice, whether or not the sponsor is a member of the ABPI.

5.7.5. Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses may be acceptable, but only where the employee seeks authorisation in advance from their Executive or Divisional Director and it is clear that acceptance will not compromise purchasing decisions in any way.

5.7.6. Any sponsorship agreement must have a break clauses built in to it to enable the Trust to terminate the agreement if it becomes clear that it is not providing expected value for money and/or clinical outcomes. (Footnote 2)

5.7.7. Acceptance of any and all sponsorship must be declared in keeping with corporate responsibilities. Misconduct and Fraud Research Policy.

Note 1: ABPI code states that The Department of Health defines joint working between the NHS and the pharmaceutical industry as situations where, for the benefit of patients, one or more pharmaceutical companies and the NHS pool skills, experience and/or resources for joint development and implementation of patient centred projects and share a commitment to

successful delivery. Each party must make a significant contribution and the outcome must be measured. Treatments must be in line with nationally accepted clinical guidance where such exists. Joint working between the pharmaceutical industry and the NHS must be conducted in an open and transparent manner. Joint working must be for the benefit of patients but it is expected that the arrangements will also benefit the NHS and the pharmaceutical company or companies involved.

Note 2: A formal written agreement must be in place and an executive summary of the joint working agreement must be made publicly available before arrangements are implemented. ABPI is more detailed on the content of this agreement and its transparency and public availability.

5.8. Favouritism in Awarding Contracts

5.8.1. Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of the NHS Standing Orders and of Directive 2014/24/EU, Public Procurement. This means that:

- No private, public or voluntary organisation which may bid for NHS business should be given an advantage over its competitors.
- Each new contract should be awarded solely on merit, taking into account the requirements of the NHS and the ability of the contractors to fulfil them.

5.8.2. Staff must ensure that no special favour is shown to current or former employees or their close relatives or associates in awarding contracts. Contracts awarded to such businesses must be won in fair competition and the selection process must be conducted impartially.

5.9. Warnings to Potential Contractors

5.9.1. All invitations to potential contractors to tender for NHS business should include a notice warning with regard to the consequences of engaging in any corrupt activity involving employees of the Trust. All contractors should be made aware of the Trust's Whistleblowing Policy.

5.10. Rewards for Initiative

5.10.1. Managers should ensure that they are in a position to identify intellectual property rights (IPR) as and when they arise so that they can exploit them properly. This will ensure that the Trust receives any reward or benefit (such as royalties), both in respect of work carried out by third parties, or work carried out by employees of the Trust. To ensure this is achieved managers should build appropriate specifications and provisions into the contractual arrangements before work is commissioned or begins, and seek legal advice in relation to specific cases. The Trust's Legal Services Department can be approached to obtain legal advice. Managing Intellectual Property Policy

5.11. Bribery Act 2010

5.11.1. Under the Bribery Act 2010, it is a criminal offence to give, promise or offer a bribe and to request, agree to receive or accept a bribe. The maximum penalty for bribery is 10 years imprisonment, with an unlimited fine. The Trust does not, and will not, pay bribes or offer improper inducements to anyone for any purpose; nor will it accept bribes or improper inducements. It is important that all employees, contractors and agents are aware of the standards of behaviour expected of them. Irrespective of the legal position, the Trust has the power to terminate the employment of staff if it has reasonable belief that improper behaviour has occurred. In these circumstances action will be taken in accordance with the Anti-Bribery Policy and Disciplinary Policy.

5.12. Commercial in Confidence

5.12.1. Staff should ensure they are aware of information relating to business conducted by the Trust which is "commercial in confidence". All such information should be restricted with regard to disclosure particularly if its disclosure would prejudice the principle of a purchasing system based on fair competition. This refers to both private and public providers of services.

5.12.2. The term "commercial in confidence" should not be taken to include information about service delivery and activity levels, which should be publicly available, under the Freedom of Information Act 2000. The exchange of data for medical audit purposes is subject to the rules governing patient confidentiality and data protection.

5.13. Whistleblowing

5.13.1. An important element of the Trust's Standards of Business Conduct is the commitment to an open culture where people feel secure in seeking advice and raising concerns. Anyone who suspects that a wrongdoing is happening, has taken place, or is likely to happen in the future, is strongly encouraged to raise their concerns in confidence through the internal whistleblowing procedure. As part of the open culture, The Trust has signed up to the Nursing Times, Speaking Out Safely Campaign, should staff wish to raise a concern through this route.

5.13.2. It is important to note that anyone who raises a genuinely held concern, in good faith, concerning a matter which they reasonably believe to be true, will not suffer any form of reprisal or retribution as a result. This will be the case even where the individual raising the concern is mistaken and there is no case to answer. Harassment or victimisation, including informal pressure of anyone raising a genuine concern is unacceptable and any such conduct could itself constitute a breach of the Trust's Standards of Business Conduct and be treated as a serious disciplinary matter. Anti-Bullying and Harassment Policy. Whilst no one who comes forward in good faith has anything to fear, false allegations raised maliciously, tendentiously or carelessly, could be treated as misconduct and may be dealt with in accordance with the Trust's Disciplinary Policy

5.13.3. Although not exhaustive, examples of suspected wrongdoing that should be raised in this way include:

- a criminal offence;
- failure to comply with a legal obligation;
- an act or omission which will, or is likely to unlawfully endanger the health or safety of any individual;
- a breach of human rights;
- an accounting malpractice or falsification of documents;
- any other breach of the Standards of Business Conduct;
- a miscarriage of justice; and
- concealment of any of the above.

5.14. Counter Fraud

5.14.1. Local Counter-Fraud Specialists (LCFS) are in place to assist in reducing fraud and corruption to the absolute minimum within the Trust. If any member of staff or member is aware of potential fraud or corruption concerning anyone within the Trust, even if this is just a suspicion, then this information should be passed to the Local Counter Fraud Specialist. All correspondence or calls received will be

treated in the strictest confidence and any information will be professionally assessed and evaluated. Callers can remain anonymous if they wish. All leads given or information received are followed up. Anti-Bribery Policy and Local Counter Fraud and Corruption Policy

5.14.2. To report any concerns please use the following contact information:

- Director of Finance and Information
- Local Counter Fraud Specialist.

You can also report concerns using the on-line referral form or by calling the National NHS Fraud and Corruption reporting line on: 0800 028 40 60.

6. TRAINING/SUPPORT

6.1. The Corporate Governance Risk and Standards Team will support and advise on the use of this Policy.

7. PROCESS FOR MONITORING COMPLIANCE

7.1. See **Appendix 4** for monitoring of compliance.

8. EQUALITY IMPACT ASSESSMENT

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

9. REFERENCES /BIBLIOGRAPHY

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Appendix 1

Short Guide for Staff

DO:

- Make sure you understand the guidelines on standards of conduct, and consult your manager if you are not sure.
- Make sure you are not in a position where your private interests and NHS duties may conflict.
- Declare to your employer any relevant interests; if in doubt ask yourself:
    - Am I, or might I be in a position where I (or my family/friends) could gain from the connection between my private interests and my employment?
    - Do I have access to information with which I could influence purchasing decisions?
    - Could my outside interests be in any way detrimental to the NHS or patients' interests?
    - Do I have any other reasons to think I may be risking a conflict of interest?
- If still unsure – declare it to the Director of Governance or Chief Executive.
- Observe the Trust's Standing Order rules on tendering if you are involved in any way with the purchase of goods and services.
- Obtain your manager's permission before accepting any commercial sponsorship.
- Declare all offers of gifts and hospitality whether finally accepted or not.

DO NOT:

- Accept any inducements, personal gifts (other than items of nominal value or of no personal nature) or inappropriate hospitality.
- Accept any gifts of cash (regardless of value) or cash equivalents (e.g. vouchers).
- Abuse your official position to obtain preferential rates for private deals.
- Unfairly advantage one competitor over another or show favouritism in awarding contracts.
- Misuse or make available official "commercial in confidence" information.

Appendix 2

The Dudley Group NHS
NHS Foundation Trust

Declaration of Interests
2015 – 2016

I, , make the following statement:

I have the following interests:

Directors Name	
Designation	
Description on Interests (see reverse of the form for examples of interests)	

I confirm that I undertake no activities that commit the Trust to any decisions in relation to the interests declared above.

Signed .....

Date .....

When completed please return to : The Risk and Standards Team, Corporate Governance Department, Trust HQ, Block C, Russells Hall Hospital

Interests that require declaring may be pecuniary or non-pecuniary. Examples of relevant and material interests include:

- Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies) which may seek to do business with the Trust
- Ownership or part ownership of companies, businesses or consultancies which may seek to do business with the Trust
- Significant share holdings (more than £25,000 or 1% of the nominal share capital) in organisations which may seek to do business with the Trust
- Membership of or a position of trust in a charity or voluntary organisation in the field of health and social care
- Receipt of research funding / grants from the Trust or its Charity
- Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the Trust must be declared)
- Formal interest with a position of influence in a political party or organisation
- Current contracts with the Trust in which the individual has a beneficial interest
- Any other employment, business involvement or relationship or that of a spouse or partner or close family member that conflicts, or may potentially conflict with the interests of the Trust

If in doubt then the interest should be declared.

Appendix 3

The Dudley Group NHS
NHS Foundation Trust

DECLARATION OF HOSPITALITY / GIFTS / SPONSORSHIP

Name:	
Job title:	
Place of work	

Description of Hospitality / Gift / Sponsorship *Offered and / or Received*
note gifts of cash or cash equivalents eg vouchers MUST NOT be accepted
note sponsorship, hospitality or gifts MUST not be given

Sponsor – Suppler of Gift / Hospitality (Name and address)	Venue of hospitality (if applicable)	Type of sponsorship/gift (Training, lunch etc.)	Date received	Value £ (Please estimate if not known)	
			Please indicate if the above was offered but was politely refused	**Yes**	**No**

Do you have any **personal** relationship or **personal** business connection with the person / organisation from whom you received, or to whom you gave, the item(s) declared above?		**Yes**	**No**
If yes, please describe relationship			

Declarations
Individual Declaration
I declare that the above record represents a complete and accurate statement of the hospitality/sponsorship/gift I have received. Signature Date:
Line Manager Declaration
This level of gift / hospitality / sponsorship is not deemed to be excessive and not deemed to pose a risk regarding any current or possible future relationship with this firm / person. Signature Date: Name

When completed please return to : The Risk and Standards Team, Corporate Governance Department, Trust HQ, Block C, Russells Hall Hospital.

Appendix 4

Monitoring Compliance with this Policy

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Compliance with this policy will be upheld and monitored by all managers within the Trust. Oversight and overall monitoring of the policy will be led by the Director of Governance	Director of Governance	Locally managed data base on the Trust's Register of Interests and annual report	Annually	Audit Committee	Executive Directors Non-Executive Directors All Managers Group will consider, challenge, agree and monitor poor compliance identified and actions from the report – identifying appropriate leads to take action forward	Executive Directors Non-Executive Directors All Managers
The policy and the registers of gifts and hospitality and of interests will be reviewed by the Audit Committee at least annually and more frequently if appropriate to do so.	Director of Governance	Locally managed data base on the Trust's Register of Interests and annual report	Annually	Audit Committee	Executive Directors Non-Executive Directors All Managers Group will consider, challenge, agree and monitor poor compliance identified and actions from the report – identifying appropriate leads to take action forward	Executive Directors Non-Executive Directors All Managers
Ensure compliance with this policy	Director of Governance	Self-review supported by work of the Trust's External and Internal Auditors	Annually	Audit Committee	Executive Directors Non-Executive Directors All Managers Group will consider, challenge, agree and monitor poor compliance identified and actions from the report – identifying appropriate leads to take action forward	Executive Directors Non-Executive Directors All Managers

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 2nd July 2015

TITLE:	Mortality Annual Review 2014-2015		
AUTHOR:	Teekai Beach Directorate Manager to the Medical Director	**PRESENTER**	Paul Harrison Medical Director

CORPORATE OBJECTIVE: SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

This report gives an overview of the Trust's mortality review activities for the financial year to date.

The committee should note the following achievements:

- Both major Mortality indicators remain within the expected range.
- The Information team and Deputy Medical Director were finalists at the national E-Health Insider awards for the Mortality Tracking System.
- Using the Mortality Tracking System the trust has achieved the Quality Priority to review 85% of deaths within 12 weeks by March 2015.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: EFFECTIVE**
	Monitor	**Y**	**Details:** Link to compliance framework
	Other	**Y**	**Details:** HSMR, SHMI

ACTION REQUIRED OF GROUP:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD

To receive the report and note the actions to be undertaken within the next year.

The Dudley Group NHS Foundation Trust

Mortality Review 2014-2015

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List of Appendices

1. Overview of Mortality Review Process.
2. Response to CQC Re: Imperial College Dr Foster mortality outlier alert for 'pulmonary heart disease' at The Dudley Group NHS Foundation Trust 27th May 2015
3. Response to CQC RE: CQC Re: Imperial College Dr Foster mortality outlier alert for 'Septicaemia except in labour' at The Dudley Group NHS Foundation Trust 4th June 2015

Annual Objectives 2014-2017

	2014-2015	2015-2016	2016-2017	Objectives 2017+	Strategic Objectives
	SHMI reduced from 1.07 to 1.03 HSMR 98.68 (reporting within acceptable range since Q4 11/12)	Proactive audit of 1) Areas alerted by Dr Foster/CQC. Or 2) Highest SHMI (top5) reported in advance to CQC with action plans Reduce number of mortality alerts.	Active dialogue with CQC to 1) develop methodology to anticipate mortality alerts and 2) evaluate impact of quality improvement on	SHMI & HSMR to remain within the acceptable range Continuous improvement of response to/engagement with mortality indices.	**SO2: Safe and Caring Services** **SO3: Drive service improvements, innovation and transformation**
	Quality Priority to review 85% of in- hospital deaths within 12 weeks by March 2015 achieved.	Quality Priority to review 90% of in- hospital deaths within 12 weeks by March 2015 achieved.	Quality Priority to review 95% of in- hospital deaths within 12 weeks by March 2015 achieved.	100%* of in hospital deaths reviewed within 12 weeks by a multidisciplinary team	
	Aggregated Complaints & Incidents Learning Report produced. Datix Improvement programme in place	Develop or adopt methodology for rating "avoidable deaths". Include rating scale in Mortality Tracking System© update	Adapt case note review methodology for current inpatients based on 2015/2016 evaluation if feasible. Measurable learning in quality reports	Triangulated mortality/case note review, complaints & incidents reporting and shared feedback and learning by speciality/area.	
	NHS innovation Hub engaged to identify commercial partner. Mortality Tracking System© shared and deployed in 2nd provider, Beta site.	Commercial Partnership agreement. Evaluate Beta site results Undertake improvement work with partners.	Use Beta Site data to identify new partners: and attract first NHS clients.	Commercialised Mortality Tracking System© deployed in partner organisations with continuous improvement.	

1. Introduction

This report gives an overview of the Trust's mortality review activities for the financial year to date. The report details the various strands of our mortality review activity, including morbidity/mortality review, the Mortality Tracker and information we receive from external sources, such as the Health & Social Care Information Centre, Dr Fosters at Imperial College and Healthcare Evaluation Data at University Hospital Birmingham. The appendices give the details of the reports that have gone to the Care Quality Commission following mortality outlier alerts.

The Trust achieved the quality priority set around mortality in 2014/2015 having 85.5% of deaths reviewed within 12 weeks by a multidisciplinary team and seeks to improve over the next year by achieving 90%. The Mortality Tracking System© developed by the Information Department and the Deputy Medical Director is at the centre of this process. The system placed as a finalist for the prestigious E-Health Insider Awards in October 2014 and the team should be congratulated on their achievement.

The Trust continues to see a peak in crude mortality during winter periods and the most recent winter is highlighted as a concern. Although it must be noted that reliable data is not yet available to analyse this January 2015 which saw a significant increase in deaths nationally and locally. However based on preliminary data our position seems to be typical of acute trusts in that period.

There is a clear downward trend in both key mortality indices, the Hospital Standard Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) from which the board should be assured. However it is the aim of the Medical Director that more emphasis should be placed in developing our process for detailed case note review using the Mortality Tracking System©.

More importantly the report outlines the objectives of the mortality review process for the next two years and how the team responsible for mortality at this Trust will achieve them. Our systems for tracking mortality related issues are undergoing a process of continuous improvement which is highlighted in the report. The Trust is committed to providing the best possible care for our patients and the robust processes around monitoring mortality related issues is clearly a part of this overall commitment.

2. Performance- External Indicators

2.1 It cannot be understated that the performance of The Trust with regards to mortality has improved considerably within the last year, and indeed the last 3 years. Both HSMR and SHMI have fallen from well above the expected range, the primary reason the Trust was included in the Keogh Review, to below the expected range for HSMR and within the expected range for SHMI.

Figure 1: HSMR 3 Year Trend October 2011-September 2014

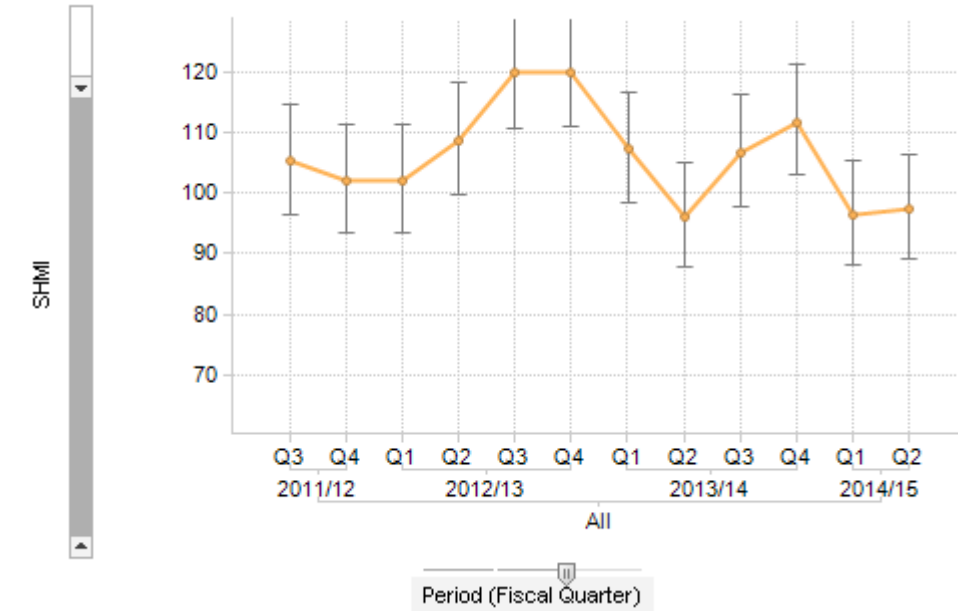


Figure 2: SHMI 3 Year Trend October 2011-September 2014

The SHMI has seen the most progressive improvement, the most recent publication continuing the trend. The value for the latest publication of HSMR for October 2013 to September 2014 is 98.68; SHMI for the same period is 1.03. The improvement journey is illustrated below.

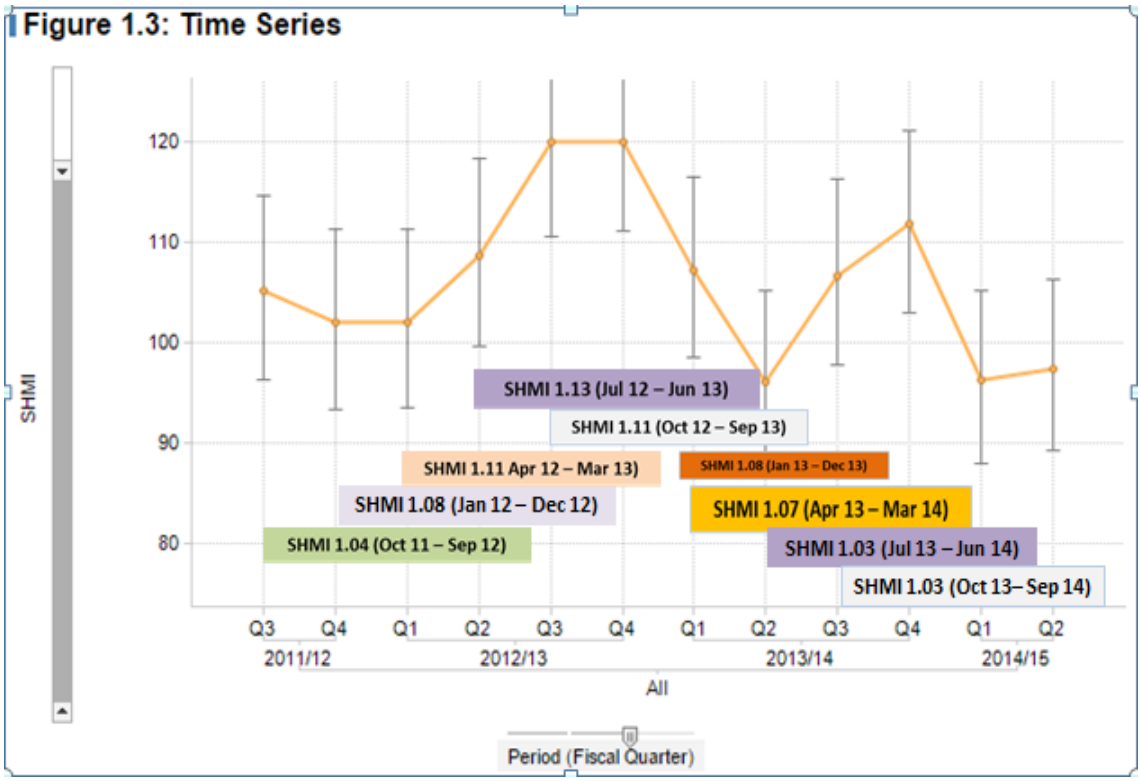


Figure 3 SHMI Time Series October 2011 to September 2014

2.2 In addition to the SHMI and HSMR the CQC Intelligence Monitoring for Hospitals includes 15 aggregated mortality indicators across a number of condition groups. A risk assessment on each indicator is undertaken for each trust based on an analysis which includes, but not exclusively, information from Mortality Alerts from The Doctor Foster Unit at Imperial College. The Intelligence Monitoring reports are published with no fixed schedule. In the last year there has been one report published in December 2014 with Risks and Elevated Risks for Mortality. The Trust also receives alerts from the Dr Foster Unit at Imperial College who produce the HSMR. The CQC typically base their risk ratings on these alerts. The trust progress against each of these is set out below.

Dr Foster Unit Alert	CQC Risk or Elevated Risk	Status
Skin & Subcutaneous Infection	None- Closed	Closed April 2014
Septicaemia (except in Labour)	Elevated Risk -Composite indicator: In-hospital mortality - Infectious diseases (May 2015)	Additional detail requested by CQC – Trust replied June 2015
Pulmonary Heart Disease	Elevated Risk -Composite indicator: In-hospital mortality - Cardiological conditions and procedures (May 2015)	Additional detail requested by CQC – Trust replied May 2015

Figure 4 Dr Foster Alerts subject to CQC Review 2014-2015

Details of the above alerts and the Trusts' response to the CQC are enclosed in the appendices. There are 3 other condition groups identified as a "Risk" using the Intelligent Monitoring scoring system which have not been the subject of an alert from Dr Fosters.

Indicator	Intelligence	Trust Summary/Comments and Actions	Risk
Composite indicator: In-hospital mortality - Neurological conditions	*In-hospital mortality: Neurological conditions (01-Nov-13 to 31-Oct-14)*	This indicator has been cross referenced with other mortality indicators. Although the condition groups which make up this indicator do not directly correlate with others, a related condition group, Coma; Stupor; and brain damage, has a high SHMI in the latest reporting period and therefore the related deaths are under investigation by the Deputy Medical Director.	**Risk**
Composite indicator: In-hospital mortality - Vascular conditions and procedures	In-hospital mortality: Vascular conditions (01-Nov-13 to 31-Oct-14)	There are no condition groups from this compound indicator, that appear in the top 25 SHMI or are related to any other specific alerts, and it appears to have been generated by a statistical function called 'Z' score. Assurance was sought from Vascular Surgery in their recent report to the Chairman and Chief Executive Mortality & Morbidity Meetings with the usual investigative report submitted by the Information Team and no concerns have currently arisen.	**Risk**
Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures	In-hospital mortality: Gastroenterological and hepatological conditions (01-Nov-13 to 31-Oct-14)	This indicator has been cross referenced with other mortality indicators. There are a number of individual condition groups in the top 25 of the SHMI that appear in this indicator and therefore this area is currently under investigation by the Deputy Medical Director.	**Risk**

In one area 'Vascular Conditions and procedures' the Trust could find little evidence to support the CQC's analysis and have raised the matter with the CQC analysts. The Trust has not had a corresponding alert and for the relevant period May 2013 to April 2014, the SHMI for that condition group is 96.79 and HSMR 95.6, both below the expected range. A break down of the condition groups and corresponding HSMR is shown below in figure 5. The numbers against each condition is both small and statistically insignificant or the HSMR is below the expected range. The SHMI for the indicator overall is shown in figure 6 as being within the expected range. Additionally, the condition group with the highest crude mortality rate is isolated in figure six and shown to be also within the expected range. Indeed our Information team analysed periods just outside the range isolated in the CQC report (January 2014 to December 2014) and found that the HSMR was even lower at 86.

The CQC could not account for the difference in analysis, but have not removed the risk in the latest report (May 2015). A November 2014 response stated:

> *"I note that the outputs you have shared from the HED system show different numbers of discharges and deaths for a number of the CCS groups. Having compared your breakdown with our*

own, we are unable to match your figures and would ask whether the HED analysis includes admission types in addition to emergency admissions (which are the focus of our analysis)? There are also discrepancies in the numbers of expected deaths in our respective outputs, which are likely to be the result of different adjustments that have been applied. CQC does not use the HED system and without understanding the differences in the methodology used we are unable to comment further on why the results of our analysis differ to those generated by your own system." (CQC, Surveillance Queries Team Response, 14th November 2014")

To be clear the Healthcare Evaluation Data (HED) tool that the Trust use for analysis does include all admission types and can be filtered by admission type to make a comparative analysis as per the query above, but we have yet to produce the same data set as the CQC. Although this is frustrating, as outlined in the first section it is the strategy of the Medical Directorate to work with the CQC to improve our mutual understanding.

CCS	CCS Group	Number of Expected Deaths	Number of Observed Deaths	Number of Discharges	HSMR	Crude Mortality Rate
114	Peripheral and visceral atherosclerosis	42.41	32	357	75.5	9%
115	Aortic; peripheral; and visceral artery aneurysms	27.2	30	245	110.3	12%
116	Aortic and peripheral arterial embolism or thrombosis	8.1	7	107	86.4	7%
117	Other circulatory disease	4.75	5	256	105.3	2%
118	Phlebitis; thrombophlebitis and thromboembolism	1.5	3	103	200	3%
119	Varicose veins of lower extremity	1.24	2	40	161.1	5%
120	Haemorrhoids	0.23	1	69	427	1%
121	other diseases of veins and lymphatics	0.32	2	29	616.8	7%
Subtotal		85.76	82	1206	95.6	7%

Figure 5: HSMR for CCS Groups- Vascular Conditions May2013-April 2014

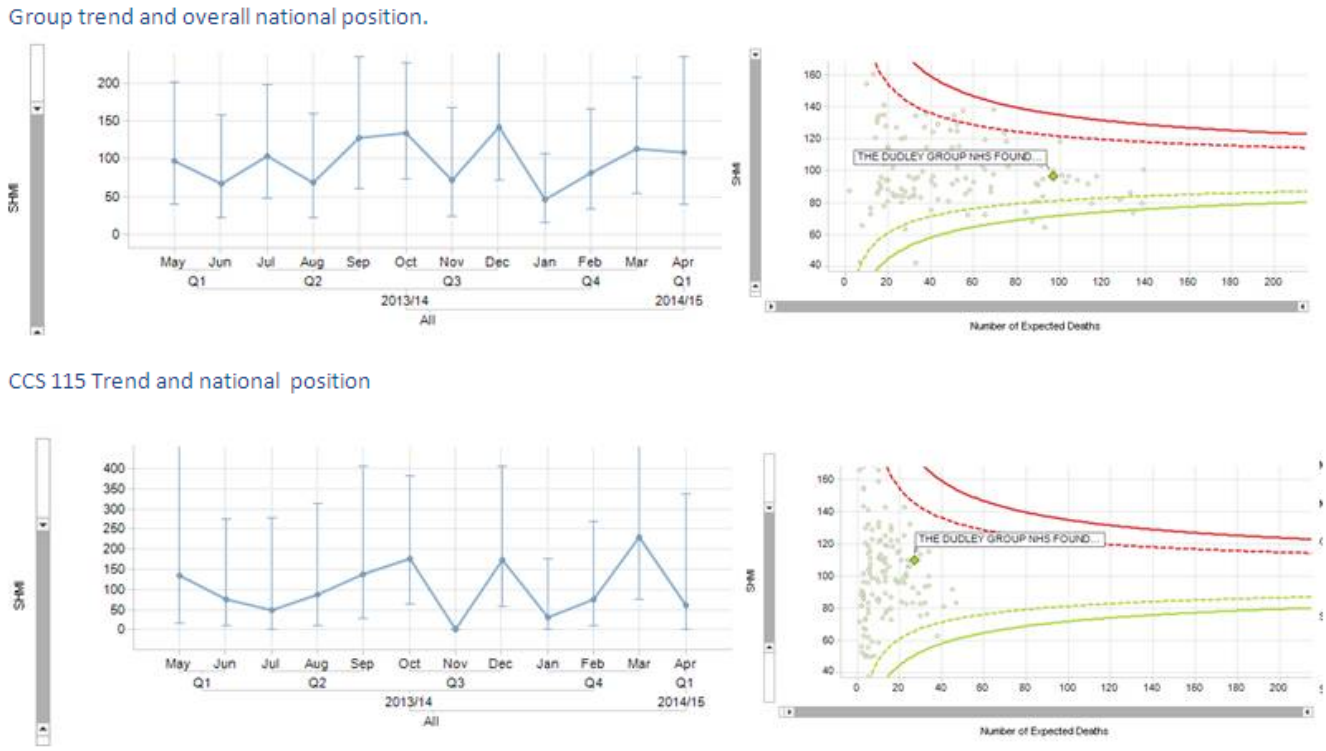


Figure 6: SHMI Vascular Condition Groups and CCS 115 May 2013 – April 2014

In the other two CQC mortality indicators, where a risk has been raised, there is evidence from other mortality indices to merit additional investigation. For both 'Gastroenterological Conditions' and 'Neurological Conditions' the HSMR for the period May 2013- April 2014 is 113.20 and 174.4 respectively. In addition other indicators have shown that conditions within these two indicators are outside of the expected range for the Trust.

The last two reporting periods for SHMI show related conditions within the top 20 conditions with the highest number of deaths occurring above the expected level. Some condition groups have deteriorated over the two periods. As the indicators triangulate, the team have reviewed this information and found no evidence of any systematic failures in care.

SHMI Diagnostic Group	Cases	Expected	Observed	SHMI	Excess		SHMI Diagnostic Group	Cases	Expected	Observed	SHMI	Excess
Septicaemia (except in labour), Shock	368	81.74	105	128.46	23.26		Septicaemia (except in labour), Shock	403	90.84	124	136.5	33.16
Secondary malignancies	197	45.06	66	146.48	20.94		Secondary malignancies	199	45.1	68	150.76	22.9
Aspiration pneumonitis; food/vomitus	123	50.55	66	130.57	15.45		Aspiration pneumonitis; food/vomitus	143	61.49	79	128.49	17.51
Acute myocardial infarction	292	29.95	45	150.24	15.05		Acute myocardial infarction	295	29.47	45	152.69	15.53
Cystic fibrosis, Other lower respiratory disease	201	12.89	25	193.99	12.11		Cystic fibrosis, Other lower respiratory disease	223	14.08	25	177.59	10.92
Pulmonary heart disease	162	12.45	21	168.68	8.55		Acute and unspecified renal failure	148	28.7	39	135.87	10.3
Superficial injury; contusion	1009	20.94	29	138.47	8.06		Intestinal infection	968	26.41	35	132.55	8.59
Epilepsy; convulsions	634	10.31	18	174.57	7.69		Superficial injury; contusion	1008	18.66	27	144.7	8.34
Acute and unspecified renal failure	153	31.44	39	124.03	7.56		Fracture of neck of femur (hip)	538	49.24	57	115.75	7.76
Joint disorders and dislocations; trauma-related, Other fractures etc.	621	13.11	20	152.59	6.89		Pulmonary heart disease	158	12.68	20	157.72	7.32
Fracture of neck of femur (hip)	524	49.44	56	113.26	6.56		Epilepsy; convulsions	646	9.7	17	175.32	7.3
Intestinal infection	966	27.46	34	123.84	6.54		Coma; stupor; and brain damage	27	4.7	12	255.41	7.3
Chronic obstructive pulmonary disease and bronchiectasis	1140	78.56	85	108.19	6.44		Gastrointestinal haemorrhage	542	37	44	118.9	7
Coma; stupor; and brain damage	25	4.11	10	243.46	5.89		Aortic and peripheral arterial embolism or thrombosis	105	7.81	14	179.35	6.19
Liver disease; alcohol-related	80	13.42	19	141.62	5.58		Deficiency and other anaemia, 60 - Acute post-haemorrhagic anaemia	274	11.9	18	151.23	6.1
Aortic and peripheral arterial embolism or thrombosis	103	8.2	13	158.47	4.8		Liver disease; alcohol-related	99	16.42	22	134.01	5.58
Complications of surgical procedures or medical care	582	7.74	12	155	4.26		Complications of surgical procedures or medical care	595	7.68	13	169.22	5.32
Other inflammatory condition of skin, Chronic ulcer of skin, Other skin disorders	563	14.79	19	128.47	4.21		Aortic; peripheral; and visceral artery aneurysms	250	26.68	32	119.96	5.32
Deficiency and other anaemia, Acute post haemorrhagic anaemia	266	12.07	16	132.6	3.93		Joint disorders and dislocations; trauma-related, Other fractures etc.	653	13.13	18	137.11	4.87
Diverticulosis and diverticulitis, Anal and rectal conditions	405	7.43	11	148	3.57		Non-infectious gastroenteritis	36	1.61	6	373.2	4.39

Figure 7: Top 20 Highest number of deaths occurring above the expected level; SHMI July 2013 to June 2014 & October 2013 –September 2014

2.3 Despite an overall improvement of mortality indicators, and a downward trend in overall crude mortality, the Trust continues to note a period of increased crude mortality each year, usually, from the end of Quarter 3 to Quarter 4, the winter period, corresponding with an increased mortality ratio for both HSMR and SHMI as shown in figure 8. Last year's Annual Mortality Report addressed this issue by looking at 3 condition groups where there was a significant increase in SHMI to give assurance to the Trust and regulators that although there was a national upward trend in crude mortality, that there were no failings in the quality of care or service received by these patients in hospital.

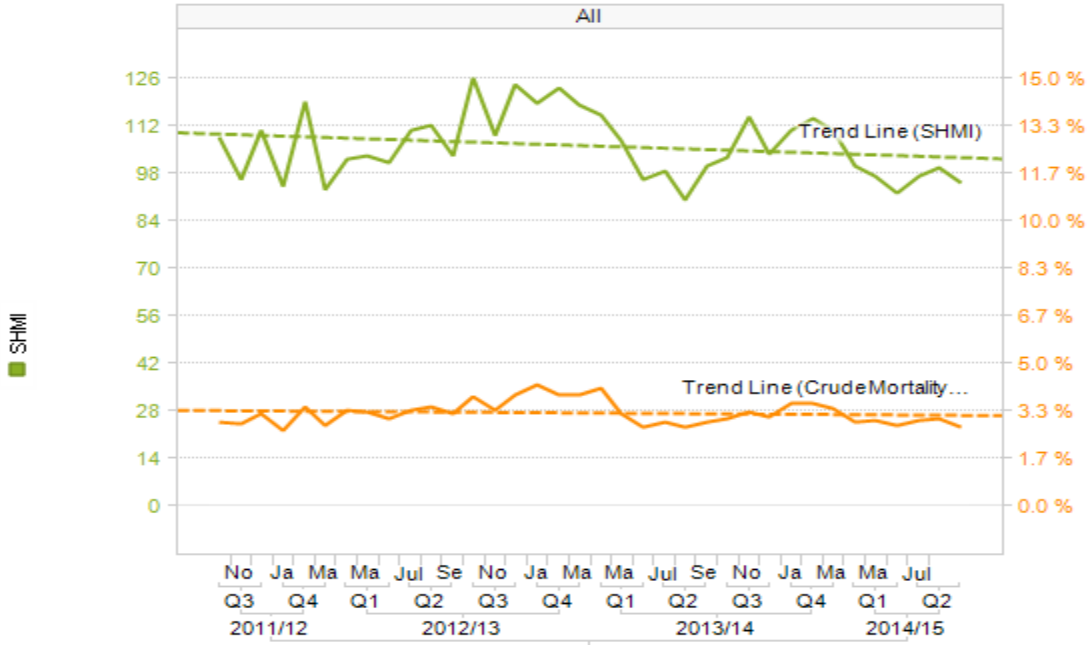


Figure 8 SHMI vs Crude Mortality, 3 Year, October 2011 to September 2014

The Trust followed the national trend in reporting a lower than average trend for winter deaths in 2013/2014. Final numbers for 2014/2015 are yet to be published but Public Health England Bulletin suggests that nationally winter deaths will exceed the previous year's levels. (Monthly Figures on Deaths Registered by Area of Usual Residence, England and Wales, (Provisional) ONS)

	2012/2013		2013/2014		2014/2015	
	Trust	**England**	**Trust**	**England**	**Trust**	**England**
November	144	39,337	132 -8.3% ▼	37,322 -5.1% ▼	164 24.2% ▲	36,864*-1.2% ▼
December	149	39,671	139-6.7% ▼	39,974 .76% ▲	192 38.1% ▲	46,429*16.1% ▲
January	160	49,490	153 -4.4% ▼	45,931* -7.19% ▼	236 54.2% ▲	57031*24.1% ▲

*provisional ONS figures

Figure 9 Winter Deaths 2012-2014 National vs Trust Increase

Figures 9 and 10 show that January 2015 represented a period of significantly higher mortality for the Trust and although there was a large increase in crude mortality nationally, the Trust had a 54% increase from the previous year compared to a 24% increase nationally.

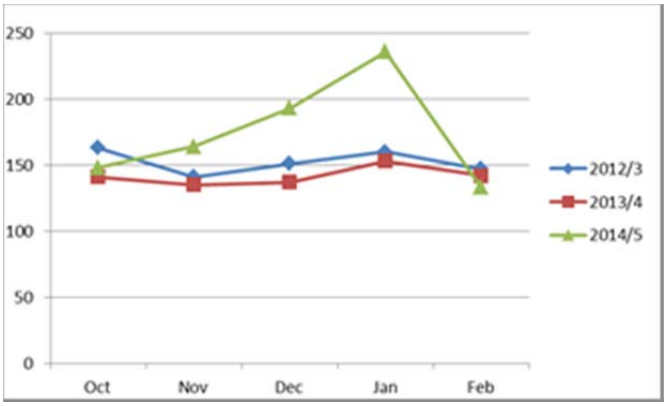


Figure 10 Crude Mortality The Dudley Group NHS Foundation Trust October-February 3 year.

For these reasons mortality indicators may be useful in terms in order to make adjustments based on a variety of factors to account for differences between areas. However, meaningful data is not yet available for January 2015, given the delays in producing Hospital Episode Statistics, Statistics on Registered Deaths and the SHMI. It is an action for the Quarter 3 Mortality Report that the Medical Director provides some analysis on the period to understand what caused the significant increase in January 2015 in particular.

In the interim preliminary data obtained from HED, seen in figure 11 below, shows that the Trust position is typical of acute trusts.

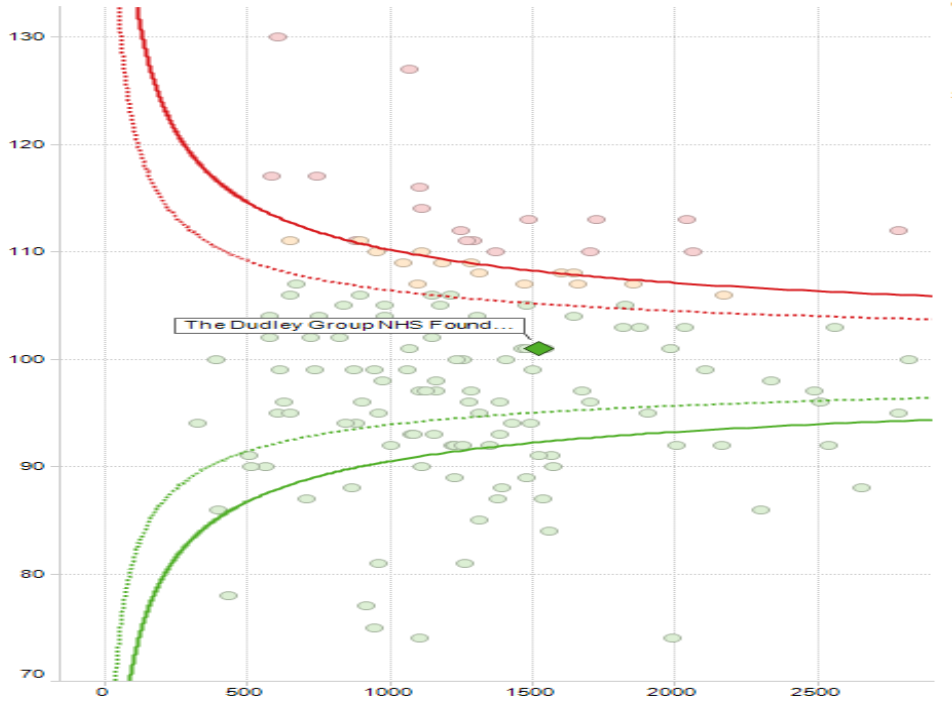


Figure 11 Crude Mortality Acute Trusts in England, January 2015

3. Performance- Trust Level- Mortality Tracking System©

In previous reports and in our strategic plan as outlined in section 1, it is the aim of this Trust to move away from a focus on mortality indicators and instead on detailed case note review supported by the Mortality Tracking System©.

As discussed above, there is a growing body of evidence which clearly defends the Trusts' emphasis on detailed case note review as opposed to mortality indicators. The Keogh Review highlighted the difficulty in relying on mortality indices alone to assess quality of care. There is little need to repeat Sir Bruce Keogh's clear statement that mortality indicators should not be used to quantify actual numbers of avoidable deaths. (Keogh; 2013) As such the Trust will not attempt to quantify numbers of deaths or areas where deaths could have been avoided. Instead the Trust has undertaken to ensure that all deaths are reviewed by a multidisciplinary team responsible for the patient's care within a reasonable time. A report on the subject was commissioned from Professor Nick Black at the London School of Hygiene and Tropical Medicine and Professor Lord Ara Darzi at Imperial College London. This has yet to be published. However in a recent webinar Professor Black made the case for the methodology by which the Trust wishes to proceed. The presentation warned against a reliance on mortality indicators, but supports a range of approaches including reviewing incidents, patient experience data, adhering to evidence based guidelines. As well as retrospective case note review which considers if the death was preventable, arguably the most useful way to learn from mortality from and effect change.

In 2014/2015 the Trust prioritised mortality in the quality account by undertaking to ensure that deaths were reviewed in a timely manner by a multidisciplinary team. The trust target of 85% reviews to be undertaken within 12 weeks was achieved and the Trust is aiming for an ambitious 90% in 2015/2016.

Meeting 85% target **Above 50%- Below 85% Target** **Below 50%**

Trust Overall	85.6%

Specialty	% audited within 12 weeks	Specialty	% audited within 12 weeks
Cardiology	88.7	Renal	88.2
Gastroenterology	74.6	Haematology	43.3
General Medicine	83.4	Oncology	29.7
Medical Assessment	92.3	Care of the Elderly	97.8
Orthogeriatrics	100	ENT	66.7
Rehabilitation	94.1	General Surgery	69.2
Respiratory	92.9	Urology	54.5
Stroke Medicine/Stroke Rehab	79.3	Vascular Surgery	82.7
Diabetes	100	T&O Rehabilitation	96.2
Endocrinology	88.2	Trauma and Orthopaedics	96
Neonate	77.8	Gynaecology	50
Plastic Surgery	100	Rheumatology	100

While most specialities achieved the target in at least one quarter, two specialities did not achieve quarterly or overall. For Haematology a recovery plan is in place and the speciality is now achieving within the target. Oncology remains an on going area of concern due to cross organisational working, where speciality multi disciplinary teams are coordinated across several trusts. The primary employer of the majority of consultants responsible for case note review has been notified. Given the recorded evidence of MDT meetings, the Trust can be assured that case reviews are undertaken.

Regardless of this relatively minor issue the medical workforce is engaged with the tracking system and the Trust has been able to use the information from mortality audits and panel reviews to respond to the CQC alerts as outlined in section 2. Additionally where there are areas of concern, either through our continuous analysis of mortality indicators or from the CQC Intelligent Monitoring reports audit information on the majority of deaths in hospital is available for case note review.

4. Learning from Death

The aim of reviewing deaths in hospital is to improve patient care the mortality review programme is designed to do this.

Last year's report highlighted the need to improve the audit questions to ensure that actions for improvement following recommendations or concerns raised by the Mortality Panel were followed up. That process was put in place and we were able to assure the CQC in recent responses of specific improvements made. Another key change to the audit form was to prompt teams to share learning with or to highlight the involvement of another team. This has allowed the panel to engage multiple specialities involved in a patient's care in evaluating a death in hospital. As Mortality indicators do not allow for this cross speciality attribution and engagement, this has been a positive addition to the audit.

The appendices contain examples of how this rich data set has supported responses to the CQC. The Clinical Quality Safety & Patient Experience has seen the Trusts' initial response to the two mortality outlier alerts, sent to the CQC in January 2015 for Septicaemia and Pulmonary Heart Disease. The CQC requested more detail on the quality of care for each patient. Without the MTS© the Trust would have used costly and vital clinical resources to conduct further case note audits on each case.

Despite these improvements the team has not successfully engaged non-clinicians in the process and a key action for this year will be sharing areas of concern and follow-up of actions with divisional management teams.

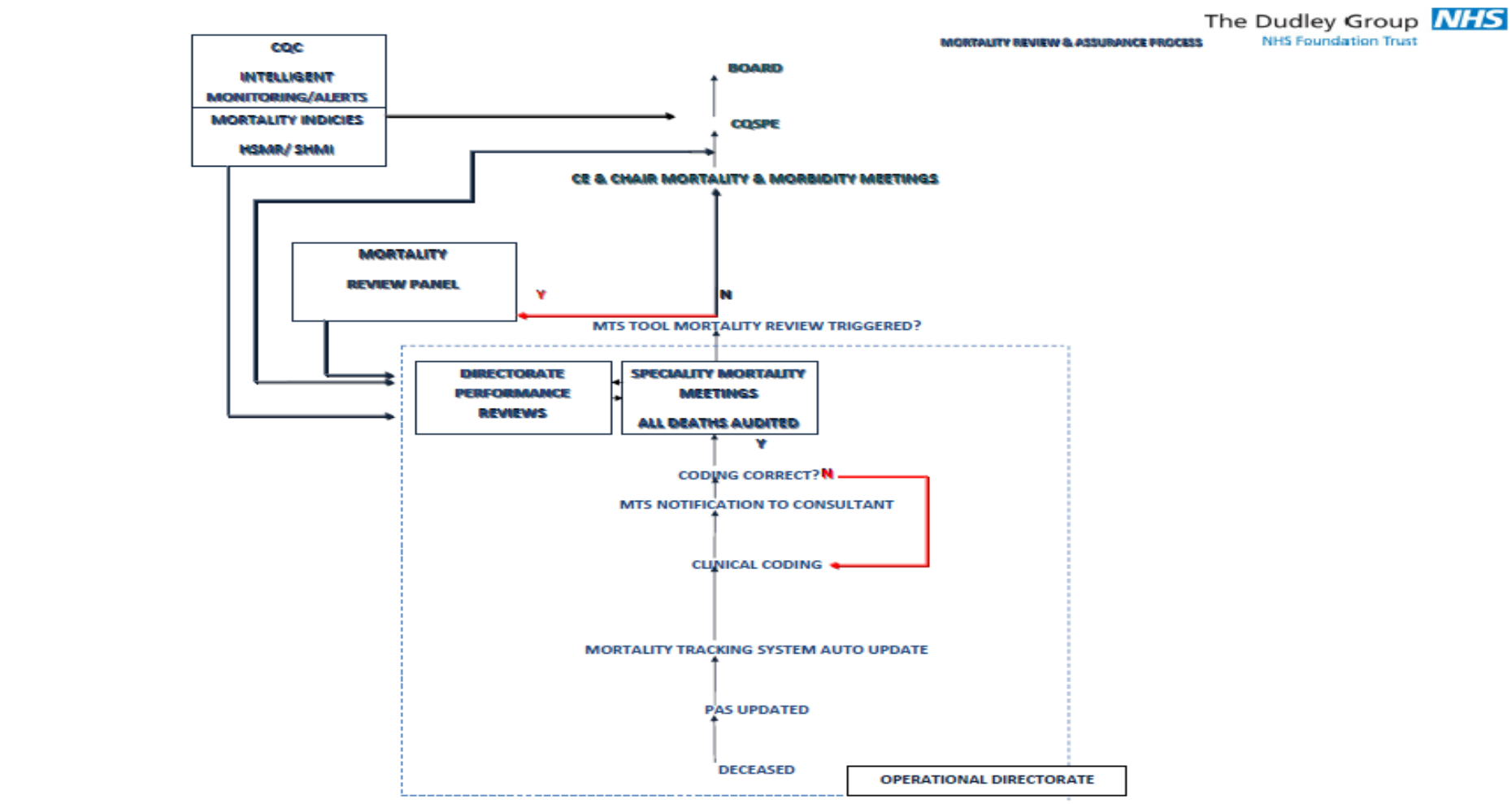
5. Next Steps: Actions to Improve the Mortality Review Process

The summary below sets out the actions which are necessary to improve the review process following this review. A similar exercise should be undertaken in six months in order to give assurance to the board tat progress has been made.

Action	Owner	2015/2016 Objective	Review Date
Audit of top 5 SHMI Proactive report to CQC on receipt of any Dr Foster Alerts via CQSPE or Q&S Group Review of January 2015 winter deaths	Deputy Medical Director/Directorate Manager to Medical Director/CQSPE	Proactive audit of 1) Areas alerted by Dr Foster/CQC. Or 2) Highest SHMI (top5) reported in advance to CQC with action plans Reduce number of mortality alerts.	August 2015 (quarterly) Ongoing in Response to any Dr Foster Alert August 2015
Escalation Reports & action plans to Divisions & CQSPE on specialities failing to achieve target	Directorate Manager to Medical Director	Quality Priority to review 90% of in-hospital deaths within 12 weeks by March 2015 achieved.	March 2016 Quarterly updates
Literature Review and test of methodology by MTS panel	Deputy Medical Director/ Directorate Manager to Medical Director	Develop or adopt methodology for rating "avoidable deaths". Include rating scale in Mortality Tracking System© update	December 2015

Action	Owner	2015/2016 Objective	Review Date
		Commercial Partnership agreement. Evaluate Beta site results Undertake improvement work with partners.	

Appendix 1 :The Mortality Tracking System



V3 November 2013. TB

Appendix 1 :The Mortality Tracking System

The Mortality Tracking System (MTS) was developed by our Information Team and launched in January 2012. Since then the Trust has worked to achieve three primary objectives:

First, to ensure that every death within hospital is reviewed by the team responsible the care of the patient. Secondly to learn and share experiences with colleagues across the trust to continuously improve the quality of care we provide. Finally that the Medical Director, as professional lead, has oversight of the process of reviewing deaths and is therefore able to give assurance to the board, regulators, commissioners and patients.

The figure above is a representation of the review process. The MTS records every death, coding and consultant validation.

The next step is the most important. Every death is audited in a regular multidisciplinary meeting for each speciality. An audit tool within the tracking system is completed during that meeting which may trigger a Mortality Panel Review.

The Mortality Review Panel is a fortnightly panel chaired by the Deputy Medical Director. Its membership includes consultants, matrons, and the Clinical Coding Manager. GPs are invited from NHS Dudley CCG and attend panels when available. The panel reviews the case notes and will request additional information from the consultant responsible and identify actions when necessary. This panel reports monthly to the Quality & Safety Group.

To provide assurance at a committee and board level there are three forums specific to this process.

Clinical Directorates are provided with a quarterly mortality report as part of their performance review. Actions are recorded for each directorate and progress is reported quarterly.

In addition the Chief Executive and Chairman hold a monthly Mortality & Morbidity meeting which every speciality attends on an 18 month rotation. The Minutes of these meetings are included as an appendix with mortality reports to the relevant board committee.

A quarterly Mortality Report and monthly update is provided to our Clinical Quality, Safety & Patient Experience Committee, which includes external data which such as Mortality Indices (SHMI and HSMR), CQC alerts, directorate action plans and mortality tracker usage.

It is important to note that we have other systems within the trust to capture those cases which fall into the category of serious or untoward incidents. They are captured and recorded via the incident reporting system, Datix, and are investigated outside of the mortality review process.

The trust is confident that the mortality review process provides a robust framework through which we are able to understand and act upon the experience of caring for those patients who die in hospital. Its primary purpose is to identify issues which have an impact upon hospital deaths and ensure that there are actions in place to address them.

The Keogh review of this Trust earlier this year noted the following about our mortality tracking system:

"Good practice identified:

It was clear that there was a focus on mortality at a high level in the organisation and there is a mortality review process in place which had been operating for a number of years. It was noted that current mortality indices are not outside expected limits. There was evidence of two processes in place to review mortality:

- *An audit of every death at Directorate level; and*
- *A monthly meeting focused on individual Directorates attended by the Chair, Medical Director and Chief Executive. The CCG has also sent representatives.*

Information supplied indicated that the monthly mortality review meetings had taken place in 2013 and that the relevant directorates were provided with mortality data to review in the meeting."

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Clinical Quality, Safety and Patient Experience on 2nd July 2015

TITLE:	Trust Quality Report 2014-15 - Quality Report External Assurance Review		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER:**	Yvonne O'Connor Deputy Chief Nurse

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

SUMMARY OF KEY ISSUES:

Attached is the final version of the Trust Quality report for 2014-15. This has now been sent to Monitor and will be laid before Parliament as part of the overall Annual Report prior to it being placed in the public domain.

Also attached is the external auditors Quality Report External Assurance Review dated 21st May 2015. The review is a statutory requirement and is primarily commissioned by the Council of Governors and so it will be circulated to Governors and presented at the Council of Governors Meeting in September. It can be seen (page 4) that the review concludes that the content of the Quality Report and data consistency and data testing all meet the key national standards and there are no significant issues with the Quality Report. It can also be seen that there are six recommendations associated with some minor issues related to the data testing (p20). Four of these are related to the 18 week referral-to-treatment time audit. Deloitte indicated verbally that other Trusts had significantly greater problems with this issue compared to ourselves.

The relevant managers/staff are already aware of these recommendations and are progressing actions as described in the management response. It has suggested to the Clinical Quality, Safety and Patient Experience Committee that a review of these actions are presented to them in October as part of the quarterly quality account report.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details:** Quality Report requirements
	Other	**Y**	**Details:** DoH Quality Account requirements

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
✓		✓	

RECOMMENDATIONS FOR THE BOARD:
a) to note the final Quality Account report
b) the agree the reporting of the progress with the recommended actions in the Deloitte report.

The Dudley Group NHS
NHS Foundation Trust

Quality Report 2014/15

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Contents

Throughout this document, there are a number of quotes taken from reviews that patients themselves have posted online on NHS Choices and Patient Opinion.

Part 1: Chief Executive's statement

I am again pleased to introduce the annual Quality Report and Account, where we give a detailed picture of the quality of care provided by our hospital, outpatient centres and adult community services. This report covers the year from April 2014 to the end of March 2015.

Our primary focus is to provide high quality treatment and care for all of our patients. By this, we mean we strive to provide:

- A good patient experience
- Safe care and treatment
- A good and effective standard of care

As in previous years, this report uses these three elements to describe the quality of care at the Trust over the year, providing an overall picture of what the organisation is achieving and where it still needs to improve.

Following on from this introduction, in Part 2 we have outlined our priority quality measures and charted their progress throughout the year. A summary of current and previous priorities can be seen in the table on page 8 as can more details on each priority on the page numbers listed in that table. These details include progress made to date, as well as our new targets for 2015/16. This part of the report also includes sections required by law on such topics as clinical audit, research and development and data quality.

In Part 3 we have included other key quality initiatives and measures, and specific examples of good practice on all of the three elements of quality which hopefully give a rounded view of what is occurring across the Trust as a whole. As we provide both acute and community care, you will see some parts of the report are divided into hospital and community sections for ease of reference.

In terms of independent reviews of the quality of care at the Trust, the key event this year was a visit from the Care Quality Commission (CQC). A CQC inspection team of 40 people assessed the Trust, visiting many wards and departments and talking with a wide variety of staff and patients. This report contains a section (Section 2.2.5) providing the details of that review but, in summary, we were pleased to note that the Trust was rated 'Good' in 30 out of the 38 core services inspected. The majority of the group categories (five out of eight) also received an overall rating of 'Good'. Despite this, the overall rating for the Trust was 'Requires Improvement', which was a disappointment. The Chief Inspector of Hospitals, Professor Sir Mike Richards, believes we are not far off achieving an overall 'Good' rating and he has confidence that we are addressing the issues highlighted by the inspection. It is a credit to all of the staff that the inspection team found much evidence of excellent practice and that patients see them as highly caring with many examples of staff going the extra mile.

As well as the CQC, we are monitored by a variety of other external organisations and agencies (see Section 2.1.1) and, as this report indicates, we are constantly monitoring ourselves in many ways on the quality of our care. This allows us to assure both patients and ourselves of what we are doing well and learn where we need to change practice and improve our services.

Although there is much debate about the usefulness of mortality indicators, I am pleased to be able to report that the Trust has now been consistently within the expected range for the Summary Hospital-level Mortality Indicator (SHMI) the whole of this year and, in fact, constantly from the period commencing October 2012.

Our quality priorities

You will see in Part 2 that we have made excellent progress with the majority of our 2014/15 priorities. I am pleased to report reductions in both healthcare associated infections and pressure ulcers. We have met both our C. difficile and MRSA targets, with this being the first year we have had none of the latter. Whilst we unfortunately had a single stage 4 avoidable pressure ulcer in the hospital, stage 3 avoidable pressure ulcers were reduced by more than 50 per cent from last year. The community had no stage 4 avoidable ulcers, whilst stage 3 avoidable ulcers remained at a low number throughout the year.

Our mortality tracking process includes clinical coding, validation, multidisciplinary specialist audit and, where necessary, senior medical and nursing review led by our Deputy Medical Director. This process is to ensure that each death occurring in hospital is understood and we are responsive to the information we gather from this process. We have met our new target in this regard.

In addition, the assessments that nurses undertake mean that we have met two out of three nutrition and hydration targets. The survey results for patient experience indicate we have also met the connected target regarding patients' perceptions of receiving enough help to eat at meal times. As part of the same survey, we had a target that at least 90 per cent of patients would indicate that their call bells are always answered in a reasonable time but we were unable to reach this target and so further work is required in this area.

Finally, the results of our local annual survey of community patients show that, unfortunately, we have not met the targets we set ourselves. In 2014/15 we introduced the national Friends and Family Test (FFT) into the community. We have included this, along with the inpatient FFT, as a quality priority for 2015/16 in order to allow us to compare ourselves with other providers, both locally and nationally.

With regards to 2015/16, we have retained all of the topics from 2014/15 due to their importance from both a patient and organisational perspective, and to build on the good work already undertaken.

Measuring quality

This report includes a wide range of objective indicators of quality, and we have also included a few specific examples of the many quality initiatives from around the Trust and what patients have said about us. We could not include them all but hopefully the examples, together with awards, innovation and initiatives that Trust staff have achieved and implemented in the year, give a flavour of our quality of care.

A fundamental part of improving quality at the Trust is listening to our patients' experiences. I am especially pleased to report that the Trust is receiving positive and better than national average scores and feedback from our inpatients, mothers on our Maternity Unit and patients being seen in the Emergency Department in the national Friends and Family Test (Section 3.2.2). Our nurses continue to improve the

quality of care they provide as measured by our detailed monthly Nursing Care Indicator assessments (Section 3.3.4). I am also particularly pleased to report that a number of our nurses and midwives from both the hospital and community have won some prestigious national awards, ranging across a number of specialties (Section 3.4.2).

I hope you will find it helpful to see some of the information we use to monitor our quality of care, creating a picture of quality across the Trust.

We would appreciate any feedback you would like to give us on both the format and content of the report but also the priorities we have chosen. You can either telephone the communications team on (01384) 244403 or email communications@dgh.nhs.uk

In addition, we summarise this lengthy report in our annual summary, 'Your Trust', and publish quarterly updates on the progress of our quality priorities on our website www.dudleygroup.nhs.uk

The Trust and its Board of Directors have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported. Following these steps, to the best of my knowledge, the information in this document is accurate.

Finally, 2015/16 will be challenging for the Trust as we enter the second year of austerity measures. We will continue to work with patients, commissioners and other stakeholders to deliver further improvements to quality in the context of growing demand for services and developments in healthcare provision generally.

Signed **Date: 21st of May 2015**

Paula Clark
Chief Executive

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

2.1 Quality improvement priorities

2.1.1 Quality priorities summary

The table below gives a summary of the history of our quality priorities and also those we will be working towards in 2015/16.

Priority	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Notes
Patient experience Increase in the number of patients who report positively on their experience on a number of measures.	Achieved	We improved on one measure but had a slight decrease in another	Hospital: Partially achieved Community: Achieved	Hospital: Achieved Community: Partially achieved	Hospital: Partially achieved Community: Not achieved	Hospital: Partially achieved Community: Partially achieved	Priority 1	See page 10 for more information
Pressure ulcers Improve systems of reporting and reduce the occurrence of avoidable pressure ulcers.	N/A	N/A	Hospital: Achieved Community: Partially achieved	Hospital: Achieved Community: Achieved	Hospital: Partially achieved Community: Achieved	Hospital: Partially achieved Community: Partially achieved	Priority 2	New in 2011/12 See page 14 for more information
Infection control Reduce our MRSA rate in line with national and local priorities.	Achieved	Achieved	Achieved	Achieved	Not achieved	Achieved	Priority 3	See page 19 for more information
Reduce our Clostridium difficile rate in line with local and national priorities.			Not achieved	Achieved	Not achieved	Achieved		
Nutrition Increase the number of patients who have a risk assessment regarding their nutritional status.	N/A	N/A	N/A	Achieved	Partially achieved	Partially achieved	Priority 4	New in 2012/13 See page 22 for more information
Hydration Increase the number of patients who have their fluid balance charts monitored.	N/A	N/A	N/A	Achieved	Achieved	Achieved		New in 2012/13 See page 22 for more information
Mortality Improve reviews of hospital deaths.	N/A	N/A	N/A	N/A	N/A	Achieved	Priority 5	New in 2014/15 See page 26 for more information
Hip operations Increase the number of patients who undergo surgery for hip fracture within 36 hours from admission (where clinically appropriate to do so).	N/A	Achieved	Achieved	N/A	N/A	N/A	N/A	As the target was achieved for two consecutive years this priority was replaced in 2012/13
Cardiac arrests Reduce the numbers of cardiac arrests.	Achieved	Achieved	N/A	N/A	N/A	N/A	N/A	With a decrease from 32 per month in 2008 to 13 per month by 2011 this no longer remained a challenge

2.1.2 Choosing our priorities for 2015/16

The Quality Priorities for 2014/15 covered the following six topics:

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

These topics were agreed by the Board of Directors due to their importance both from a local perspective (e.g. based on key issues from patient feedback, results from our Nursing Care Indicators, see Section 3.3.4) and a national perspective (e.g. reports from national bodies such as Age UK, CQC etc.). The first five topics (ie. excluding mortality) were initially endorsed by a Listening into Action event on the Quality Report, hosted by the Chief Executive and Director of Nursing, attended by staff, governors, Foundation Trust members and others from the following organisations: Dudley LINK, Dudley Primary Care Trust, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC). The sixth topic, mortality, was added from the recommendation of an external review of the Trust.

Following consultation with governors, those who attended the Annual Members Meeting, the public generally via an online questionnaire and suggestions from our main commissioner, it has been agreed that the same priority topics will be retained in 2015/16.

All of the topics have a fundamental role in providing good quality patient care. Good patient experience of our services is a core purpose of the Trust. The Trust is committed to minimising healthcare associated infection rates which is a key commissioner and patient expectation. There are national campaigns of zero tolerance to avoidable pressure ulcers and the need to focus on patients' nutrition and hydration. Monitoring mortality indicators is seen as a useful device as they can act as a 'warning sign' or 'smoke-alarm' for potential quality issues.

All of our priorities have named leads who have the responsibility of coordinating the actions aimed at achieving the targets. Every quarter our progress on all the targets is reported to the Clinical Quality, Safety and Patient Experience Committee, the Board of Directors and the Council of Governors. In addition, a summary of the progress is placed on the Trust website.

Outstanding doesn't come close to describing the level of care the midwives give... it was obvious it's more than just a job and they are more than willing to go above and beyond to ensure that mom and baby are happy and safe.

2.1.3 Our priorities

Priority 1 for 2014/15: Patient experience

Patient experience	
Hospital	**Community**
a) Maintain an average score of 8.5* or above throughout the year for patients who report receiving enough assistance to eat their meals.	a) Equal or improve the score of patients who state they were informed who to contact if they were worried about their condition after treatment. (2013/14 was 8.8 out of 10)
b) By the end of the year, at least 90 per cent of patients will report that their call bells are always answered in a reasonable time.	b) Equal or improve the score of patients who state they know how to raise a concern about their care and treatment if they so wished. (2013/14 was 8.3 out of 10)

*Change of scoring system to be consistent with the national surveys. Now out of 10 rather than 100

How the Trust measures and records this priority

Hospital

This priority has been measured using our real-time survey system. A random sample of inpatients is asked to share their experiences by participating in the survey about their stay before they leave hospital. Responses to the surveys are entered directly into a hand-held computer and downloaded straight into our database to provide timely feedback. During 2014/15, 1479 patients participated in the surveys. All surveys are anonymous and results are shared with individual wards enabling them to take action in response to patient comments.

Community

The community priority has been measured using an annual survey. A paper questionnaire was distributed to community patients who were also provided with a freepost envelope to ensure an anonymous response; 571 responses to the survey were received, with question (a) answered by 541 respondents and (b) answered by 532.

Developments that occurred in 2014/15

- Changing and improving the food and drink for our inpatients has been a focus this year with numerous interventions including: new water jugs which are easier to handle, fresh fruit available every day, daily mealtime observations, refreshed training for housekeepers, and increased availability of chips and jacket potatoes. There was also a complete new menu trial conducted on four wards which included tasting sessions and feedback from patients, staff and governors resulting in a new *Chosen by Patients* menu which will be rolled out during 2015.
- Dedicated lead nurse on all wards for mealtimes to ensure enough nursing support during mealtimes.
- New Wellbeing Worker role developed and recruited across the Trust to provide one-to-one care for our most vulnerable patients and, in particular, those living with dementia.
- Dementia Friends campaign and training launched across the Trust, with almost 400 members of staff now signed up.
- Three wards initially trialled a 30 second response time to answering call bells, including information posters displayed to advise patients of what can be expected. This was then rolled out across the Trust.
- Improved highway signage on main roads leading to the Guest Outpatient Centre site.
- Card payment system introduced on parking machines.
- Environmental improvements to the admissions lounge and day case area, including daily newspapers, better signage and a review of seating arrangements.
- Establishment of the Patient Experience Group incorporating representatives from the Clinical Commissioning Group, Healthwatch Dudley and the Council of Governors. The group is chaired by the Chief Executive and reports into the Clinical Quality, Safety and Patient Experience Committee.
- Development and agreement of new reporting style on patient experience to our commissioners.
- Development of a patient experience mobile phone app to be launched in 2015 to provide another platform for patients and the public to share their views.
- Business cards developed to advise patients of how to raise a concern, compliment or complaint and posters refreshed across all sites.
- Regular patient videos or letters presented to Board of Directors each month.

I received a warm welcome from the accompanying nurse and the consultant himself. The consultation left me feeling reassured and comforted, and we even exchanged a few laughs which helped to ease the worry.

Current status: Hospital

Quality priority hospital (a)	Q1	Q2	Q3	Q4	2014/15
a) Maintain an average score of 8.5 or above throughout the year for patients who report receiving enough assistance to eat their meals.	8.5	9.6	9.2	7.04	8.72
Number of patients who felt they sometimes or never got the help they needed	5 (out of 400 surveyed)	2 (out of 440 surveyed)	3 (out of 300 surveyed)	8 (out of 339 surveyed)	18 (out of 1479 surveyed)
Quality priority hospital (b)	**Q1**	**Q2**	**Q3**	**Q4**	**2014/15**
b) By the end of the year at least 90 per cent of patients will report that their call bells were always answered in a reasonable time	85.5%	86%	89%	78.1%	86.75%

We are pleased the Trust has met the target relating to patients' perceptions of receiving enough assistance to eat their meals (target 8.5 with actual score of 8.72). It is disappointing that there was a small number of patients who felt they did not receive enough assistance to eat. When a patient indicates this, the independent person undertaking the survey immediately contacts the nurse in charge who resolves the issue with the patient.

With regards to the call bell target, it is disappointing to see that this has not been met (in 2013/14 the target of 80 per cent was achieved and so the target was made more difficult this year). A system is being implemented to monitor and improve this next year.

Current status: Community

Quality priority community (a)	2013/14	2014/15
a) Equal or improve the score of patients who state they were informed who to contact if they were worried about their condition after treatment.	8.8	8.9 ▲

Quality priority community (b)	2013/14	2014/15
b) Equal or improve the score of patients who state they know how to raise a concern about their care and treatment if they so wished.	8.3	8.1 ▼

The Trust has achieved part (a) of the community priority achieving a higher score to the previous year for the number of people who felt they knew who to contact if they were worried about their condition after treatment in community services. However, priority (b) has seen a slight decrease from 8.3 in 2013/14 to 8.1 in 2014/15 for patients who knew how to raise a concern about their care or treatment.

New priority 1 for 2015/16

Patient experience	
Hospital	**Community**
a) Achieve monthly scores in the inpatients Friends and Family Test (FFT) that are equal to or better than the national average. b) Achieve monthly scores in the outpatients Friends and Family Test that are equal to or better than the national average. *(First planned publication during 2015/16).*	a) Achieve monthly scores in the community Friends and Family Test that are equal to or better than the national average. *(First planned publication May 2015)*

Rationale for inclusion

The hospital and community targets have changed this year to focus on the Friends and Family Test. This is a national measure of patient experience and allows the Trust to benchmark itself against other trusts, both regionally and nationally, on a monthly basis. The Friends and Family Test aims to provide a simple headline metric to drive continuous improvements. It makes sure staff providing the service and the Board of Directors obtain regular feedback from patients on how the services are being received, what is working well and where improvements are needed. The simple survey asks patients if they would recommend the service to a friend or relative and to rate this recommendation from extremely likely to extremely unlikely.

We consistently achieved the hospital priority (a) target set in 2014/15 throughout the year and so chose to identify a different priority where the target can be benchmarked against both local and national results, ultimately aspiring to be in the top 20 per cent of trusts nationwide.

Developments planned for 2015/16

Actions being undertaken to achieve the Trust target include:

- Continue the patient catering developments including the roll out of new *Chosen by Patients* menus.
- Refresh volunteer recruitment to target volunteers into the areas of greatest patient need, including mealtime volunteers.
- Review patient gowns.
- Complete implementation of soft close bins to help make ward areas quieter for patients during the night.
- Review appointment and discharge letters to ensure patients receive information on who to contact if they are worried after treatment and how to raise a concern.
- Launch patient feedback mobile phone app.
- Provide patient and public Wi-Fi access across the three hospital and outpatient centre sites.

Board sponsor: Paula Clark, Chief Executive
Operational lead: Liz Abbiss, Head of Communications and Patient Experience

Priority 2 for 2014/15: Pressure ulcers

Pressure ulcers	
Hospital	**Community**
Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2014/15 does not increase from the number in 2013/14.	Ensure that there are no avoidable stage 4 pressure ulcers acquired throughout the year on the district nurse caseload. Ensure that the number of avoidable stage 3 acquired pressure ulcers on the district nurse caseload in 2014/15 does not increase from the number in 2013/14.

How we measure and record this priority

Pressure ulcers, also called pressure sores or bed sores, are staged one to four with four being the most serious and one being the least. When a patient is identified as having a pressure ulcer, the details are entered into the Trust's incident reporting system to be reviewed by the tissue viability team prior to reporting externally.

If pressure damage is noted within 72 hours of admission to the hospital, and the patient has not been under the care of the community teams or on the district nurse caseload, this is not considered to have developed whilst under the care of the Trust. This time frame is agreed regionally as it is recognised that pressure damage can occur but not be visible immediately.

Developments that occurred in 2014/15

The Trust has updated the pressure ulcer prevention guidelines, taking into account all recent research developments.

Standardised pressure ulcer prevention and management documents are now being used across the hospital and community. The prevention document includes a standardised assessment and treatment record known as a bundle. The SKIN (Surface Keep moving Incontinence Nutrition) bundle is completed by all staff across the Dudley health economy to ensure every aspect of pressure ulcer prevention is addressed at each patient care episode.

The Trust has recognised the importance of continually updating community and social care carers in pressure ulcer prevention and completion of the SKIN bundle document. Training sessions continue for this group of staff across the year on a rolling programme and all sessions are well attended.

In the hospital, each ward has tissue viability co-ordinating link nurses who complete ongoing audits of the SKIN bundle documents to ensure they are completed correctly. There has been an additional audit completed as part of a study programme that revealed some changes were required to these documents to

ensure a standard approach across the Trust. The tissue viability team have started work to ensure these changes are carried out.

The Trust also introduced new static air mattresses to all inpatient beds (excluding maternity and children areas) during 2014/15. This type of mattress is known as a hybrid mattress and combines foam and air cells which makes them suitable for patients who are at a very high risk of developing pressure ulcers. Plug-in specialist mattresses may still be required for a small number of patients; however, because this need has been reduced, we are able to provide patients with this specialist high risk equipment without delay. As a result of the switch, the Trust has made significant cost savings and there was no increase in the number of patients developing stage 3 or 4 pressure ulcers.

The tissue viability team and other senior nurses now see and assess all patients that have been reported to have developed stage 3 or 4 pressure ulcers. This assessment not only helps to verify that the correct type of wound has been identified, but also ensures that a specialist who can make sure the appropriate care is in place has seen the patient.

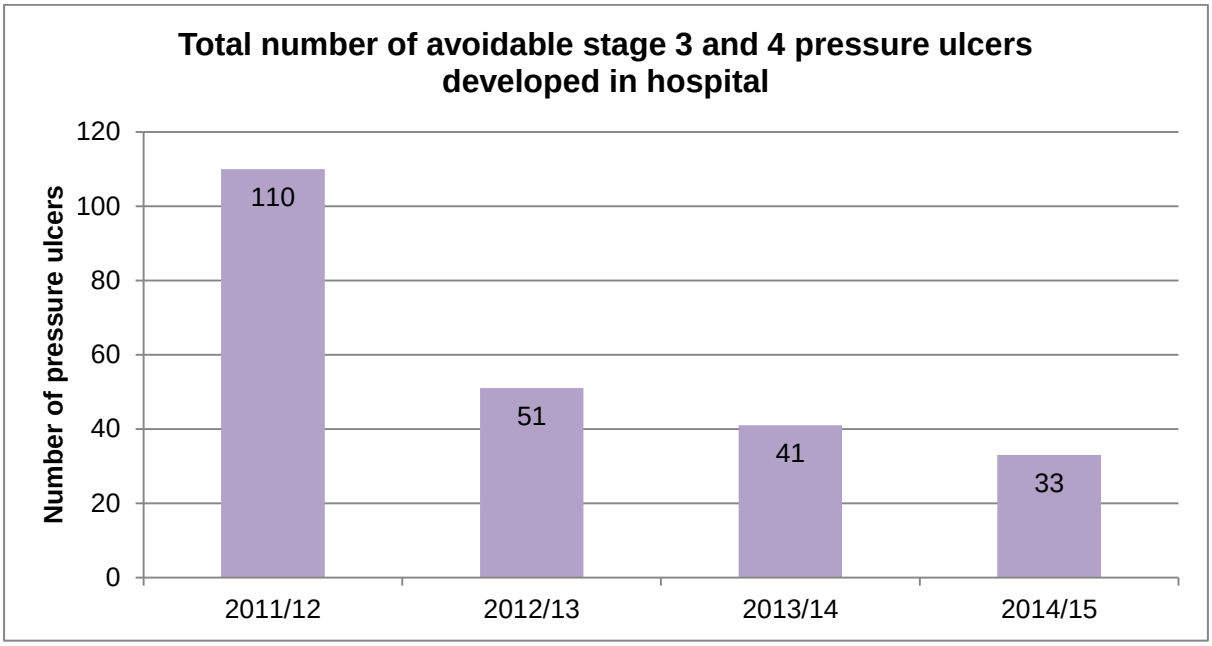
The Trust has employed community tissue viability nurses to focus on the correct use of pressure-relieving equipment in the community. This has, again, involved education and training for community teams and our social care colleagues. These nurses have implemented a new equipment selection flow chart which gives staff more guidance than was available previously. This process involved roadshows to which all staff were invited to collect their guidance and receive a short education session on all equipment available to them.

The team has also developed a good relationship with Dudley MBC's equipment service that supplies different types of pressure reduction equipment to patients at home and in care homes. We have been working with this service to ensure all equipment is tested correctly and fit for purpose and now hold regular meetings to ensure delivery and collection time frames are maintained.

The Trust also has a representative at the national tissue viability group which works closely with NHS England to ensure standards are in place locally. This year the group has worked together to develop a poster which helps nurses with the identification of skin damage.

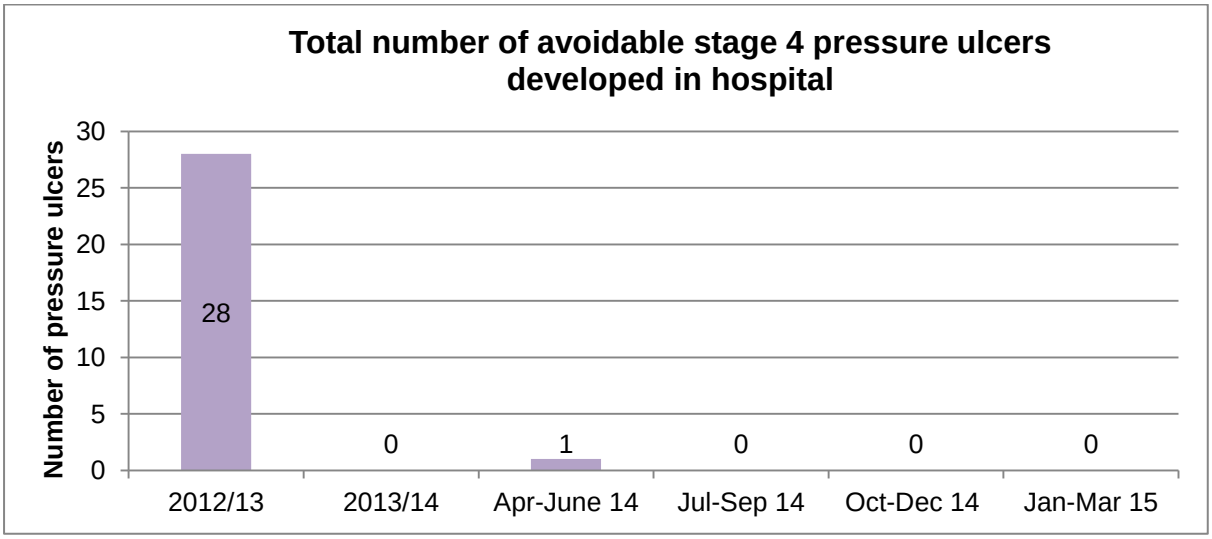
Current status: Hospital

The graph below shows the total number of avoidable stage 3 and 4 pressure ulcers that have developed in the hospital from 2011/12 to the present. It gives an indication of the dramatic fall in numbers due to the hard work of all staff involved. While there were 41 stage 3 and 4 ulcers in 2013/14 these have been reduced to 33 this year.

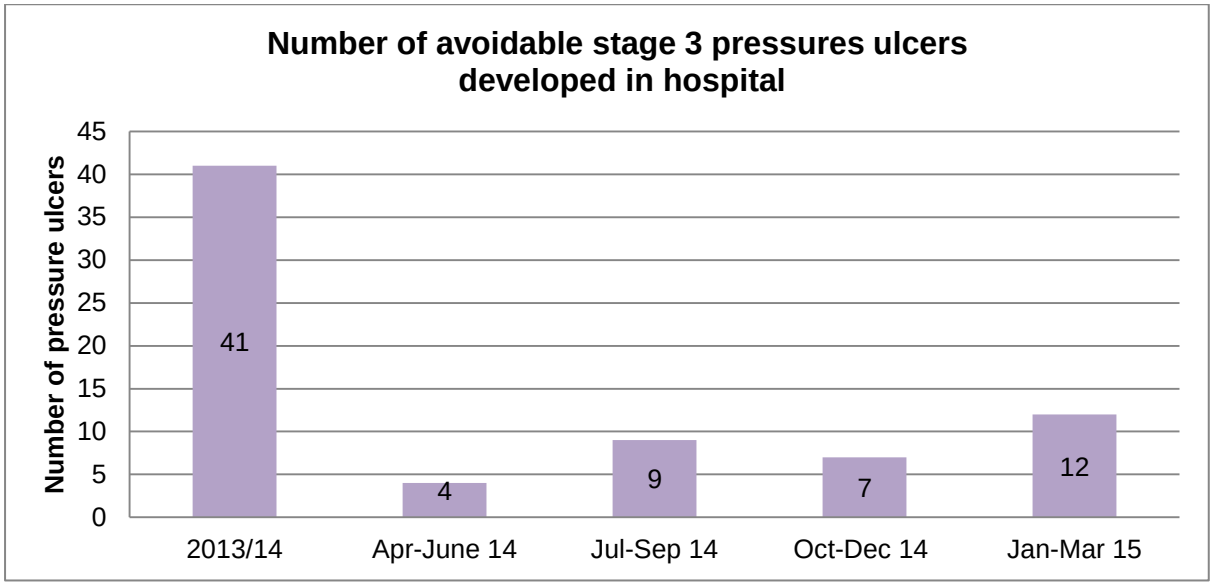


(In the 2013/14 Quality Report we reported a lower number of avoidable stage 3 pressure ulcers (36). Investigations that continued after the year end later found a further five avoidable ulcers)

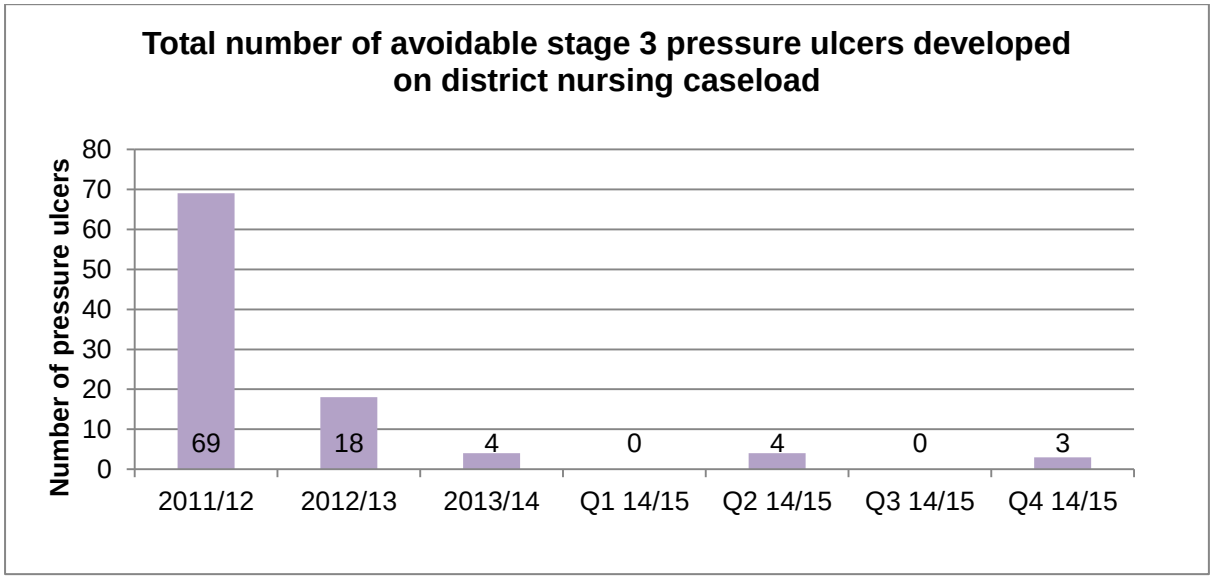
Specifically for avoidable stage 4 hospital acquired pressure ulcers, the target set was that there would not be any. This year there has unfortunately been a single avoidable stage 4 ulcer and so this target has not been achieved.



With regards to avoidable stage 3 hospital acquired pressure ulcers, the target set was that the number in 2014/15 would not increase from the number in 2013/14. In 2013/14 there were 41 avoidable stage 3 ulcers. It can be seen that this year there have been 32 and so this target was achieved.



Current status: Community



(In the 2013/14 Quality Report we reported a lower number of avoidable stage 3 pressure ulcers (3). Investigations that continued after the year end later found a further one avoidable ulcer)

The target of there being no avoidable stage 4 pressure ulcers acquired throughout the year on the district nurse caseload has been achieved. With regard to the avoidable stage 3 acquired pressure ulcer numbers not increasing from the number in 2013/14, this was a difficult target to achieve as there were only four in 2013/14, a dramatic drop from the previous two years.

New priority 2 for 2015/16

Pressure ulcers	
Hospital	**Community**
a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year.	a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year.
b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2015/16 reduces from the number in 2014/15.	b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2015/16 reduces from the number in 2014/15.

Rationale for inclusion

- Pressure ulcers are difficult to treat and slow to heal, and prevention is therefore a priority.
- Although the Trust has continued to reduce the overall number of pressure ulcers, it realises there is still much to do and moving to a zero tolerance approach should be the aim.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

Developments planned for 2015/16

Actions being undertaken to achieve the new Trust target include:

- Audits of all pressure relief equipment within residential home care settings to ensure it is maintained and used as per the Trust guidance
- Amend education programmes to include short one hour sessions with a specific focus each month
- Continue to provide regular educational sessions for community and social care staff
- Continue weekly joint (community/hospital) pressure ulcer group meetings to ensure Trust-wide learning
- Update the pressure ulcer prevention document and ensure teams have the required education and support for its continued use
- Agree process for lead nurses to support tissue viability nurses in the verification of stage 3 and 4 pressure ulcers
- Once the verification process has been agreed, the tissue viability team will support specific wards with prevention work through structured ward walks and audits
- Develop a ‘refusal of care’ pathway to ensure patients have a clear understanding of the risks associated with refusing equipment or positioning
- Investigate the use of a new device that can detect possible pressure damage before any redness occurs on the skin
- Continue to work with the regional group to assist the national-level work such as updating and maintaining the national *Stop the Pressure* website.

Board Sponsor: Denise McMahon, Director of Nursing
Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

Priority 3 for 2014/15: Infection control

Infection control	
Reduce our MRSA bacteraemia and Clostridium difficile (C. diff) rates in line with national and local priorities.	
MRSA	**Clostridium difficile**
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 48 post 48 hour cases of Clostridium difficile.

How we measure and record this priority

Infections are monitored internally, along with other key quality indicators, on the Trust's electronic dashboard (see page 29). In addition, these infections are monitored by our commissioners at quality review meetings

Positive MRSA bacteraemia and C. diff results are also reported onto the national Healthcare Associated Infections data capture system

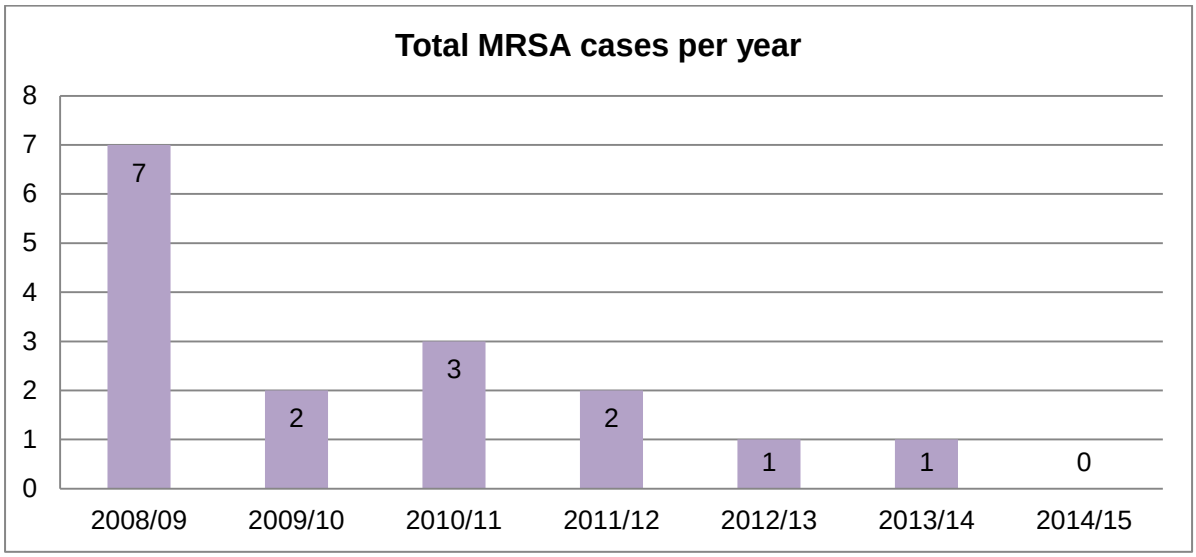
Developments that occurred in 2014/15

- We worked with our hydrogen peroxide vapour fogging contractor to agree a rolling programme of decontamination across all inpatient areas to assist in the prevention of infection
- We provided additional training for staff around the correct procedures for collecting specimens
- We developed education programmes and competencies for infection control that can be utilised across the Trust
- We have worked with our community teams to enhance their knowledge around infection prevention and auditing of practice
- We have worked with our commissioners to agree a process for determining whether or not C. diff cases are avoidable

The community is fortunate to have such a dedicated and expert medical staff working with terminally ill patients in the Georgina Ward.

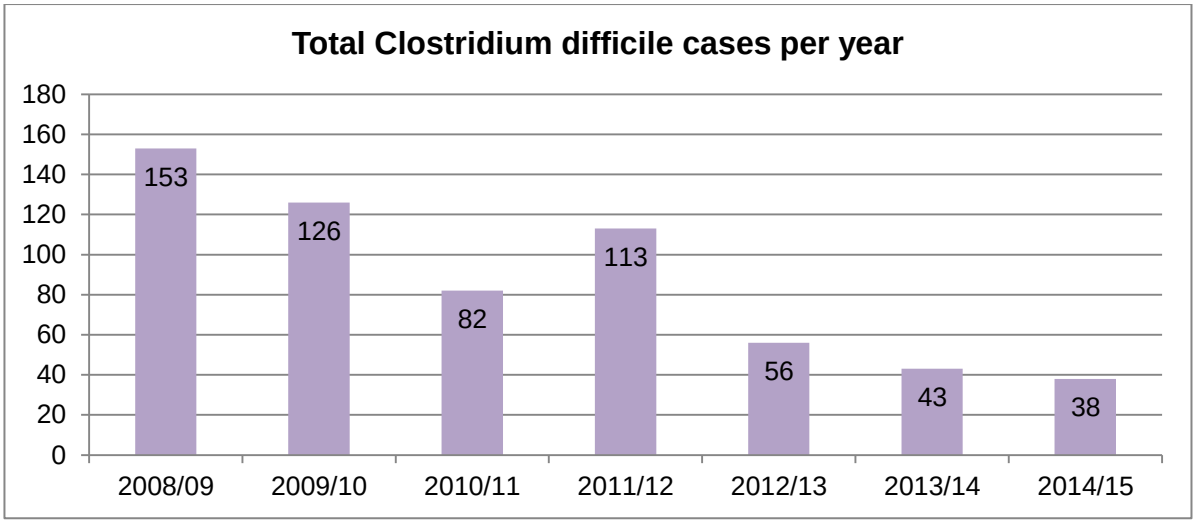
Current status: MRSA

NHS England has set a zero tolerance approach to MRSA bacteraemia. We have successfully reported zero MRSA bacteraemia for 2014/15.



Current status: Clostridium difficile

We have reported a total of 38 cases of C. diff for 2014/15. This rate is well below the threshold set of no more than 48 cases and shows a significant reduction on the previous year. We have achieved this through a continued focus on the clinical management of patients with identified or suspected infection.



New priority 3 for 2015/16

Infection control	
Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley Clinical Commissioning Group to agree on any avoidability/lapses in care.	
MRSA	**Clostridium difficile**
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 29 post 48 hour cases of Clostridium difficile.

Rationale for inclusion

- The Trust and the Council of Governors have indicated that the prevention and control of infections remains a Trust priority.
- NHS England has a zero tolerance of MRSA bacteraemia.
- The Trust has a challenging target set national of 29 C. diff cases for the coming year.

Developments planned for 2015/16

Actions planned to achieve the above aims include:

- Review the current documentation used to monitor intravenous cannulae
- Develop an information leaflet for patients who are identified as C. diff carriers
- Develop protocols for the implementation of faecal transplant for patients who have relapses of C. diff. The purpose of faecal transplant is to provide appropriate bowel flora in the gut after infection with C. diff
- Review and redesign the isolation cards displayed on the rooms of patients with an infection to indicate specific precautions are required
- Plan a focus day – C the Difference – to highlight the importance of all aspects of management for C. diff

Board sponsor: Denise McMahon, Director of Nursing
Operational lead: Dr. E Rees, Director of Infection Prevention and Control

I would like to thank all who attended to me from cleaners to consultant surgeons. The nursing staff on B2 were exceptional and the care I received was second to none.

Priorities 4 and 5 for 2014/15: Nutrition and Hydration

Nutrition
Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Throughout the year on average at least 90 per cent of patients will have their weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2015).

Hydration
Ensure that, on average throughout the year, 93 per cent of patients' fluid balance charts are fully completed and accumulated at lunchtime.

How we measure and record these priorities

Every month 10 observation charts are checked at random on every ward as part of the wider Nursing Care Indicators (NCI) monitoring (see Section 3.3.4). This process includes checking the Malnutrition Universal Screening Tool (MUST) assessment which is a rapid, simple procedure commenced on first contact with the patient and weekly thereafter so that clear guidelines for action can be implemented and appropriate nutritional advice provided.

MUST has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. The tool has been in use at the Trust for a number of years. The NCI monitoring also includes checking that recorded fluid input and output of patients is added up both at lunchtime and at the end of the day. The completion rates of each ward are fed back to matrons and lead nurses for action where necessary.

Each ward and the whole Trust is RAG (Red/Amber/Green) rated. Up until 2013/14 'Green' was given for a 90 per cent or greater score, 'Amber/Yellow' for 89-70 per cent scores and 'Red' for scores of 69 per cent or less. Due to the overall improvement in scores across the Trust, from 2013/14 onwards 'Green' is given for a 93 per cent or greater score, 'Amber/Yellow' for 92-75 per cent scores and 'Red' for scores of 74 per cent or less.

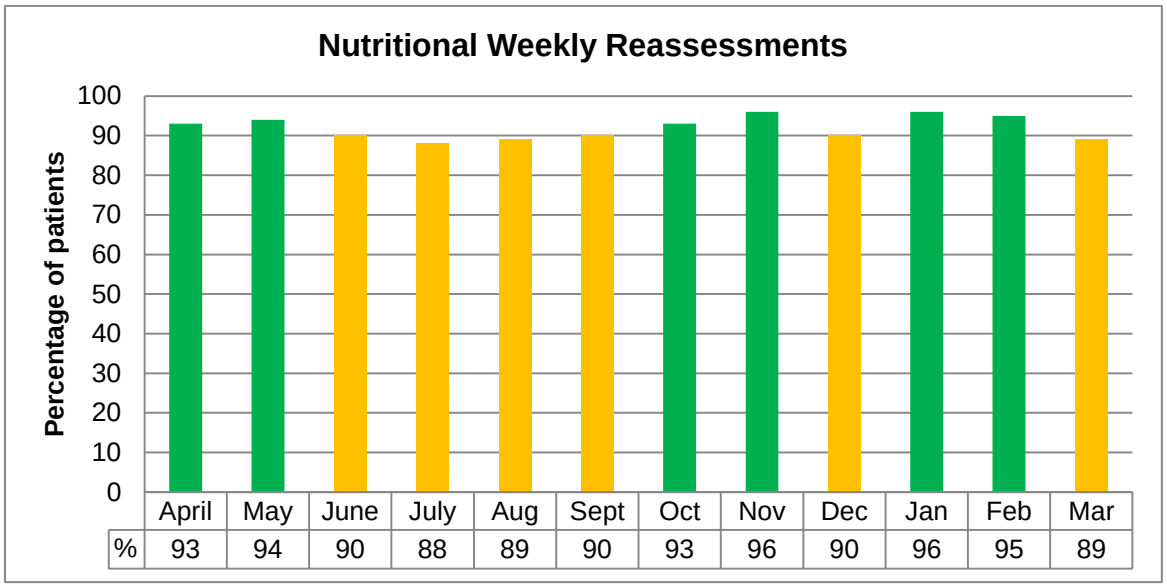
Developments that occurred in 2014/15

- An escalation process has been developed for tracking areas of concern from the mealtime audits
- An electronic based learning package has been identified and we are awaiting verification of compatibility with current Trust IT systems
- Freestanding notices at the entrance of each ward area to denote that Protected Mealtime is taking place have been introduced
- New national descriptors for speech and language therapy in relation to food consistency grading have been rolled out
- New *Chosen by Patients* menus, which have been tried and tested by patients and staff, have been trialled on three wards for future roll out across the Trust
- We participated in International Nutrition and Hydration Week when the importance of a good diet was publicised in a variety of ways across the Trust

Current status: Nutrition

The results of monitoring weekly reassessments indicate that for the whole year the 90 per cent average score was exceeded with 92 per cent being the average (compared to 89 per cent last year) and so the first target was met.

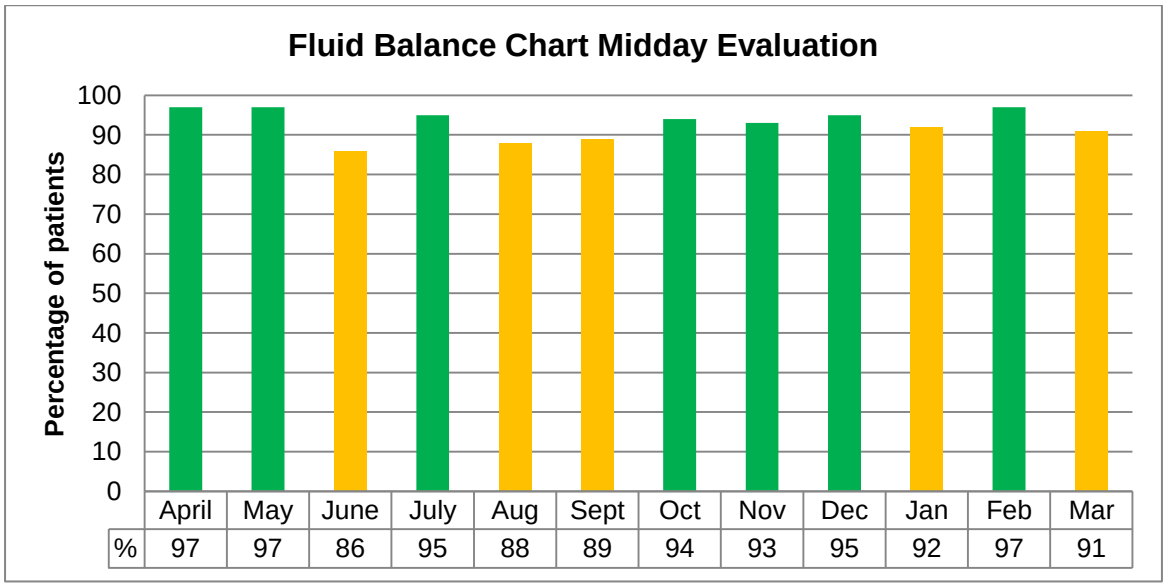
Although scores of 93 per cent or more were achieved in six months during the year, a dip in March meant that the target of 93 per cent or above by the year end was not met.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
%	93	94	90	88	89	90	93	96	90	96	95	89

Current status: Hydration

The results of monitoring fluid balance charts completion at midday show that, for the year as a whole, the 93 per cent target has just been met.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
%	97	97	86	95	88	89	94	93	95	92	97	91

New priority 4 for 2015/16

Nutrition and Hydration
Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items): a) is 90 per cent or above in each of the first three quarters for the Trust as a whole b) has a 'Green' rating (93 per cent or above) in the final quarter for every ward in the hospital

Rationale for inclusion

- To retain the emphasis on nutrition and hydration.
- Two of the specific targets for 2014/15 were met.
- The new target covers all of the 24 items of the nutrition and hydration audit, rather than focusing on just two or three specific issues, and so is more comprehensive.
- The new target also covers every ward separately as well as an overall Trust score. By publishing the results for each ward in the final quarter the situation on each ward will be clear.
- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The consequences of poor nutrition and hydration are well documented and include increased risk of infection, poor skin integrity and delayed wound healing, decreased muscle strength, depression and, sadly, premature death. Put simply, poor nutrition and hydration causes harm.

From October 2014, as part of the monitoring of care relating to nutrition and hydration, a more comprehensive audit tool was introduced. This follows the NCI model looking at what is recorded in the nursing notes but also asks patients for their experiences of being offered drinks and choice of food. It also includes observations of the environment, for instance, whether patients have drinks within reach and whether they are placed in an optimal position for eating.

In total, there are 24 elements to the audit and it is undertaken on ten patients on every ward each month. The results up to the end of December 2014 can be seen over the page. It can be seen that there is scope for improvement, particularly in terms of achieving the target we have set ourselves. During late 2014 there have been 13 occasions where wards have scored below the 93 per cent standard required for quarter 4.

I recovered on Ward C6, with very attentive nurses and doctors, well fed and hydrated! A big thanks to all involved in my stay from the consultant to the porters and cleaners

Table of overall results of the nutrition and hydration audits for each ward starting October 2014

Area	Oct 2014	Nov 2014	Dec 2014	Average score
A1 (Discharge Lounge, OPAT, Hot Clinic)	*	*	92	92
A2 (Short Stay Unit)	92	96	94	94
A3 (Frail and Elderly Short stay Unit and Elderly Care)	92	99	98	96
A4 (Acute Stroke)	98	99	98	98
B1 (Orthopaedics)	99	88	99	95
B2 (Hip and Trauma)	97	91	99	96
B3 (Vascular Surgery)	99	97	79	92
B4 (Mixed Colorectal and General Surgery)	99	96	97	97
B5 (Surgical Assessment Unit, Gynaecology Surgery/Admissions and General Surgery)	100	99	100	100
B6 (Ear Nose and Throat, Maxillofacial and Male Plastics	100	97	100	99
C1 (Renal and Endocrinology)	96	91	94	94
C3 (Elderly Care)	100	100	100	100
C4 (Georgina Unit/Oncology)	99	99	100	99
C5 (Respiratory)	99	95	93	96
C6 (Respiratory and GI overflow)	99	94	100	98
C7 (Gastrointestinal Medicine)	92	94	90	92
C8 (Elective Medical Unit, Rheumatology Outpatients, Stroke Rehabilitation and General Rehabilitation)	97	100	98	98
Medical High Dependency Unit	92	89	100	94
Coronary Care Unit	100	100	100	100
Critical Care Unit	+	94	99	97
Emergency Assessment Unit	99	97	96	97
Clinical Decision Unit	92	94	85	90

**Ward A1 was reconfigured in November and so the results from that month and October are not comparable.*
+The Critical Care Unit commenced auditing in November 2014

Developments planned for 2015/16

- New visual display boards will be introduced which comply with national descriptors in relation to food consistency grading to ensure patients get the right consistency of food and therefore correct nutritional input.
- Development of a Nutrition and Hydration Care Bundle, incorporating a flow chart for escalation when intake is poor.
- Monthly multi-agency meal time audits to ensure patients and staff views are heard and real time actions are taken if required.
- Development of Trust standards for nutrition and hydration for inpatients.
- Training for volunteers and non ward-based staff to support meal times.

Board Sponsor: Denise McMahon, Director of Nursing
Operational Leads: Kaye Sheppard, Head of Nursing-Medicine, Jenny Davies, Matron for GI and Renal Services, Rachel Tomkins, Matron for Elderly

Priority 6 for 2014/15: Mortality

Mortality
Ensure that 85 per cent of in-hospital deaths undergo specialist multidisciplinary review within 12 weeks by March 2015.

How we measure and record this priority

The Trust's Mortality Tracking System (MTS) was developed by our Information Team and launched in January 2012. Every patient death is recorded on the MTS and tracked through the following processes: coding, consultant validation, mortality audit and review. Monthly reports will be provided to the Mortality Review Panel and quarterly to the Clinical Quality Safety and Patient Experience Board Committee.

Rationale for inclusion

- Feedback from the Keogh Review in May 2013 indicated that the Trust should consider including mortality as a Quality Priority.
- The Keogh Review highlighted the importance of detailed and systematic case note review as the way forward in learning from hospital deaths and, therefore, the Trust needs to ensure that this is undertaken regularly in all specialities.

Developments that occurred in 2014/15

The Trust has remained within the expected range for the most widely used risk adjusted mortality indicators Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). It is, therefore, even more important the Trust develops its use of mortality ratios as an indicator to investigate specific areas and respond appropriately where care has not met our high standards. This year data from the Mortality Tracking System has been used to provide information for external assurance to Dudley Clinical Commissioning Group and the Care Quality Commission (CQC). Timely review of deaths is particularly important if the Trust receives mortality outlier alerts from external bodies. We have been able to demonstrate this year that we have current, peer reviewed, quantitative, as well as qualitative, data on all deaths in hospital.

The Mortality Tracking System used to capture and record this data, and on which the target is based was placed in the finals of the prestigious E- Health Insider Awards in October 2014.

I would like to thank the surgeon and his team and all the wonderful nurses on ward B1... Thanks to the staff for all their helpfulness and cheerfulness each time I have had to contact them.

Current status

The Trust achieved an average of 85.6 per cent of in-hospital deaths undergoing specialist multi-disciplinary review within 12 weeks for 2014/2015, meeting our target and greatly improving upon our position at the end of last year in which we only achieved 70.6 per cent. The details by speciality are below:

Meeting 85% target **50% or above but below 85% target** **Below 50%**

Trust Overall	Quality Report 2013/14	Year to Date
	70.6%	85.6%

	% audited within 12 weeks					% audited within 12 weeks			
	Q1	Q2	Q3	YTD*		Q1	Q2	Q3	YTD*
Cardiology	88.9	93.3	73.3	88.7	**Renal**	69.2	88.2	61.5	88.2
Gastroenterology	0	68.4	88.9	74.6	**Haematology**	0	80	62.5	43.3
General Medicine	80.6	79.5	78.8	83.4	**Oncology**	33.3	0	0	29.7
Medical Assessment	91.7	96.7	87	92.3	**Care of the Elderly**	98.6	93.7	97.9	97.8
Orthogeriatrics	100	N/A	97.9	100	**ENT**	50	N/A	.100	66.7
Rehabilitation	100	80	100	94.1	**General Surgery**	90.3	43.7	57.1	69.2
Respiratory	98.2	91.9	84.4	92.9	**Urology**	100	0	40	54.5
Stroke Medicine/Stroke Rehab	91.3	40	79.4	79.3	**Vascular Surgery**	58.3	81.8	81.8	82.7
Diabetes	100	100	100	100	**T&O Rehabilitation**	100	83.3	100	96.2
Endocrinology	100	100	50	88.2	**Trauma and Orthopaedics**	83.3	100	100	96
Neonate	50	100	50	77.8	**Gynaecology**	N/A	100	0	50
Plastic Surgery	N/A	100	N/A	100	**Rheumatology**	N/A	N/A	100	100

**Due to the 12 week target for completion of each audit, the full year position will not be available until 12 weeks after the end of the final quarter which will be 30/06/2015. The year to date calculation shows all audits of deaths in hospital completed within 12 weeks between 01/04/2014 and 31/03/2015 as available.*

New Priority 5 for 2015/16: Mortality

Mortality
Ensure that 90 per cent of in-hospital deaths available for review undergo specialist multidisciplinary review within 12 weeks by March 2016.

Rationale for inclusion

- We believe that all specialities are able to improve beyond the current target of 85 per cent if those audits delayed as a result of issues beyond our control, such as cases referred to the coroner, are taken into account.
- The Trust maintains that timely case note review of deaths provides us with the best source of information regarding patients who died in hospital and the quality of care they received.
- The Trust will be able to respond more effectively internally to make appropriate changes where care falls below the standards we expect and externally to give assurance if as many in hospital deaths as possible are reviewed within 12 weeks.

Developments planned for 2015/16

- Escalated exception reports by specialty to divisional management through to directors
- Development of the Mortality Tracking System with other Trusts
- Additional End of Life Care Audit to be completed where appropriate as part of mortality audits

Board sponsor: Paul Harrison, Medical Director
Operational lead: Teekai Beach, Directorate Manager to Medical Director

2.2 Statements of assurance from the Board of Directors

2.2.1 Review of services

During 2014/15, The Dudley Group NHS Foundation Trust provided and/or sub-contracted 59 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2014/15 represents 99.4 per cent of the total income generated from the provision of relevant health services by The Dudley Group NHS Foundation Trust for 2014/15.

The above reviews were undertaken in a number of ways. With regards to patient experience and safety, the Trust executive and non-executive directors continue to undertake Patient Safety Leadership Walkrounds (see section 3.3.2). Morbidity and mortality reviews are undertaken by the Chairman, Chief Executive and Medical Director. External input is provided by Dudley Clinical Commissioning Group (CCG). These occur on an 18-month rolling programme, covering all services. Each service presents information from a variety of sources including: internal audits, national audits, peer review visits, as well as activity and outcome data such as standardised mortality indicator figures.

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

- Nursing Care Indicators; monthly audits of key nursing interventions and their documentation. The results are published, monitored and reported to the Board of Directors every other month (see section 3.3.4).
- Ongoing patient surveys that give a ‘feel’ for our patients’ experiences in real time allow us to quickly identify any problems and correct them (see section 3.2.2).
- Every other month, senior medical staff attend the Board of Directors meeting to provide a report and presentation on performance and quality issues within their speciality areas.
- Every other month, a matron attends the Board of Directors meeting to provide a report and presentation on nursing and quality issues across the whole Trust.
- The Trust has an electronic dashboard of indicators for directors, senior managers and clinicians to monitor performance. The dashboard is essentially an online centre of vital information for staff.
- The Trust works with its local commissioners, scrutinising the Trust’s quality of care at joint monthly Clinical Quality Review Meetings.
- External assessments, which included the following key ones this year:
    - In February 2015, Dudley Clinical Commissioning Group undertook an unannounced visit to the Trust’s frail elderly services. The Trust has received a positive report and no actions are required.

- In February 2015, an expert review of the Trust's radiological services was led by the ex-vice president of the Royal College of Radiologists. The conclusion of the review was that the Trust has an excellent department.
- The Clinical Pathology Accreditation (CPA) (UK) Ltd, which was the longstanding body which approved laboratories, visited Haematology in October 2014 and Biochemistry in November 2014. Both maintained accredited status. Cellular Pathology and the Mortuary Services also had a very good inspection in March 2015 and maintained CPA accredited status. They will also be offered accreditation to ISO 15189:2012 Medical Laboratories – Requirements for Quality and Competence once some improvement actions are completed.
- The Human Tissue Authority (HTA) inspected the Trust Mortuary Services in June 2014 and there was a successful outcome.
- In January 2015, the Trust had a JACIE assessment (The Joint Accreditation Committee-ISCT [Europe] & EBMT) and was re-accredited for haematopoietic stem cell (HSC) transplantation. The re-accreditation panel highlighted a well-established quality management system.
- In June 2014, NHS Quality Control North West visited the Trust's aseptic pharmacy unit and concluded that the unit continues to operate to a very high standard, with a well maintained and well documented quality system. The overall risk rating for the unit remains 'Low'.
- The West Midlands Quality Review Service (WMQRS) visited the Trust on three occasions. In April 2014, the service reviewed our Frail Elderly Services from which no major issues of note were found and a number of improvements were implemented. In February 2015, a team reviewed Day Case Surgery and in the following month our services relating to Transfer of Care from Acute Hospital and Intermediate Care were reviewed. At the time of publishing we are still awaiting the final reports from these reviews.
- With regards to education and training, the West Midlands Deanery undertakes a variety of checks on the education of doctors at the Trust. This year the Emergency Medicine services were visited in both May and September 2014. Following some initial concerns in May, the latest visit resulted in a commendation for the improvements made.

Thank you to the doctor who showed me empathy and also the anaesthetist who took time out to discuss everything. Thank you for all information you gave in a professional manner.

2.2.2 Participation in national clinical audits and confidential enquiries

During 2014/15, 32 national clinical audits and four national confidential enquiries covered relevant health services that the Trust provides. During that period, the Trust participated in 100 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1

National clinical audits that the Trust was eligible to participate in, actually participated in during 2014/15 and the percentage of the number of registered cases submitted by the terms of the audit

Name of Audit	Type of Care	Participation	Submitted %
ICNARC Case Mix Programme Database	Acute Care	Yes	100%
Adult Community Acquired Pneumonia	Acute Care	Yes	100%
National Emergency Laparotomy Audit	Acute Care	Yes	100%
National Joint Registry	Acute Care	Yes	96%
Pleural Procedures Audit	Acute Care	Yes	100%
TARN Severe Trauma Audit	Acute Care	Yes	51.1%
National Comparative Audit of Blood Transfusion: 2014 Survey of Red Cell Use	Blood & Transplant	Yes	100%
National Comparative Audit of Blood Transfusion: 2014 Blood Use in Sickle Cell Anaemia	Blood & Transplant	Yes	100%
National Bowel Cancer Audit Project	Cancer	Yes	100%
Data for Head and Neck Oncology	Cancer	Yes	100%
National Lung Cancer Audit	Cancer	Yes	100%
National Oesophago-gastric Cancer Audit	Cancer	Yes	100%
National Prostate Cancer Audit	Cancer	Yes	100%
MINAP Acute Coronary Syndrome/Acute Myocardial Infarction Audit	Heart	Yes	100%

Name of Audit	Type of Care	Participation	Submitted %
Cardiac Rhythm Management	Heart	Yes	100%
National Cardiac Arrest Audit	Heart	Yes	100%
National Heart Failure Audit	Heart	Yes	76% to end Jan 2015
National Vascular Registry	Heart	Yes	96%
National Diabetes Foot Care Audit (NDFA)	Long-term Conditions	Yes	100%
National Pregnancy in Diabetes Audit	Long-term Conditions	Yes	100%
National Paediatric Diabetes Audit	Long-term Conditions	Yes	100%
Inflammatory Bowel Disease Audit	Long-term Conditions	Yes	100%
National Chronic Obstructive Pulmonary Disease Audit programme	Long-term Conditions	Yes	100%
Renal Replacement Therapy (Renal Registry)	Long-term Conditions	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Long-term Conditions	Yes	100%
Mental Health (care in emergency departments)	Mental Health	Yes	100%
Falls and Fragility Fractures Audit Programme	Older People	Yes	100%
Sentinel Stroke National Audit Programme	Older People	Yes	100%
Older people (care in emergency departments)	Older People	Yes	100%
Elective Surgery (National PROMs Programme)	Other	Yes	99%
Epilepsy 12 Audit (Childhood Epilepsy)	Women & Children's Health	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme	Women & Children's Health	Yes	100%
National Neonatal Audit Programme	Women & Children's Health	Yes	100%
Fitting Child (care in emergency departments)	Women & Children's Health	Yes	100%

Table 2

National confidential enquiries that the Trust was eligible to participate in and actually participated in during 2014/15 and the percentage of the number of registered cases required by the terms of the enquiry

Name of Audit	Type of Care	Participation	Submitted %
Tracheostomy Care	NCEPOD	Yes	100%
Lower Limb Amputations	NCEPOD	Yes	100%
Gastrointestinal Haemorrhage	NCEPOD	Yes	100%
Sepsis	NCEPOD	Yes	Still in progress

NCEPOD: National Confidential Enquiry into Patient Outcome and Death

As well as the national clinical audits in Table 1, from the officially recognised Healthcare Quality Partnership (HQIP) list, the Trust has also taken part in these further national audits:

Table 3

Additional National Clinical Audits that the Trust participated in during 2014/15

Name of Audit	Type of Care	Participation	Submitted %
National Postpartum Haemorrhage Audit	Obstetrics	Yes	100%
First Sprint National Anaesthesia Project (SNAP-1)	Anaesthesia	Yes	100%
BAUS National Nephrectomy Audit Database	Urology	Yes	100%

In the Day Case Unit I was put at ease by the nurses. A further visit from the anaesthetist and the surgeon laid any further worries to rest. Following my surgery the aftercare throughout the rest of the day was excellent and reassuring.

The reports of the following 18 national clinical audits were reviewed in 2014/15:

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
College of Emergency Medicine (CEM) Asthma in Children Audit
CEM Paracetamol Overdose Audit
CEM Severe Sepsis Audit
National Anaesthesia Sprint Audit Project (ASAP)
National Audit of Dementia
National Audit of Seizure management in Hospitals (NASH2)
National Bowel Cancer Audit
National Care of the Dying Audit for Hospitals (NCDAH)
National Chronic Obstructive Pulmonary Disease Audit Programme
National Diabetes Inpatient Audit (NaDIA)
National Emergency Laparotomy Audit (NELA)
National Joint Registry
National Lung Cancer Audit
National Oesophago-Gastric Cancer Audit
NCEPOD Lower Limb Amputation: working together
Sentinel Stroke National Audit Programme (SSNAP)
Trauma Audit Research Network (TARN)

From the above reviews, the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

CEM Severe Sepsis Audit
Audit outcome and recommendations identified for improved management of patients discussed and disseminated to all Emergency Department (ED) staff through the ED Governance Newsletter.

National Care of the Dying Audit for Hospitals (NCDAH)
Planned introduction of a Trust-wide local audit of care of the dying to be included on the annual mandatory audit programme. VOICES bereavement survey has been introduced with results reported to the Patient Experience Group. The End of Life (EOL) workstream is currently reviewing End of Life Care Guidelines working with community, primary care and hospice teams. The Trust's Chaplaincy Service is currently writing a strategy to identify adequate resource for the spiritual needs of the dying patient.

National Audit of Seizure Management (NASH2)
Subsequent recommendations for a sustained improvement include: the development of local guidelines, education of doctors in the assessment and management of epilepsy and introduction of regular departmental audits against NICE guidelines and NASH2 recommendations.

National Anaesthesia Sprint Audit Project (ASAP)
Pathway to be developed in conjunction with the trauma and orthopaedic speciality for provision of pre-operative femoral nerve blockade to all fracture neck of femur patients.

Local clinical audit

The reports of 30 completed local clinical audits were reviewed in 2014/15 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Microbiology
Review and further elaborate the section explaining notification in the meningitis element of the Trust's antimicrobial guidelines. The same is to be included in the meningitis section of the antimicrobial mobile phone app.

Acute Medicine
A senior review of patients in the afternoon with the junior doctor and/or nurse in charge is now routine practice, with a designated specialist registrar on the rota for the afternoon ward round. The Trust is holding a series of training sessions to raise awareness of encephalitis and its management and posters are now displayed in the relevant clinical areas. We will be re-auditing our performance in the future.

With regards to the Sepsis Six, re-audit has shown improved compliance to achieving this within one hour compared to the previous 2010 audit. We will continue education on the Sepsis Six pathway by including it in induction for all new junior doctors rotating to the Trust and encourage the use of the proforma. We will also set up a Trust-wide coordinating group to improve the identification and treatment of sepsis.

Gastrointestinal Medicine
A flow chart showing appropriate management and education on sigmoid volvulus will be rolled out to junior doctors in surgical teaching sessions.

A simple flowchart will be introduced, and available on the The Hub, the Trust's staff intranet, to highlight the indication of a proton-pump inhibitor (PPI) and the appropriate duration of treatment.

The department will introduce rectal administration of Nonsteroidal Anti-inflammatory Drug (NSAID) for all patients undergoing Endoscopic Retrograde Cholangiopancreatography (ERCP).

Stroke Medicine
It was recommended that all patients presenting with atrial fibrillation (AF) should be assessed for stroke risk using CHADS2/CHADVASC score and should be considered for anticoagulation if the bleeding risk is low using the HAS-BLED score, taking into account patients' preferences.

There is now a pathway to identify patients with acute ischaemic stroke undergoing intravenous thrombolysis at Russells Hall Hospital that may potentially benefit from thrombectomy which is performed at the Queen Elizabeth Hospital.

Rheumatology
A database has been created of patients receiving denosumab in hospital on which a serum calcium is recorded both before and after the injection. A patient information

leaflet is now given at the time of injection on which the importance of monitoring serum calcium is highlighted. New Trust guidelines for Acute Hot Joint are currently awaiting ratification.

Anaesthetics
The Trust is now using the West Midlands palliative care document as our guidance on opioid conversion. A Standard Operating Procedure for anaesthetic pre-op clinic/CPET (Cardio Pulmonary Exercise Testing) clinic has been introduces and letters now go to all patients' GPs when anaemia is identified.

Dietetics
A new dysphagia menu has been devised and introduced to the Trust, giving patients a better variety of meals and texture to suit their needs.

District Nursing
For patients requiring IV therapy in the community, 8cm midlines will now be used for IV antibiotics of more than five days.

Intensive Care Medicine
A maximum dose has been added to the electronic prescription for propofol. This ensures that doses greater than 4mg/kg/hr cannot be prescribed and, therefore, given. An advisory has also been developed to prompt clinicians to look for features of propofol infusion syndrome and to consider alternative strategies for sedation.

Paediatrics/Neonates Audit
A simpler flow chart for therapeutic hypothermia has been introduced on the Neonatal Unit. We are ensuring strict adherence to the new therapeutic cooling and referral pathway to help better identify suitable patients for therapeutic hypothermia.

A new Paediatric Assessment Unit proforma with sections to record the date and time is now within the medical notes. Staff have also been reminded of the importance of documenting the time the patient is seen. A re-audit over a longer period of time will take place in the next audit year and will include a wider range of staff.

All staff very friendly and helpful. The procedure was carried out by my consultant who explained the procedure and put me at ease. Her and her staff were very reassuring and helped me relax.

Obstetrics and Gynaecology
Abdominal sacrocolpopexy patients are now pre-assessed to review appropriateness for laparoscopic surgery.

A programme for updated training sessions on infant feeding is now in place. The Specialist Midwife will now be contacted via bleep when required to attend the Children's Ward and a process is also now in place for staff on the Children's Ward to contact a Maternity Infant Feeding Assistant (MIFA) to provide support when required.

Midwifery staffing figures are submitted monthly and shortfalls are now monitored at the monthly manager meetings. A monthly report is presented at the manager meeting to outline the number of incidents in relation to staffing shortfalls and escalation within the Maternity Unit.

Lead midwives now complete a DATIX incident report if a community midwife is unable to support a home birth. Work will be done to further recruit and establish competence for four whole time equivalent support workers.

Ophthalmology
All new prescribers to the department now have a training meeting with a non-medical prescriber regarding prescription form completion and an annual presentation of findings at the doctors' audit meeting will take place.

Pharmacy
Access to all antimicrobial guidelines has been significantly improved with the introduction of the new mobile phone app. Both sets of guidelines are now constantly being updated, with memos sent out to highlight any significant changes.

Handy hints card have also been made for healthcare professionals, these include the sepsis criteria, signs of organ dysfunction, the Sepsis Six and the antibiotic guidelines for treating sepsis.

Podiatric Surgery
Bleeding risk and contraindications to compression stockings and dalteparin have all been incorporated into one deep vein thrombosis (DVT) assessment tool. This includes the blood test requirements as a tick list and the discussion of stopping hormone replacement therapy or the combined oral contraceptive pill as part of the DVT assessment process.

Trauma & Orthopaedics
A new proforma will now be used by the on-call post-take team and put in the notes or inpatient referral.

A proforma will be developed for patients needing an MRI scan for suspected Cauda Equina Syndrome.

2.2.3 Research and development

The number of patients receiving health services provided or sub-contracted by the Trust in 2014/15, that were recruited during that period to participate in research approved by a research ethics committee, was 1913.

Our performance data is reported nationally and a copy can be found on the Trust's website under Research and Development: www.dudleygroup.nhs.uk/research

In last year's Quality Report we predicted that dermatology and endocrinology would grow in importance in terms of research. In autumn 2014, the dermatology research team won a national prize for the success of their commercial work, recruiting to time and target and delivering high quality research data. Dermatology's commercial research income now provides sufficient funding for the Trust to have recruited a senior dermatology research nurse in May 2014. During the same period, more diabetes studies have started, with an equivalent increase in research nurse time.

This year's success story is the opening of several academic studies in the Stroke, Anaesthetics and Critical Care Departments. This has been made possible by successfully bidding for Clinical Research Network: West Midlands funding for additional research nurse time. The Trust is also participating in an important regional vascular surgery trial. Musculoskeletal clinical disciplines and cardiology continue to recruit well to commercial trials. The reorganisation of cancer services and increasing number of very selective, targeted treatment has reduced participation in oncology studies; commercial cancer studies are still undertaken.

The Trust continues to host several research fellows and PhD students from local universities. Two researchers based in rheumatology are currently writing up their doctoral theses.

Trust publications for the calendar year 2014, including conference posters, stand at 202, an increase of approximately 100 per cent on 2013, possibly due to improved methods of collecting and recording these publications.

In the field of haematology, the interim results of a recently closed multicentre Hodgkin's disease study have shown that the introduction of centrally funded PET (Positron Emission Tomography) scans for younger patients is an effective prognostic tool. Scan results indicate to clinicians when to escalate treatment, after which 75 per cent of the patients have improved, progression free survival.

Dudley dermatology patients' participation in clinical trials has helped to secure the UK marketing authorisation and NICE approval for the use of existing drugs to treat psoriasis.

2.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

What are CQUINs and what do they mean for the Trust?

The CQUIN payment framework was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. Whether the Trust receives its CQUIN payments is dependent on achieving certain quality measures.

This means that some of the Trust's income is conditional on achieving certain targets that are agreed between the Trust and our commissioners (Dudley Clinical Commissioning Group and NHS England).

A proportion of the Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body it entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2014/15 and for the following 12 month period are available online at:

http://www.england.nhs.uk/nhs-standard-contract/

CQUIN is a quality increment that applies over and above the standard contract. The sum is variable based on 2.5 per cent of our activity outturn and conditional on achieving quality improvement and innovation goals.

The value of CQUIN in 2014/15 is £6.14m forming part of our contracts with clinical commissioning groups and specialised services commissioners. Each CQUIN scheme consists of one or more goals for achievement by agreed milestones. A total of 11 CQUIN schemes were agreed for 2014/15 with a combination of locally agreed goals and two schemes, Dementia and Friends and Family Test, which are nationally determined.

At the end of the financial year we have achieved, or it is forecasted that we will achieve, the majority of the indicators. Validation of data for pressure ulcer prevalence for Quarter 4 is still in progress but the indication given is that the target has been achieved. Similarly, Patient Safety Culture is anticipated to be achieved but the final quarter report still requires sign off by the commissioners.

Mitigating actions have been put in place to ensure the quality of care is improved in those areas where goals are partially achieved.

The 'Letters returned to the referring clinician' CQUIN scheme was reviewed in February 2015 as it was identified as unachievable for reasons outside the control of both the Trust and Dudley CCG. A decision was reached to allocate the financial value associated with the this CQUIN proportionally across all remaining schemes.

The final settlement figure for 2014/15 has not yet been agreed as some targets, as indicated above, are contingent upon outstanding information and actions. However, for the purpose of the year-end accounts, we are assuming this will equate to an estimated 85 per cent, which is approximately £5.22m, based on secured and

expected income. In the previous financial year 2013/14, the final settlement figure based on achievement of CQUIN schemes was £5.1m.

The CQUINs for 2014/15 have been rated on a RAG (red/amber/green) basis dependent on achievement to date as detailed in the tables below:

CQUINs 2014/15

Acute and community 2014/15

Goal No.	CQUIN targets and topics	Quality domains and RAG rating
1	Friends and Family Test (6 parts)	Patient experience
2	Dementia and Delirium (3 parts)	Patient experience Safety/Effectiveness
3	NHS Safety Thermometer – Pressure Ulcers (Acute and Community)	Safety/Effectiveness Patient experience
4	Culture of Learning	Safety/Effectiveness Patient experience
5	Safeguarding	Safety
6	Patient Experience for Learning Disability Patients	Patient experience
7	Letters returning to the referring clinician*	Effectiveness
8	Patient Safety Culture	Safety/Effectiveness

**See explanation in text above*

Specialised services 2014/15

Goal No.	CQUIN targets and topics	Quality domains and RAG rating
1	Friends and Family Test (6 parts)	Patient Experience
2	Dementia and Delirium (3 parts)	Patient Experience Safety/Effectiveness
3	Quality Dashboards	Safety/Effectiveness
4	Renal Dialysis – Shared Haemodialysis Care	Patient Experience Effectiveness
5	Neonatal Intensive Care – Total Parenteral Nutrition	Safety/Effectiveness

Key Achieved = Partially Achieved =

Throughout my trips to visit the Ophthalmology Department I was always treated with the utmost care and dignity by all of the nurses and staff, who always had a smile and a kind word for you no matter how busy they were.

CQUINs 2015/16

In 2015/16, the amount the Trust is able to earn is 2.5 per cent on top of the actual outturn value. The estimated value of this is approximately £6.3m.

Acute and community 2015/16

Goal No.	CQUIN targets and topics	Quality domains
1	Physical Health: Acute Kidney Injury	Safety Effectiveness
2	Physical Health: Sepsis	Safety Effectiveness
3	Mental Health: Dementia	Patient Experience Effectiveness
4	Urgent and Emergency Care - Improving recording of diagnosis in A&E	Safety Effectiveness
5	Wellbeing of frequent service users	Effectiveness
6	Cancer Survivorship	Patient Experience Effectiveness
7	Discharge summary letters	Effectiveness
8	Advanced Nurse Practitioner development	Safety Effectiveness

Specialised services 2015/16

Goal No.	CQUIN targets and topics	Quality domains
1	HIV: Reducing unnecessary CD4 monitoring	Safety Effectiveness
2	Renal: EGFR monitoring system	Effectiveness
3	Right Care Right Place: improved outpatient new to follow-up rates	Effectiveness

2.2.5 Care Quality Commission (CQC) registration and reviews

The Dudley Group NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2014/15. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period. On the 26th and 27th March 2014 a team from the CQC inspected the Trust and also returned on a number of unannounced visits in the following two weeks. Both a summary and full report of that inspection has been published and is available from www.cqc.org.uk/provider/RNA

The Trust was rated 'Good' in 30 out of the 38 core services inspected. The majority of the group categories (five out of eight) received an overall rating of 'Good'. Despite this, the overall rating for the Trust was 'Requires Improvement' (see below):

Our ratings for Russells Hall Hospital (including Corbett and Dudley Guest)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity & family planning	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Children & young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Dudley Group NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident & Emergency and Outpatients.
2. The rating for overall trust for the well-led key question is different for the rating for well-led for the location. This reflects the inspection team's view of strong leadership from the executive team, trust board and the chief executive.

Chief Inspector of Hospitals, Professor Sir Mike Richards, believes we are not far off achieving an overall ‘Good’ rating and has confidence that we are addressing the issues highlighted by the inspection.

He noted the following key findings:

- The Trust’s staff are seen as highly caring by many of the patients spoken to and staff were praised for ‘going the extra mile’.
- The Trust’s leadership team is seen as highly effective by staff; and is recognised to be clearly in touch with the experience of patients and the work of the staff.
- Staff value The Dudley Group as a place to work and a team spirit is clearly evident.
- The Trust has responded well to the Keogh Review in 2013.
- There are a number of areas of good practice in the Trust, which should be encouraged. Staff feel able to develop their own ideas and have confidence that the Trust will support them.
- The Emergency Department (A&E) is busy and overstretched. There remains challenges in the flow of patients, but much of this relates to flow across the rest of the hospital. Only a small proportion relates to the Emergency Department itself.
- The Trust does not always follow its own policy in relation to DNACPR (do not attempt resuscitation) notices.
- The ophthalmology clinics require review to ensure that all patients are followed up as required and that there is capacity for these clinics.
- The Trust must review its capacity in phlebotomy clinics as this is seen as insufficient.

The Trust has already taken action to improve many areas of concern, including:

- Phlebotomy (blood testing) provision has been expanded to offer more choice about where and when patients can have a blood test. Patients can now have a blood test at one of our hospital or outpatient sites Monday to Friday, 8am until 7.30pm, as well 8am until 10am on Saturday morning.
- Awareness raising across all staff regarding the correct process for DNACPR. A recent audit of documentation shows that the recording of such decisions has improved.

2.2.6 Quality of data

The Trust submitted records during 2014/15 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number

	The Dudley Group	National average
Admitted patient care	99.8%	99.1%
Outpatient care	99.8%	99.3%
Accident and Emergency care	99.0%	95.1%

The percentage of records in the published data which included the patient's valid General Practitioner Registration Code

	The Dudley Group	National average
Admitted patient care	100%	99.9%
Outpatient care	100%	99.9%
Accident and Emergency care	100%	99.2%

All above Trust figures are for April 2014 to Feb 2015 with national figures to Dec 2014

The Trust's Information Governance Assessment Report overall score for 2014/15 was 78 per cent and was graded 'Green'.

The Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

During 2014/15, the Trust has been required to report one data protection incident to the Information Commissioner's Office, when a letter sent out to a patient had further letters attached to it in error.

The Trust will be taking the following actions to improve data quality:

To continually emphasise the importance of information governance, the Trust's mandatory eLearning training programme on the topic has been further supported by face-to-face training sessions which are more accessible to a wider Trust audience.

To reinforce the training the Trust's Caldicott Guardian who leads on confidentiality and safeguarding is championing an Information Governance Lesson of the Week bulletin on the Trust's intranet – the Hub – which will inform staff of best practice and lessons learnt.

2.2.7 Core set of mandatory indicators

All trusts are required to include comparative information and data on a core set of nationally-used indicators. The tables include the two most recent sets of nationally-published comparative data as well as, where available, more up-to-date Trust figures. It should be appreciated that some of the 'Highest' and 'Lowest' performing trusts may not be directly comparable to an acute general hospital, for example, specialist eye or orthopaedic hospitals have very specific patient groups and so generally do not include emergency patients or those with multiple long-term conditions.

Mortality			
Topic and detailed indicators	**Immediate reporting period: Jul 2013 – June 2014**	**Previous reporting period: Apr 2013 – March 2014**	**Statements**
Summary Hospital-level Mortality Indicator (SHMI) value and banding	**Value** Trust 1.04 National average 1 Highest 1.20 Lowest 0.54 **Banding** Trust 2 National average 2 Highest 1 Lowest 3	**Value** Trust 1.07 National average 1 Highest 1.20 Lowest 0.54 **Banding** Trust 2 National average 2 Highest 1 Lowest 3	The Trust considers that this data is as described for the following reasons: • The Trust is pleased to note that the Trust's SHMI values are within the expected range The Trust has taken the following action to improve this indicator and so the quality of its services by: • Continuing to improve reviews of all mortality (see new Quality Priority). There is evidence that the Trust's SHMI is reducing
Percentage of patient deaths with palliative care coded at either diagnosis or specialty level (Context indicator)	Trust 27.1% National average 24.95% Highest 49% Lowest 7.4%	Trust 26.2% National Average 23.94% Highest 48.5% Lowest 6.4%	The Trust considers that this data is as described for the following reasons: • There is a very robust system in place to check accuracy of palliative care coding The Trust has taken the following actions to improve this percentage, and so the quality of its services by: • Ensuring this percentage will always be accurate and reflect actual palliative care.

Patient Reported Outcome Measures (PROMS)					
Topic and detailed indicators	**Immediate reporting period: 2013/14 Provisional**		**Previous reporting period: 2012/13 Final**		**Statements**
Groin Hernia Surgery	Trust	0.04	Trust	0.07	The Trust considers that this data is as described for the following reasons: • using feedback data (from HSCIC) we are very pleased with the outcomes that patient report. Patients who said that their problems are better now when compared to before their operation: • Groin hernia: 95% *(national = 94%),* • Hip replacement: 98% *(national = 95%),* • Knee replacement: 88% *(national = 89%),* • Varicose veins: 93% *(national = 89%)* The Trust has taken the following actions to improve these scores, and so the quality of its services by: • ensuring the Trust regularly monitors and audits the pre and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures.
	National average	0.09	National average	0.09	
	Highest	0.14	Highest	0.15	
	Lowest	0.01	Lowest	0.01	
Varicose Vein Surgery	Trust	0.03	Trust	0.05	
	National average	0.09	National average	0.09	
	Highest	0.15	Highest	0.18	
	Lowest	0.02	Lowest	0.01	
Hip Replacement Surgery	Trust	0.41	Trust	0.44	
	National average	0.44	National average	0.44	
	Highest	0.55	Highest	0.54	
	Lowest	0.34	Lowest	0.32	
Knee Replacement Surgery	Trust	0.31	Trust	0.32	
	National average	0.32	National average	0.32	
	Highest	0.42	Highest	0.42	
	Lowest	0.22	Lowest	0.21	

In the above table the higher the score, the higher the average patient health gain

Readmissions					
Topic and detailed indicators	**Immediate reporting period: 2011/12**		**Previous reporting period: 2010/11**		**Statements**
% readmitted within 28 days **Aged 0-15**	Trust	9.09	Trust	9.34	The Trust considers that this data is as described for the following reasons: • since the national published figures (see across) are historical, we have looked at our latest locally available (pre-published) data. This indicates recent improvements (Aged 16 and over: 2012/13 10.2%, 2013/14 9.9%) (Age 0-15: 2012/13 10.3%, 2013/14 9.7%) The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: • undertaking a review of the model of care that supports seven day services • further improving discharge processes • investing into community teams to support the concept of care closer to home • supporting the development of a discharge to assess model with community partners
	National average	10.15	National average	10.15	
	Highest	NA*	Highest	NA*	
	Lowest	NA*	Lowest	NA*	
% readmitted within 28 days **Aged 16 and over**	Trust	11.62	Trust	11.55	
	National average	11.45	National average	11.42	
	Highest	NA*	Highest	NA*	
	Lowest	NA*	Lowest	NA*	

**comparative figures not available*

Responsiveness to inpatients' personal needs					
Topic and detailed indicators	**Immediate reporting period: 2013/14**		**Previous reporting period: 2012/13**		**Statements**
Average score from a selection of questions from the National Inpatient Survey measuring patient experience **(Score out of 100)**	Trust	66.5	Trust	64.9	The Trust considers that this data is as described for the following reasons: • the Trust notes that it is only slightly lower than the national average and is making year on year improvements, The Trust intends to take the following actions to improve this score, and so the quality of its services by: • ensuring the Trust continues to ask these questions as part of the real-time surveys, and ensure actions are taken through the 'You said we did' plans and monitor performance and seek assurance on progress through the Patient Experience Group
	National average	68.7	National average	68.1	
	Highest	84.2	Highest	84.2	
	Lowest	54.4	Lowest	57.4	

Staff views					
Topic and detailed indicators	**Immediate reporting period: 2014**		**Previous reporting period: 2013**		**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care	Trust	72%	Trust	66%	The Trust considers that this data is as described for the following reasons: • the Trust is pleased to see an increase in the percentage of staff who would recommend the Trust as a place to receive treatment. The Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services by: • multidisciplinary groups focusing on action planning for improvements. • communicating with and supporting managers to understand their data broken down by division and area and take actions where necessary. • involving and communicating with staff though adopting the Listening in Action programme. This has covered a wide range of topics and new areas are being agreed for 2015/16.
	National average	67%	National average	64%	
	Highest	89%	Highest	89%	
	Lowest	38%	Lowest	40%	

Venous Thromboembolism (VTE)					
Topic and detailed indicators	**Immediate reporting period: Q3 Oct – Dec 2014**		**Previous reporting period: Q2 Jul - Sep 2014**		**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism	Trust	95%	Trust	95.2%	The Trust considers that this data is as described for the following reasons: • the Trust is pleased to note that it is similar to the national average in undertaking these risk assessments. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: • continuing the educational sessions with each junior doctor intake • continuing with a variety of promotional activities to staff and patients
	National average	96%	National average	96%	
	Highest	100%	Highest	100%	
	Lowest	81%	Lowest	86.4%	

Infection control					
Topic and detailed indicators	**Immediate reporting period: 2013/14**		**Previous reporting period: 2012/13**		**Statements**
Rate of Clostridium difficile per 100,000 bed days amongst patients aged 2 or over	Trust	19.3	Trust	23.9	The Trust considers that this data is as described for the following reasons: • the Trust acknowledges it needs to improve its rate and has done so in 2014/12 having had 38 cases, compared to 43 the previous year (see page 19), making the most recent (pre-published) rate 17.3 The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services by: • the process for reviewing individual C. diff cases is continuing and has developed further to enable particular themes to be identified • The antimicrobial guidelines are functioning well on the smart phone app and this has enabled guidelines to be updated easily. Recently the CCG has undertaken to adopt this method of publication for their primary care prescribing guidelines • Treatment protocols for c. diff continue to be updated to ensure they reflect current evidence-based practice.
	National average	14.7	National average	17.3	
	Highest	37.1	Highest	30.6	
	Lowest	0	Lowest	0	

Clinical incidents					
Topic and detailed indicators	**Immediate reporting period: Apr 2014 – Sept 2014**		**Previous reporting period: Oct 2013 – Mar 2014**		**Statements**
Rate of patient safety incidents **(incidents reported per 1000 bed days)** **(Comparison is with 140 acute Trusts)**	Trust	41.93 (number 5022)	Trust	44.6 (number 5495)	The Trust considers that this data is as described for the following reasons: • as organisations that report more incidents usually have a better and more effective safety culture, the Trust is pleased to note it has higher than average reporting rates and its severe incidents are less than the national average. The Trust has taken the following actions to improve this rate and the numbers and percentages, and so the quality of its services by: • continual raising of awareness of what constitutes as an incident and how to report and continual improvement of quality investigations and learning using improved report templates.
	Average	35.9	Average	33.3	
	Highest	74.96	Highest	74.9	
	Lowest	0.24	Lowest	5.8	
Percentage of patient safety incidents resulting in severe harm or death	Trust	0% (number 0)	Trust	<0.1% (number 3)	
	National average	0.5%	National average	0.7%	

Part 3: Other quality information

3.1 Introduction

The Trust has a number Key Performance Indicator (KPI) reports which are available and used by a variety of staff groups to monitor quality on a day-to-day basis. The main repository for the reporting of the Trust's key performance measures is a web based dashboard, which is available to all senior managers and clinicians and currently contains over 130 measures, grouped under the headings of Quality, Performance, Workforce and Finance.

In addition, constant monitoring of a variety of aspects of quality of care include weekly reports sent to senior managers and clinicians which include the Emergency Department, Referral to Treatment and stroke and cancer targets. Monthly reports which include a breakdown of performance by ward based on Nursing Care Indicators, ward utilisation, adverse incidents, governance and workforce indicators, and patient experience scores are also sent to all wards. In becoming more transparent, each ward now displays its quality comparative data on a large information board (Patient Safety Huddle Boards) for staff, patients and their visitors.

To compare ourselves against other trusts, we use Healthcare Evaluation Data (HED) – a leading UK provider of comparative healthcare information – as a business intelligence monitoring tool.

The following three sections of this report provide an overview, with both statistics and examples, of the quality of care at the Trust, using the three elements of quality as outlined in the initial Chief Executive's statement:

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

Patient Safety
Are patients safe in our hands?

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

The fourth section includes general quality measures which have remained the same for 2014/15 as the Board of Directors and our stakeholders believe these take into consideration both national and local targets which will be important to patients and give a further perspective of the Trust's quality of care.

A1 ward is exceptional on all levels... All of the staff and I mean every single one of them are brilliant! Caring, kind, considerate I could go on and on. No one wants to be in hospital but this ward and team make it so much better. Thank you so much all of you.

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

3.2.1 Introduction

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

3.2.2 Trust-wide initiatives

We gather feedback in a number of ways, including:

- The Friends and Family Test (FFT)
- Real-time surveys (face-to-face surveys)
- NHS Choices/Patient Opinion (online)
- National surveys
- Comment cards
- Complaints, concerns and compliments
- Patient Safety Leadership Walkrounds
- Targeted surveys on specific topics such as food and bereavement

Below are some examples of the quantity of feedback we received during the year (2014/15) and more detailed information about some of the methods. These methods alone highlight more than 21,000 opportunities for us to listen to our patients' views.

Method	Total
FFT – Inpatient	**7,179**
FFT – Emergency Department	**10,096**
FFT – Maternity	**3,500**
FFT – Community	**594***
FFT – Day Case	**1,277***
FFT – Outpatients	**1,672***
Mystery patient programme	**87**

Method	Total
Real-time surveys – inpatient	**1,479**
NHS Choices/Patient Opinion	**278**
Community Services surveys	**1,103**
Surveys of carers of people with dementia	**141**
Discharge surveys	**212**
Bereavement Surveys	**154**
National surveys	**748**

**To qualify for CQUIN payment (see page 39) we chose to implement the FFT in outpatients, community and day case early. The total responses for these areas will therefore differ from those reported to NHS England.*

a) Real-time surveys

During 2014/15, 1,479 patients participated in our real-time surveys. Real-time surveys work well alongside the Friends and Family Test and the results of these surveys are reported in a combined report to wards and specialties, allowing them to use important feedback from patients in a timely manner. The data from these surveys also allows us to react quickly to any issues and to use patient views in our service improvement planning.

b) Patient stories

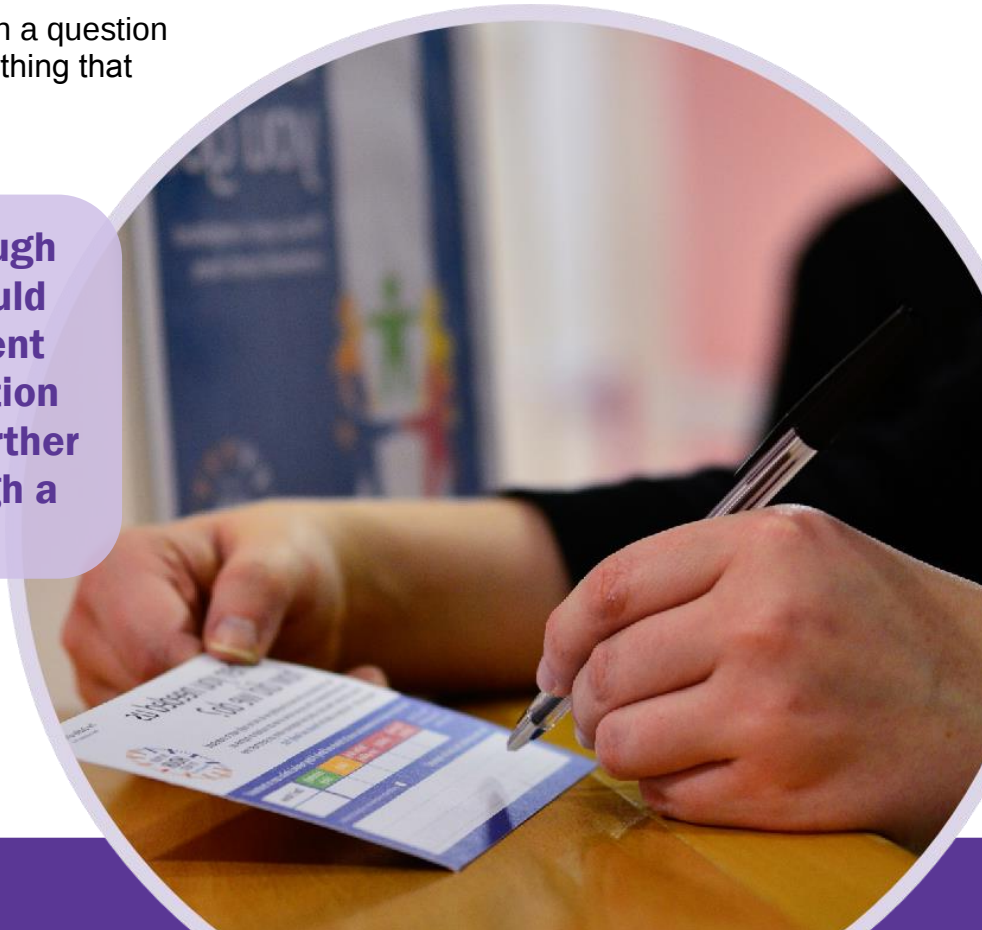
The continued use of patient stories at Board of Directors meetings during 2014/15 enables the patient voice to be heard at the highest level. Stories have been heard at Board of Directors meetings and used for service development planning and training purposes.

c) Friends and Family Test (FFT)

All inpatient and Emergency Department providers in the UK were required to participate in the Friends and Family Test from 1st April 2013 (the Trust introduced inpatient FFT in April 2012) with maternity services starting in October 2013, and further roll out into community, day case and outpatient areas during 2014/15. Results are published on NHS Choices as: normal, better or worse than others. Friends and Family Test scores are also displayed in our wards/departments and updated monthly for patients to see on 'huddle boards'.

- The test asks patients to answer a simple question "How likely are you to recommend (the particular service or department) to friends and family if they needed similar care or treatment?" with answers ranging from extremely likely to extremely unlikely.
- This is followed up with a question asking "Was there anything that could be improved?"

Thank you for caring enough to think about what I would need after my appointment with you, finding information that I could use to seek further support, to get me through a very difficult time.



This table shows our FFT scores for 2014/15 which indicates, for the majority of months, the Trust was above the national average and a high scorer in the Black Country region. For inpatients and maternity postnatal (community) we are proud to be above the national average for the whole year:

Inpatients	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Jan-15	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	74	74	70	73	76	95	96	96	94	94	95	96
Dudley Group	82	86	85	81	82	96	96	97	97	97	98	98
Royal Wolverhampton	74	75	80	74	72	89	93	92	94	94	90	86
Walsall	68	68	72	71	70	87	92	94	96	96	93	95
National average	74	74	74	74	74	93	94	95	94	94	95	95

Accident & Emergency	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	32	49	48	47	49	78	79	79	79	78	78	82
Dudley Group	64	53	57	70	71	84	85	88	75	94	91	92
Royal Wolverhampton	74	52	52	47	52	80	82	83	81	85	85	83
Walsall	52	49	54	45	46	92	90	94	92	90	86	86
National average	55	54	53	53	57	86	87	87	86	88	88	87

Maternity Antenatal	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham		67	55	45		90	78	63	83			
Dudley Group	64	80	78	79	66	97	98	97	100	98	99	100
Royal Wolverhampton	71	82	60	75	40	100					80	
Walsall	31	40	40	39	50	70	92	90	93		86	96
National average	65	67	67	62	66	95	95	96	96	95	95	95

Maternity Birth	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	60	33	64	100								
Dudley Group	62	85	83	90	94	100	98	100	99	99	97	99
Royal Wolverhampton	72	91	98	100	97	100	100	100	100	100	100	99
Walsall	79	76	90	85	88	97	87	96	100	98	100	100
National average	76	77	77	77	77	95	95	97	97	97	97	97

Maternity Postnatal Ward	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham	57	62	61	68	58	94	94	97	96	95	98	92
Dudley Group	57	85	79	87	94	100	98	100	98	99	99	99
Royal Wolverhampton	66	95	75	55	81	100	96	91	91	88	88	81
Walsall	63	74	73	74	68	90	95	94	98	98	97	98
National average	64	65	67	65	65	91	91	93	93	93	93	98

Maternity Postnatal Community	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sandwell & West Birmingham			70	71		100	99	92	98	84	96	97
Dudley Group	86	90	85	85	85	100	100	100	100	100	100	100
Royal Wolverhampton	67	70	100				100	98		94	92	100
Walsall	90	76	91	67	74	95	97	100	97	100	97	100
National average	77	77	77	75	76	96	96	97	98	97	98	98

The national scoring for FFT changed in September 2014 to be a percentage instead of a net promoter score.

Any gaps in data are a result of not enough responses - less than 5 and the data is not displayed.

3.2.3 National survey results

In 2014/15, the results of three national patient surveys were published: inpatients, cancer and emergency department.

Participants for all national surveys are selected against the sampling guidance issued. For the national surveys, 850 patients were selected to receive a survey from the sample months indicated in the table below:

Survey name	Survey sample month	Trust response rate	National Average response rate
2014 Cancer Patient Experience	Sept – Nov 2013	62%	64%
2014 A&E	Jan - Mar 2014	33%	34%
2014 Adult inpatient	June - Aug 2014	47%	47%
2014 Children's and Young Peoples Inpatient	*July – Aug 2014*	*Not yet available**	*Not yet available**
2014 Neonatal: wave two	Apr – Sept 2014	37.4%	37.6%

*Response rate and national comparators published by the CQC not available at time of publication.

What the results of the surveys told us

2014 Cancer Patient Experience
We were delighted by the news that we were the most improved trust in England for cancer patient experience in the National Cancer Patient Experience Survey out of 153 trusts that took part.

We always strive to offer our patients the best possible experience whilst in our care, and this fantastic achievement is testament to the hard work of our specialist cancer teams over the past year. Our teams have been working hard with Macmillan Cancer Support over the past few years to make improvements to patient experience and it is rewarding to see this work recognised.

Compared to 2013 results:

- 53 questions out of 62 show an improved score from previous year
- four questions score same as previous year
- five questions show a slightly worse score

Areas where improvements could be made:

- Provision of information on getting financial help and the impact cancer can have on work and education
- Patients being given a choice of treatments and being more involved in decision making
- Patients being advised of the Cancer Clinical Nurse Specialist (CNS) in charge of their care

2014 A&E survey
The survey asks questions covering 34 different sections including: arrival at emergency department, doctors, nurses, care and treatment, tests and overall experience. In six out of the 34 sections the Trust was worse than other trusts nationally with all other sections being about the same as other emergency departments.

Areas where improvements could be made:

- Waiting times
- Access to food and drink in the department
- Being told what warning signals to look out for once returned home

2014 Adult inpatient survey
The national survey results are published in comparison with all trusts nationally and uses an analysis technique called the 'expected range' to determine whether the Trust has performed 'about the same', 'better' or 'worse' than others.

The 2014 survey told us that we are 'about the same' in all eleven section scores:

- the Emergency Department
- waiting list and planned admissions
- waiting to get to a bed on a ward
- the hospital and ward
- doctors
- nurses
- care and treatment
- operations and procedures
- leaving hospital
- overall views and experiences
- overall experience

Areas where improvements could be made:

- Inpatient meals
- Communication of what to expect during an operation or procedure

2014 Neonatal survey
The Trust chose to take part in the national neonatal survey which asked 43 questions covering the seven following areas:

- Before your baby was born
- Your baby's admission to neonatal care
- Staff on the neonatal unit
- Your involvement in your baby's care
- Environment and facilities
- Information and support for parents
- Leaving the neonatal unit

For the majority of questions, the Trust was on a par with the national average.

Areas where improvements could be made:

- Better written information for parents
- Better communication between staff and parents
- More support for breastfeeding mothers

I wanted to write and say a huge thank you to all the staff on ward C5 at Russells Hall Hospital, my nan was here for the last three weeks of her life and we wouldn't have gotten better treatment if she had been in a private hospital.

We use feedback from national and local surveys to improve patient experience. Below are some examples of actions taken as a result of patient feedback:

Inpatients	
You Said	**We Did / Doing**
More information about ward routines in needed	Welcome to the ward booklets are given to all new patients. A new system has also been put in place to ensure all transferred patients receive a copy of the ward booklet.
Better information about discharge processes is needed	All discharge information is being updated and ward clerks have received training on how to access this information. Additional training of ward staff has taken place and a new patient information leaflet has been launched to support the launch of *Home for Lunch*.
Improved information about waiting for surgery is needed	Letters to patients have been reviewed to now include advice that even though they may be called to their appointment early in the day, they may not be seen in order of arrival. The day room on ward B2 has been comfortably furnished. Patients now receive a phone call the day before their planned surgery when they are advised to bring in reading materials or a hobby activity to undertake should they need to wait.

Cancer	
You Said	**We Did / Doing**
More information is needed around getting financial help	We are working with the Dudley Citizens Advice Bureau and Macmillan Cancer Support, to help patients to identify and claim benefits they are entitled to.
More information about treatments and options is needed	We are reviewing and improving our information. We have also purchased some information stands to improve the availability of cancer information.
I do not know who my Cancer Clinical Nurse Specialist (CNS) is	Additional information will be produced and made available for all patients explaining the CNS/key worker role

Emergency Department	
You Said	**We Did / Doing**
Reduce ambulance handover times	To help reduce the length of time taken to hand over patients to ED from ambulances, we have had a staff nurse and clinical support worker on the ambulance triage team since June 2014. Their work is supported by a Hospital Ambulance Liaison Officer (HALO) from WMAS to ensure timely hand over of care even at times of high demand.
Ensure effective communication between patients, their families and GPs	We aim to ensure all staff involved in an patient's care communicate with one another to avoid contradictions. We have regular patient review meetings with all staff involved in the care of a patient and have introduced a more robust handover procedure. All staff are now aware of safe discharge procedures including assessing the home/family situation. Any patient with issues in these areas are referred to our welfare nurse or the IMPACT team. Advice leaflets containing information about who to contact after discharge are given to patients, as well as a discharge letter to give to their GP.

3.2.4 Examples of specific patient experience initiatives

a) Meeting the needs of patients with learning disabilities

The Trust launched its Learning Disability Strategy in March 2014. The key principle behind the strategy is to ensure that all staff listen to and provide care and treatment appropriately and effectively to people with learning disabilities. One of the practical ways this is demonstrated is by holding patient meetings where people with learning disabilities and their carers are invited to attend. They are an opportunity for this group of patients and their carers to express their hospital experiences and have an input into our patient experience surveys such as the Friends and Family Test, enabling their views to be included in any improvements that need to be made and the future planning of hospital services. The meetings have been well attended, with people talking about what did and didn't work when they used the hospital.

A health toolkit, developed by Keele University, has also been launched at the Trust to support communication with and gain feedback from patients when they and their carers use our services. Whilst the toolkit is designed for patients with a learning disability, it is also hugely beneficial to use with patients living with dementia, and with those for whom English is not their first language.

All staff were extremely responsive to all of the learning disability nurse's suggestions ensuring our time at Russells Hall was stress free. Please continue this wonderful and very necessary service.

b) Macmillan Link Nurse

In November 2014 the Trust's Macmillan Palliative Care Educator won a prestigious Macmillan Excellence Award for her inspirational work supporting healthcare professionals to deliver high quality palliative care for people affected by cancer in Dudley. The award was for improving the coordination and integration of services across the borough which has improved the experiences and outcomes of people affected by cancer.

The Palliative Care Educator has trained and educated more than 70 healthcare professionals across Dudley to become Palliative Care Champions, who then share their new skills and expertise with their colleagues to ensure a high standard of care for patients.

The post has made a huge difference to patients as the support given has helped to give existing staff more confidence. Staff now feel more comfortable having difficult, but important, conversations with patients and carers and are better skilled to support their colleagues, both clinical and non-clinical, to understand how to give the best possible care at the end of life.

c) Food Improvements
As part of our commitment to improve nutrition and hydration, we are introducing a new *Chosen by Patients* menu. We asked patients which dishes they enjoyed on our current menu and what they would like to see offered in the future. Using this information, our dietitians created a new menu that we are now trialling on four of our wards.

Patients on our Medical High Dependency Unit (MHDU) and general surgery, respiratory and children's wards are given a choice of meals from our new menu at lunch and dinner and, during an initial trial period, were asked to give us their feedback.

The feedback we received on the new menu from patients, staff and governors has helped us develop a new menu which we hope will improve patients' experiences of food. Since trialling the new menus, we have received overwhelmingly positive feedback from patients. Just a few of the comments we have received so far include:

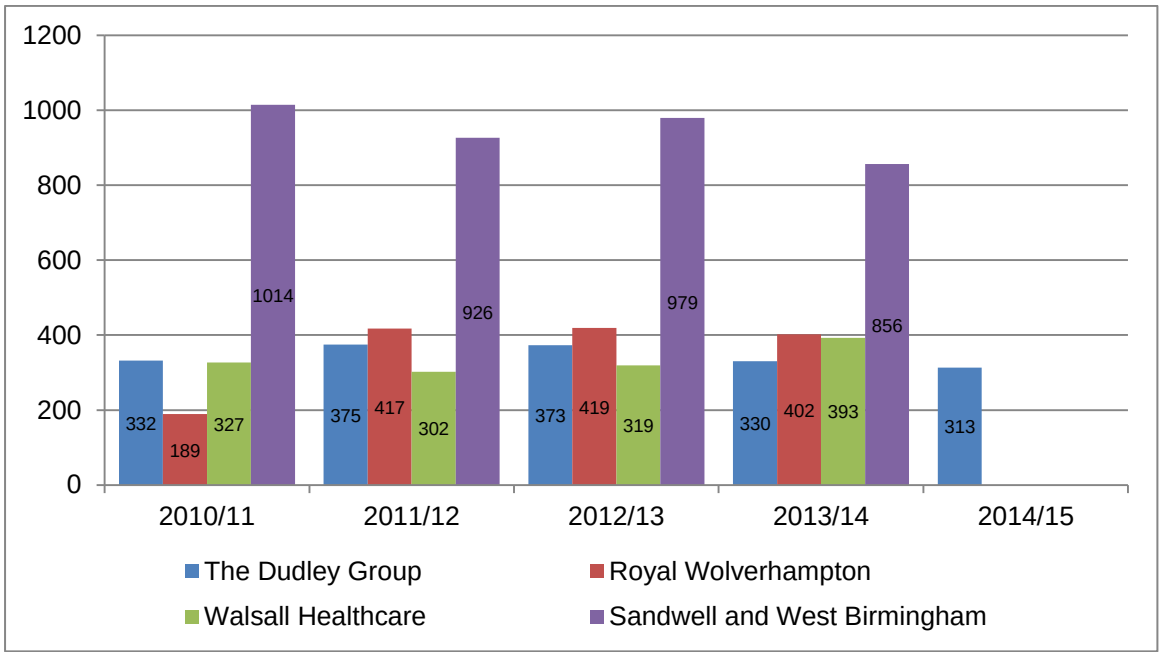
- "I was absolutely grateful for the amount and how fabulous the meals have been. Perfect – five star!"
- "Quite a varied menu – a definite improvement on my last visit to hospital."
- "Excellent to have a menu choice, especially same day prior to serving."

We also recruited 73 Nutrition Support Volunteers in September 2014 to help patients with their nutrition and hydration needs. The volunteers provide mealtime assistance by making drinks, helping with feeding, assisting with menu selection, encouraging eating and drinking and changing drinking water for patients. To make sure our patients receive the very best care and support during their stay, Nutrition Support Volunteers receive in-depth training provided by our nursing staff, dietitians and speech and language therapists.

3.2.5 Complaints, concerns and compliments

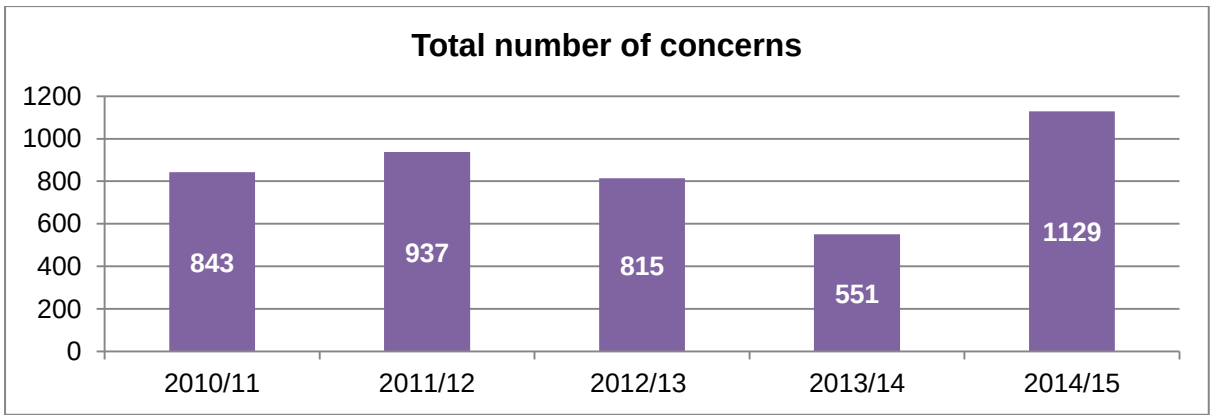
a) Total number of complaints, PALS concerns and compliments

Complaints
The graph below shows the total number of complaints received by the Trust over a number a years, alongside how we compare to neighbouring trusts. It can be seen that the number of complaints at the Trust has been reducing for the past four years.



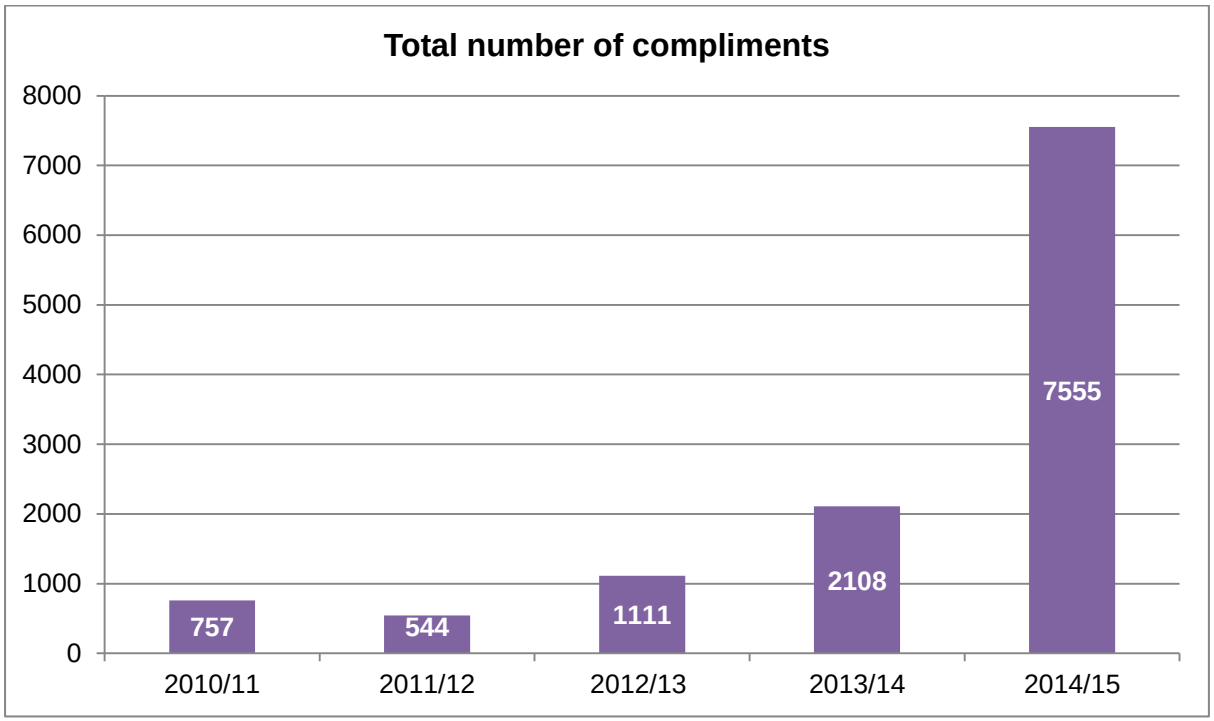
Concerns
The graph below shows the total number of concerns raised with the Patient Advice and Liaison Service (PALS). The number of PALS concerns has increased since last year; however, over the last five years, the number of concerns has fluctuated.

During 2014/15, the PALS team was re-established as a separate team to the Complaints Department, although it still retains strong links to ensure patients receive a seamless service. This change explains the difference in PALS figures from last year with 2013/14 seeing a decrease due to a different method of recording concerns during that period.



Compliments
The graph below shows the total number of compliments received during the year compared with previous years.

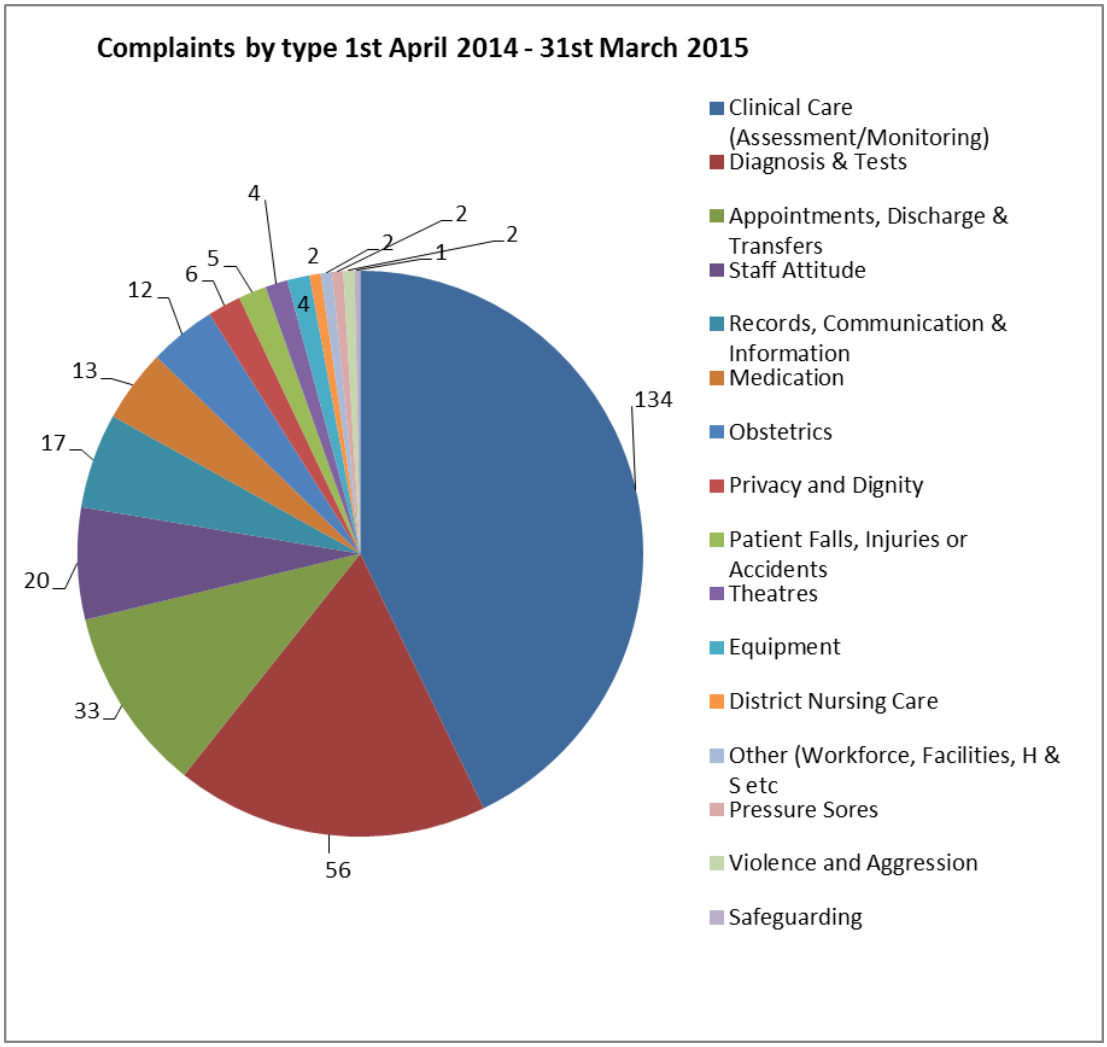
The Trust introduced an improved system of recording the number of compliments received in 2013/14 and so this will account for some of the large increase this year. It is very pleasing to see how many patients take the time to tell us of their good experiences, with 7,555 compliments in 2014/15.



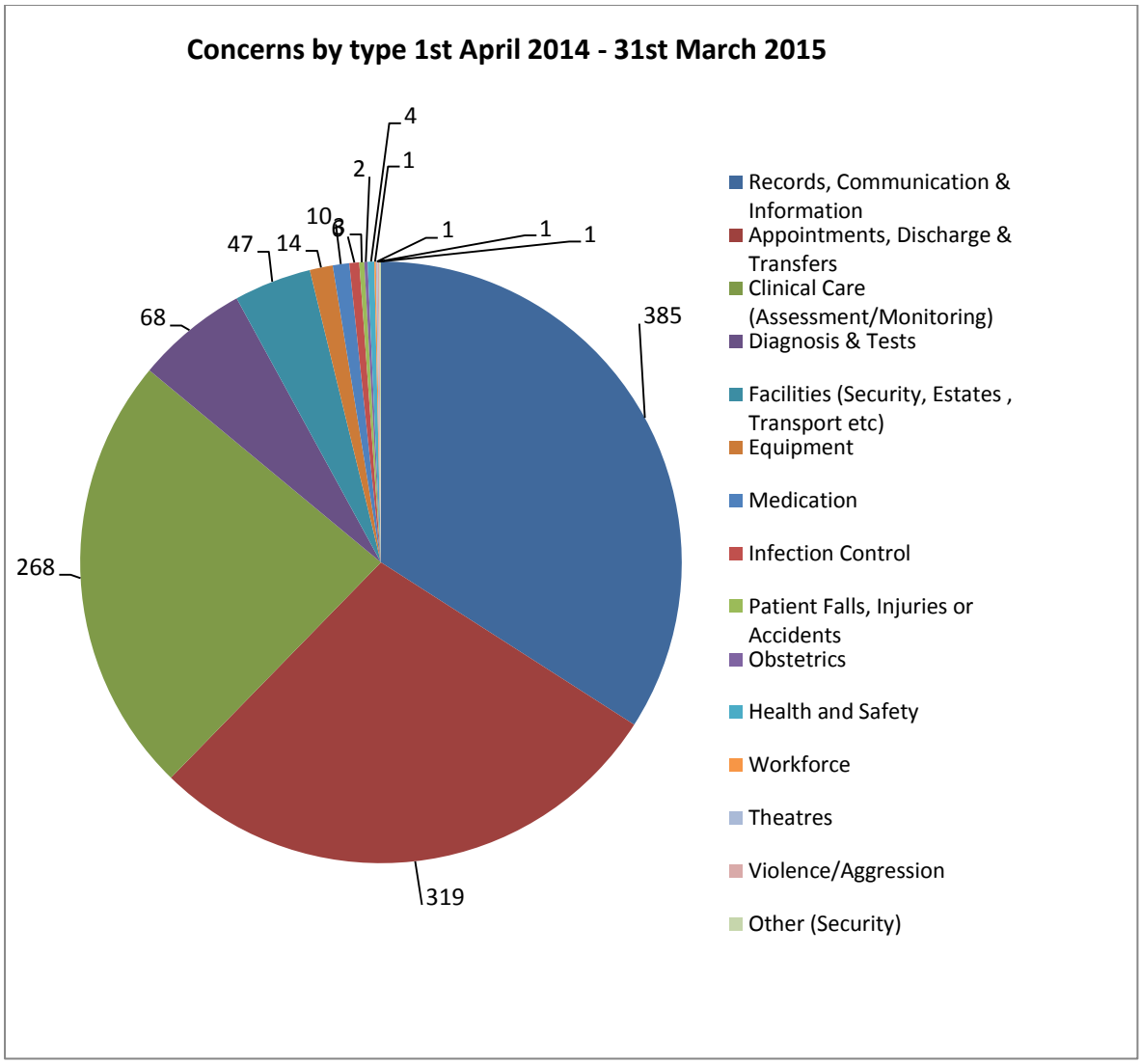
b) Types of complaints and PALS concerns throughout the year

The pie charts below show the types of complaints and concerns received during the year

Although there has been a fall in the overall number of complaints, the types of complaints we receive remain similar from year to year, reflecting the importance that patients place on effective and timely treatment from caring staff, with good communication skills. Some examples of actions taken and changes in practice following complaints and concerns are listed in section d).



Like complaint categories, the types of concerns raised remain similar year on year, reflecting the importance patients place on records, communication and information, closely followed by appointments, discharge and transfers. These top concerns are consistent with the types of comments made through other patient feedback methods.



c) Percentage of complaints against activity

The table below shows the percentage of complaints against total patient activity for each quarter in 2014/15 and for the year as a whole. As can be seen from the table, the percentage of complaints against activity has remained low and the same as 2013/14.

Activity	Total for 2013/14	Total Q1 ending 30/6/14	Total Q2 ending 30/9/14	Total Q3 ending 31/12/14	Total Q4 ending 31/3/15	Total for 2014/15
Total patient activity	734,239	181,132	187,117	184,687	183,574	**736,510**
Complaints against activity	0.04%	0.03%	0.05%	0.03%	0.05%	**0.04%**

d) Examples of actions taken and changes in practice made in response to complaints and concerns

Type of complaint or concern	Example of actions taken	Examples of changes in practice
Clinical Care, Diagnosis and Tests	• Initial X-ray examination performed was reviewed by a senior radiologist and even with the benefit of hindsight a stress fracture diagnosed some weeks later was not visible on the X-ray. A delay in diagnosing the fracture was acknowledged but explanation provided regarding difficulty diagnosing such fractures on initial X-rays. •Consultant met with patient and explained results of tests in some detail, which patient was happy with. • Consultants discussed question of use of compression stockings after aortic aneurysm surgery with team to ensure they are aware why compression stockings are not used after this type of surgery. • Staff reminded to inform parents when tests are sent to specialist hospitals, which might delay results being received. • Staff encouraged to use calculators to calculate drug dosages rather than mobile telephones as using these can give a poor impression. • Deputy matron recruited to older people's mental health team to implement and train new patient support team.	• A business case to increase urology medical staffing establishment was approved and an additional consultant, registrar grade and Senior House Officer grade doctors were appointed. • Mattress use paperwork reviewed and updated to include instruction to users to treat the chart as a guide only and use it in conjunction with other decision making processes. • All patients with a moisture lesion or red area on their skin are now placed on a two hourly skin assessment. • Wellbeing Workers introduced. • Mattresses on trolleys upgraded to provide pressure relief. • Electronic handovers introduced to ensure all information is available for both day and night staff. • Senior nurses now available during visiting hours to meet with relatives. • Two care workers released from night duties to act as 'floating' staff to ensure buzzers are answered within 30-second target. • Paediatric leaflets reviewed to highlight clinic structure. • Experienced care workers allocated to work with qualified staff at front triage and in ambulance triage area. • Patient flow co-ordinator introduced to aid qualified staff in monitoring patient waiting times.

Type of complaint	Example of actions taken	Examples of changes in practice
Records and Communication	• Advised patient he needed to be seen in clinic before going to theatre for procedure. • Staff asked to ensure patients understand what they have been told and to use non-clinical terminology. • Trust's newsletter contains information for GPs, particularly relating to ED attendances • A number of senior nursing staff have visited Mary Stevens Hospice to discuss care for the terminal patient. More nursing staff will go in future and this will be rolled out to other wards, including elderly care wards.	• Huddle boards introduced to improve staff communication. • Communication folder introduced to enable patients and families to raise questions and request meetings if staff not immediately available. • Letter of attendance formulated and available at reception for patients who require proof of attendance. • Patients with rapid access clinic appointments now receive a telephone call as well as a letter to confirm receipt of appointment. • Leaflet provided by reception staff when patients present following GP referral.
Obstetrics	• Telephone operators given emergency numbers for all local areas and these are readily available for pregnant women who contact the hospital. • Matron met with midwife concerned and asked her to reflect on contents of complaint letter, her behaviour towards her patient during her admission and to consider how improvements to her practice and approach can be made to prevent a recurrence. • Consultant reiterated to junior medical staff during meetings and teaching sessions the importance of good communication and of ensuring all patients are provided with full and easily understood explanations during consultations. • Reinforced with staff they should continue to emphasise all risks associated with procedure and continue to give written information.	• Reviewed information leaflet and statistics, post advice leaflet, service guideline (which is based on best national recommendations and practice. • Developed a letter that parents can give to doctors when attending ED departments. • Implemented access to the appropriate member of staff for advice for a number of hours following the clinic session ending. • Parents given information on SANDS (a stillbirth and neonatal death charity) who offer emotional support for parents who have suffered the loss of a baby. • Patients now provided with a comfort pack, blankets and pillows following admission from the day assessment unit.

3.2.6 Patient-led Assessments of the Care Environment (PLACE)

Patient-led Assessments of the Care Environment (PLACE) is the new system for assessing the quality of the hospital inpatient environment which replaced Patient Environment Action Team (PEAT) inspections from April 2013.

All trusts are required to undertake these inspections annually to a prescribed timescale. Patient assessors make up at least 50 per cent of the assessment team with the remainder being Trust and Summit Healthcare Staff.

The inspection covers ward and non-ward areas to assess:

- Cleanliness
- The condition of the buildings and fixtures (inside and out)
- How well the building meets the needs of those who use it, e.g. signage
- The quality and availability of food and drinks
- How well the environment protects people's privacy and dignity

	Cleanliness	Food & Hydration	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance
2014 scores	**99.69%**	**84.28%***	**90.96%***	**97.04%**
2014 national average	97.25%	89.79%	87.73%	91.97%
2013 scores	97.87%	78.36%*	90.92%*	90.46%
Variance from national average	▲ +2.44%	▼ -5.51%	▲ +3.23%	▲ +5.07%
Variance from 2013 scores	▲ +1.82%	▲ +5.92%	▲ +0.04%	▲ +6.58%

**Due to changes in the assessment methodology and scoring, the 2014 results for Food and Hydration and Privacy, Dignity and Wellbeing are not directly comparable to the 2013 results.*

We were delighted that we scored higher than the national average in three of the four above topics and all of our scores have improved on our own 2013/14 scores.

Big thumbs up to everyone one on ward C8. Thank you so much for your kindness, expertise and for going above and beyond the call of duty.

3.2.7 Single-sex accommodation

We are compliant with the government's requirement to eliminate mixed-sex accommodation. Sharing with members of the opposite sex only occurs when clinically necessary (for example where patients need specialist equipment such as in the Critical Care Unit), or when patients actively choose to share (for instance in the Renal Dialysis Unit). During the year the Trust has not reported any breaches of same-sex accommodation.

As part of our real-time survey programme, patient perception is also measured by asking patients whether they shared a room or bay with members of the opposite sex when they were admitted to hospital. Of the 1,211 patients who responded to this question, 59 (less than five per cent) had the perception that they shared a room/bay with members of the opposite sex was. This excludes emergency areas.

3.2.8 Patient experience measures

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Comparison with other trusts 2014
Patients who agreed that the hospital room or ward was clean	87%	87%	88%	8.7	8.8	9.0	**8.9**	**7.9-9.7***
Patients who would rate their overall care highly**	79%	76%	74%	7.4				**7.2-9.2***
Rating of overall experience of care (on a scale of 1-10)**					7.6	7.7	**7.8**	
Patients who felt they were treated with dignity and respect	89%	86%	86%	8.6	8.7	8.6	**8.7**	**8.2-9.8***

The above data is from national inpatient surveys conducted for CQC.

Scores were initially expressed as percentages but from 2011 scores are reported out of 10 (previously this table was compiled from raw data scores).

** National range lowest to highest score.*

***The way this question was asked changed in 2011/12 and so figures are not directly comparable.*

Patient Safety

3.3 Are patients safe in our hands?

3.3.1 Introduction

The Trust ensures the safety of its patients is a main priority in a number of ways, from the quality of the training staff receive, to the standard of equipment purchased. This section includes some examples of the preventative action the Trust takes to help keep patients safe and what is done on those occasions when things do not go to plan.

3.3.2 Patient Safety Leadership Walkrounds

All wards, therapy and community departments are visited throughout the year by a team consisting of, as a minimum, an executive director, a non-executive director, a governor and a scribe from the governance team.

The team observes practice by being shown around the ward or department by a member of staff who also provides a verbal summary of the ward activity, specialty and ways of working. The team then meets informally with staff to discuss any issues of concern related to patient safety, while governors talk to patients about their experiences of the care they are receiving. A report and action plan is produced to address areas of concern identified. Some actions taken from these visits include:

- New seating has been purchased for Genitourinary medicine (GUM) outpatient area.
- A new intercom system has been fitted for patients attending the Renal Dialysis Unit out of hours. The reception desk is not manned and ward staff were unaware patients were waiting outside trying to gain access. The system allows ward staff to open doors remotely. The Renal Dialysis Unit has extended its service hours to include late evening sessions.
- Coaxial TV aerials have been pinned back to the walls to reduce the risk of trips.
- Following a service review, regular meetings were scheduled with the Trust's non-emergency patient transport providers Ambuline. The service provides transport for patients attending clinics, outpatients or those being discharged. Previously reported delays and extended patient waits for transport have improved following the introduction of these meetings. From 1st April 2015 the Trust's non-emergency patient transport is to be provided by NSL. We hope to continue these meetings with our new provider in the coming year.
- Repairs were made to seating in the Cardiology Unit.
- A dedicated triage area has been developed on our oncology ward, C4.
- A rehabilitation chair has been introduced into critical care. This will enable ventilated patients to be sat out of bed. In addition, new dignity screens have been fitted in our Surgical High Dependency Unit to allow for greater privacy and dignity.
- A new central console monitoring unit has been purchased for the Coronary Care Unit which is currently waiting installation. It will provide the latest high specification monitoring of cardiac patients within the department.

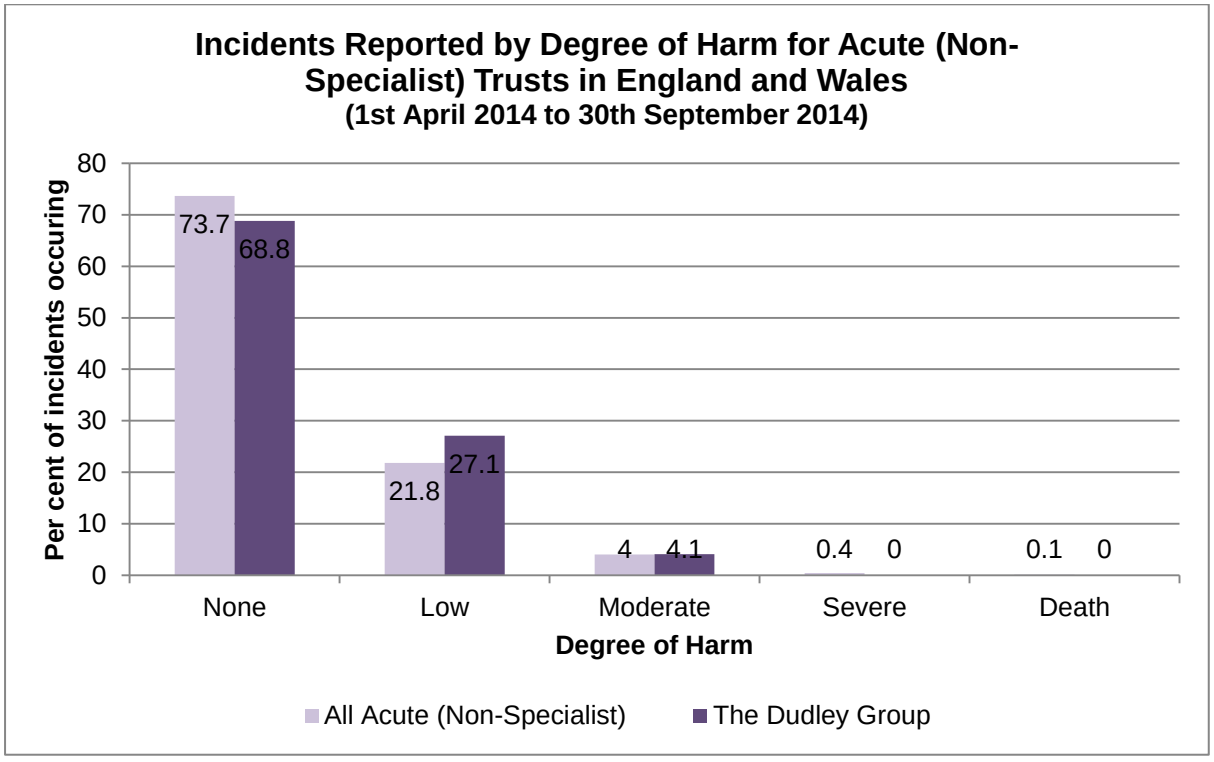
3.3.3 Incident management

The Trust actively encourages its staff to report incidents believing that, to improve safety, it first needs to know what problems exist. This reflects the National Patient Safety Organisation which has stated:

''Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.''

The latest national comparative figures available are for the period 1st April 2014 to 30th September 2014. Organisations are compared against other acute (non-specialist) trusts. The Trust is the 28th highest reporter of all incidents of the 140 acute (non-specialist) trusts.

With regards to the impact of the reported incidents, it can be seen from the graph below (for the same period stated above) that the Trust reports a similar proportion of incidents to comparable trusts. Nationally, across all medium-sized acute trusts, 73.7 per cent of incidents are reported as no harm (the Trust reported 68.8 per cent) and 0.5 per cent as severe harm or death (the Trust reported 0 per cent).



During the 2014/15 financial year, the Trust has had one Never Event (a special class of serious incident that are generally preventable) which resulted in no patient harm. It had 268 serious incidents*, all of which underwent an internal investigation and, when relevant, action plans were initiated and changes made to practice

**Serious incidents are a nationally-agreed set of incidents which may not necessarily have resulted from error but need investigating to check the circumstances of their occurrence*

Some examples of changes made to practice in response to the above incidents have been:

- Introduction of the Sign and Stamp initiative which requires all medication prescribers to stamp/print their name as well as sign so that the identity of the prescriber is clear
- Review and re-launch of the Think Glucose training programme to ensure staff on wards that do not commonly look after patients with diabetes are aware of their responsibilities when caring for such patients
- Identification of an alternative supplier of bariatric equipment
- Full review of neonatal resuscitation guidelines
- Development of a pre- and post-procedure checklist (adapted WHO Surgical Safety Checklist process) for all invasive procedures, however minor, to be used across the whole organisation to ensure increased patient safety
- Implementation of a double checking system for any procedures when a guide wire is used to have assurance of complete removal of the wire
- Introduction of an additional validation check before releasing pathology results
- Development and introduction of a clinical skills training and competency assessment for nursing staff for the collection and labelling of blood samples
- Ensuring all district nurse referrals for equipment are now followed up with a telephone call to reduce the risk of delayed equipment

I saw the psychologist, the physiotherapist and the pain specialist and they were all superb. They clearly gel together and combine their specialties to enable them to diagnose the problem and recommend an overall approach to treatment.

3.3.4 Nursing Care Indicators

Every month, ten nursing records and the supportive documentation are checked at random in all general inpatient areas and specialist departments at the hospital, and in every nursing team in the community. A total of approximately 430 records are audited each month. The purpose of this audit is to ensure nursing staff are undertaking risk assessments, performing activities that patients require and accurately documenting what has taken place.

Following a review of the audit questions and the results being obtained, the audit template has been changed. From September 2014, the hospital audits were abridged, with the community process due to be changed from April 2015. Within the hospital, the previous themes assessed were: patient observations, pain management, manual handling, tissue viability, medications, documentation, nutrition, infection control, 'Think Glucose', bowels and fluid balance. The Trust decided to concentrate on six criteria: patient observations, manual handling, falls, tissue viability, nutrition and medications. The elements no longer included in the Nursing Care Indicator audits are now managed by the relevant specialist teams in the hospital, for example, Think Glucose is now managed by the diabetes team.

As can be seen in the tables below, the Trust now assesses eight criteria in the community and six in hospital. To allow us to capture practice for specialist areas, there are two variations of the audit tool in the community, and five variations in hospital.

Community results

The table below shows the year-end results for each of the criteria assessed by the community teams. During 2014, a review was undertaken and the questions within each of the individual criteria were amended slightly. Community results are very stable with little fluctuation month on month.

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Medications	Documentation	Privacy and Dignity	Nutrition
2011	97%	98%	94%	95%	99%	98%	99%	97%
2012	97%	98%	97%	97%	99%	98%	99%	97%
2013	97%	99%	97%	99%	98%	98%	99%	98%
2014	99%	99%	97%	100%	98%	97%	99%	99%
Difference from 2013 to 2014	▲2%	=	=	▲1%	=	▼1%	=	▲1%

Inpatient results

During 2014, a slight amendment has been made to the audit questions with a new criterion of 'Falls' added. The questions for this criterion had previously been included within the Manual Handling section. By looking at each of these areas separately, the Trust is able to focus on specific patient safety initiatives. Results continue to show improvements, with the largest in the patient observation theme (an increase of four per cent from the previous year). The largest improvement over the five years reported can be seen in Nutrition (an increase from 68 to 92 per cent).

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Medications	Documentation	Nutrition	Infection Control	Think Glucose	Bowels	Fluid Balances	Falls
2010	77%	70%	71%	86%	92%		68%	95%				
2011	83%	80%	79%	93%	94%	88%	77%	97%	53%	78%		
2012	86%	88%	85%	95%	94%	88%	82%	91%	79%	81%	77%	
2013	92%	95%	91%	95%	97%	90%	89%	94%	90%	87%	91%	
2014	96%		93%	97%	99%		92%					94%
Difference from 2013 to 2014	▲4%		▲2%	▲2%	▲2%		▲3%					

I am so grateful to the attentive care that all the staff gave us at a scary and worrying time.

The nurses were also brilliant including the lovely lady in the plaster clinic who fitted me with my boot and also the staff in the ultra sound department who did my scan.

3.3.5 Harm Free Care and NHS Safety Thermometer

The NHS Safety Thermometer has been developed as a 'temperature check' on four key harm events – pressure ulcers, falls that cause harm, urinary tract infections in patients with a catheter and new venous thromboemboli. It is a mechanism to aid progress towards harm free care and has been adopted across the whole of the NHS.

Each month, on a set day, an assessment is undertaken consisting of interviews with patients, accessing the patient's bedside nursing documentation and, when required, examining the main health record. On average, 650 adult inpatients (excluding day case patients and those attending for renal dialysis) and 620 patients being cared for in the community are assessed every month.

There are national trials of a paediatric and young person's safety thermometer and a maternity safety thermometer and the Trust is taking part in these trials.

The Trust regularly monitors its performance and, although direct comparisons need to be made with caution, it is pleasing to note its harm events fall below the national averages.

Some examples of actions being taken as a result of the assessments include:

- An ongoing formal escalation process for less than average results
- A formal review and upgrade of the intentional rounding throughout the Trust (a process of each patient being seen by a member of staff at set times which is documented) has been undertaken as a patient safety measure to improve patient to nurse contact and reduce the prevalence of falls.
- Catheter care bundles have been introduced and are now embedded within the organisation. Monitoring for compliance is undertaken by annual spot check audits.

I was looked after by support workers and nursing staff with care, consideration, dignity and nothing was too much for them to do.

3.3.6 Examples of specific patient safety initiatives

a) Simulation Centre

In December 2014, a new state-of-the-art simulation centre was officially opened by the Vice Dean of Birmingham Medical School, Professor Kate Thomas.

The Ron Grimley Undergraduate Simulation Centre at Russells Hall Hospital has been designed to offer a training environment as close to real life as possible, complete with mannequins, which mimic 'real' patient illnesses and responses to treatment. The area is made up of a fully functional two-bedded ward area which can also be adapted to become an operating theatre, complete with a working anaesthetic machine and piped oxygen, medical air and suction gases. The facility also boasts an echocardiogram simulator and a state of the art virtual fibrescope that allows anaesthetists to practise the skill of fibreoptic intubation.

Controlling the facility from behind the scenes is a team of simulation trainers who can replicate a variety of scenarios from a control room next to the simulation suite. They can control the mannequins' behaviours and replicate any number of medical conditions and clinical observations. The facility also has full audio and video recording, enabling staff and students to watch their sessions back afterwards and discuss their experience with training staff.

The area is already being used by medical students and foundation year doctors as part of their training programmes, and a training pilot with final year operating department practitioners and anaesthetic trainees also took place earlier during the year. A programme for final year nursing students and student operating department practitioners has just been developed, and the facility will be extended to multidisciplinary staff in the near future.

b) Mortality Tracking System

One technique we use to ensure patient safety is to systematically review the care and treatment of all patients who have died in the hospital to see if any lessons can be learned for the effective care and treatment of future patients. To allow us to do this in a timely and efficient manner, we have developed a web-based application. The systems, which captures information about deaths as soon as they are recorded, was shortlisted and placed in the finals of a top national award for the use of Information Technology to improve patient safety.

The Mortality Tracking System (MTS) solution allows all information and documentation surrounding each individual death to be readily accessible from one place so that it is ready for review and audit by clinical staff. The system also automatically sends emails to senior staff informing them of the number of deaths ready for review, completed, or escalated for further investigation.

c) Hip A.I.D (Assess, Investigate and Diagnose)

This project was launched in February 2015 and aims to enhance our service to all patients with possible hip fractures. Many of these patients are frail or elderly so it is important that the correct specialised treatment and care starts immediately, both for the general wellbeing of the patient, and to ensure that they are fit for surgery (which should occur as soon as possible after admission).

With regards to the latter point, in the last Falls and Fragility Fracture Audit Programme (FFFAP) National Hip Fracture Database Annual Report 2014, 83.2 per cent of patients at the Trust had surgery on the day of or day after admission (in all of the West Midlands hospitals this ranged from 84.7 per cent down to 40.5 per cent with over half of hospitals less than 70 per cent). The Trust realised, however, that it could do better to ensure patients were admitted to the orthopaedic ward as quickly as possible.

This project comprises of ambulance staff phoning ahead to the Emergency Department to inform them that a patient with a possible hip fracture is on the way. The specialist hip fracture practitioner then meets the patient on arrival, allowing the patient to be assessed immediately and, if the patient does not have any comorbidities (e.g. stroke), the patient is transferred immediately to the Radiology Department for an X-ray where a hip fracture is diagnosed. The patient is then taken directly to the orthopaedic ward (Ward B2) where orthopaedic nurses can begin the necessary care, and where specialist medical staff are based to treat the patient. Any delays such as waiting in the Emergency Department are avoided with patient safety being maintained at all times.

3.3.7 Patient safety measures

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15
Patients with MRSA infection per 1000 bed days*	0.07	0.04	0.01	0.009	0.005	0.004	0
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0	1	1	1
Number of cases of deep vein thrombosis presenting within three months of hospital admission	48	48	35	143**	117**	116**	102**

Due to the small rates of MRSA infections, figures are now expressed to three decimal places.

**Data source: Numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system.*

NB: MRSA figure may differ from data available on HPA website due to different calculation methods and Trust calculations using most current Trust bed data.

***Previous data collection of Hospital Acquired Thrombosis (HAT) was identified through clinical codes alone. We found that this information was not always a true reflection for a variety of reasons including the fact that the available clinical codes for thrombosis are confusing and, in practice, misleading. Also, a majority of deep vein thrombosis (DVT) cases do not require readmission to hospital which results in further inaccuracies in data collection. To improve the accuracy of our data collection we now review all diagnostic tests for DVTs and pulmonary embolism (PE), cross referencing positive tests with past admissions. This methodology is only undertaken by relatively few hospitals as it is labour intensive, but is recognised as giving a more accurate figure for HAT. As a further check, we receive notification from the bereavement officer if PE was identified as the primary cause of death. As a result of amending our methods of identifying HAT, 2011/12 saw an increase in figures. As stated, this is down to better identification of cases.*

Everyone had so much patience and took time to answer my somewhat silly questions... They made me feel really relaxed and I went off to sleep feeling really happy to be in such good hands.

Clinical effectiveness

3.4 Do patients receive a good standard of clinical care?

3.4.1 Introduction

This section includes the various initiatives occurring at the Trust to ensure patients receive a good standard of care and examples of where we excel compared to other organisations.

3.4.2 Examples of awards received related to improving the quality of care

a) Frenulotomy service

The Trust's frenulotomy service. which cares for babies with ankyloglossia or tongue-tie, scooped a 'Highly Commended' certificate for its work and came runner up in the All Party Parliamentary Group Maternity (APPGM) Services Awards 2014 in the category of 'Most Effective Multidisciplinary Team'. The team was rewarded for its work in developing and offering the frenulotomy service to improve feeding for babies with tongue-tie and breastfeeding rates.

Head of Midwifery, Steph Mansell, said, "The frenulotomy service we offer at Russells Hall Hospital is unique and I am very proud of all the staff who have worked really hard to provide better maternity services for woman and babies in our community. This recognition is well deserved by everyone in the team."

Members of the team attended the awards ceremony at the House of Commons. The APPGM, which is serviced by the National Childbirth Trust charity, is a cross-party group that aims to highlight maternity issues within Parliament and bring together health professionals, service users and politicians.

b) Queen's Nurse

District Nurse Team Leader for OPAT (Outpatient Antimicrobial Therapy) Kate Owen was given the prestigious title of Queen's Nurse by the community nursing charity The Queen's Nursing Institute (QNI). The title is not an award for past service, but indicates a commitment to high standards of patient care, learning and leadership. Kate was presented with a badge and certificate by Jane Cummings, Chief Nursing Officer for England, at a ceremony at the Royal Garden Hotel in London

Crystal Oldman, Chief Executive of the QNI said, "Congratulations are due to Kate for her success. Community nurses operate in an ever more challenging world and our role is to support them as effectively as we can. The Queen's Nurse title is a key part of this and we would encourage other community nurses to apply."

c) National award for tissue viability

Clinical nurse specialist and lead nurse for tissue viability Lisa Turley received a national award for her presentation on the Trust's move to static air mattresses. She was presented with the only award of The Wounds UK Annual Conference – the Wounds UK Award of Excellence – for her paper on the Trust-wide changeover to the new mattresses. Her paper covered the move to static air mattresses from start to finish, covering the whole process from the initial decision making, training and planning, to the implementation, benefits for patients and cost savings.

Lisa said, "It's really nice to be recognised and to help you realise you've actually done a good job – it's a real confidence boost."

Rob Yates, Publishing Director of the WoundsGroup, said, "The judges felt that the quality of the work undertaken and the clear, positive health economic impact it demonstrated, was worthy of special mention and ultimately marked it out as a clear winner."

3.4.3 Examples of innovation

a) Ensuring radiological expertise is always available

With the national shortage of consultant radiologists and specialist medical staff with the expertise to interpret complex radiological investigations and suggest the appropriate treatment of patients, the Trust has taken the innovative step of obtaining that expertise using recent technological developments.

When emergencies occur, for example in the middle of the night, the tests are undertaken and the results sent electronically to London and onto Australia. The results are then interpreted and reported back in a 'follow the sun' manner. This ensures that the results of the tests are being interpreted and reported by consultants who are awake and alert, and not by on-call staff being woken up who may have worked throughout the previous day and are due to work the next day.

The expert interpretations and suggested treatments are returned electronically in a timely manner. The new system also means that reporting is done by dedicated specialists in that type of test. It also means that our own staff work efficiently as they are well rested and, therefore, more productive (not sleep deprived) and the service is provided in a cost effective manner. The effectiveness of the service is constantly monitored with a guaranteed turnaround time.

b) New equipment allowing improved assessment of surgical patients

A brand new machine that tests how well the body responds to exercise has been installed at Russells Hall Hospital to help consultants predict how well a patient will cope with surgery. This state-of-the-art Cardio Pulmonary Exercise Testing (CPET) machine evaluates how the heart, lungs and muscle simultaneously respond to exercise, mimicking the physiological stress on the body that surgery causes. The CPET machine tests are performed on a stationary bike and, as the patient cycles, consultants measure how much air they breathe, how much oxygen they require and how fast and efficiently their heart beats.

Adrian Jennings, consultant anaesthetist, said, “We are now able to accurately risk assess patients undergoing surgery. This is useful for clinicians as we can better direct care to each patient’s individual needs, for example, the type of anaesthetic and the type of postoperative care. Moreover, it is useful for patients who can better understand their surgical risk and make better informed decisions about their treatment opinions. In some cases, we may be able to optimise patients’ fitness further before they embark on surgery.”

In addition, the Trust has acquired a thrombelastography machine for theatres. This device allows clinicians to assess the clotting of blood in patients who are bleeding heavily, or have an underlying bleeding propensity. We can detect blood clotting problems more quickly and identify the cause. This allows treatment, usually blood transfusion, to be directed in an individualised way, ensuring patients only receive the minimum amount of blood products necessary. This reduces transfusion risk, allows blood clotting to be optimised and is cost effective.

c) Outdoor exercise

The Trust, Action Heart and Dudley MBC achieved a UK first when an outdoor gym facility was installed at Russells Hall Hospital in May 2014. The grand opening was attended by an international delegation from Portugal and has generated many enquiries within the UK.

The outdoor gym is to be used as a demonstration site for patients, stepping down from exercise rehabilitation, to be able to maintain their commitment to physical activity via one of the eight outdoor gyms that are strategically located in parks within Dudley Borough.

The Trust also hopes to lead the way in highlighting the importance of physical activity in good health by encouraging staff to use the outdoor gym (and other physical activities on site) and becoming appropriate role models for their patients.

3.4.4 Examples of specific clinical effectiveness initiatives

a) Cardiology One Stop Clinic

The Trust's Cardiology Department had a long-standing rapid access clinic for patients with chest pain who needed to be seen quickly as well as the usual outpatient (OPD) clinics. With the rising number of referrals and increasing waiting times, and with some patients being referred inappropriately to one of the two types of clinic, the department developed a one-stop clinic which helps to ensure that all patients receive a streamlined personalised effective service appropriate to their individual needs.

In collaboration with our GP colleagues, all patients are now referred into one place. The referral requires certain standard detailed information on the patient's condition, and all patients (except those with chest pain in order to avoid referral delay) to have had a heart trace undertaken (electrocardiogram – ECG). The referral information and the ECG trace allows specialist staff at the hospital to assess the best course of action:

1) Giving advice and guidance to the GP who will continue to see the patient
2) Arrange further open access investigations with specialist advice, with the results reported back to the GP
3) Ask the patient to attend the one stop clinic where a rapid assessment will be made and all necessary, non-invasive investigations will be carried out on the same day so that a plan of care can be put into place straightaway. On this pathway, priority is given to cardiac sounding chest pain, with other urgent referrals seen in two weeks or sooner if necessary
4) If the patient has a known previous or existing condition and there is no immediate concern, then a usual OPD clinic appointment is made.

This new system has resulted in a considerable drop in waiting times, improved access for those patients that need it and a more effective service overall.

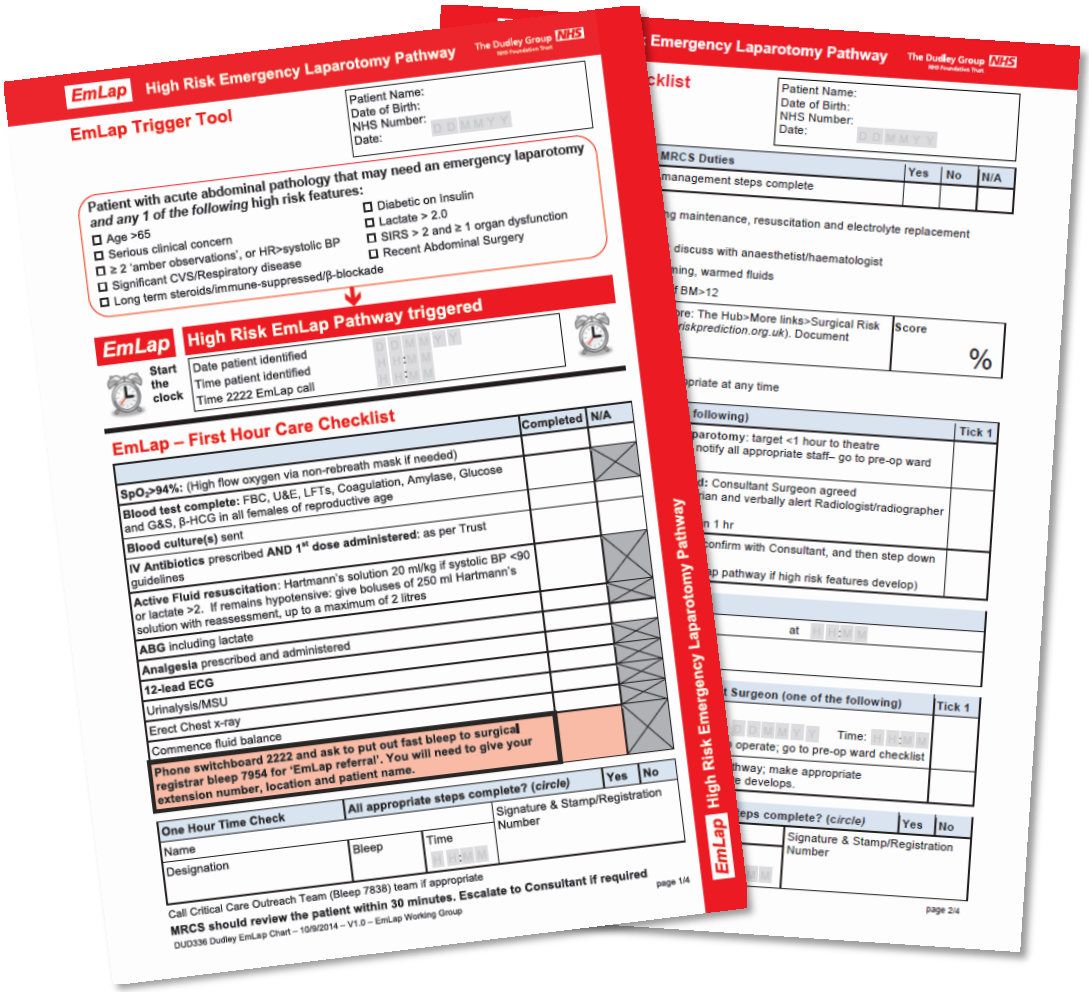
I have been in the Children's Ward twice in the last month... The care for both my son and myself was brilliant - nothing too much trouble for him or a timely hug or cup of tea for me.

b) Emergency Laparotomy Pathway (EmLap)

Patients who develop severe intra-abdominal problems can become very ill quickly; where this is due to a problem which can be corrected by surgery, many of these will need to undergo an emergency laparotomy. An emergency laparotomy is a high-risk surgical procedure that involves making an incision to provide access to the abdominal cavity, allowing the problem to be fully diagnosed and, where possible, corrected.

The longer the time between patients needing such an operation and it being carried out, the worse the outcome for the patient. Research indicates that patients who undergo an emergency laparotomy have more than a 10 per cent risk of dying within 30 days of their operation. For patients over 80 years old, the risk rises to more than 30 per cent. Many other patients will suffer post-operative complications, and have a prolonged hospital stay. However, reports do reveal a wide variation in care and outcomes, with mortality rates of up to 40 per cent. Some of this difference is related to the time between symptoms starting and the operation being performed.

To improve patient outcomes after an emergency laparotomy, an evidence based quality improvement care bundle known as the EmLap Pathway has been developed. The bundle enables prompt identification, assessment, resuscitation and operation. It also identifies how staff can ensure the most effective escalation of care so these high risk patients are cared for by the right people, in the right place at the right time. Other hospitals recently commencing such a scheme have shown a reduction in 30 day mortality by up to 50 per cent.



3.4.5 Clinical effectiveness measures

	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14#	Actual 2014/15
Trust readmission rate for surgery Vs Peer group West Midlands SHA Source: CHKS Insight	4.6% Vs 4.1%	3.9% Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%	5.6% Vs 5.0%	6.1% Vs 6.8%	6.4%* Vs 7.1%	6.7%^* Vs 7.2%
Number of cardiac arrests Source: Logged switchboard calls	397	250	170	145	119	126	158	189
Elective admissions where the planned procedure was not carried out (not patient decision) Vs Peer group West Midlands area Source: CHKS insight	N/A	2.0% Vs 1.6%	1.4% Vs 1.6%	1.4% Vs 1.3%	0.67% Vs 1.1%	0.68% Vs 1.2%	0.75% Vs 0.8%	0.86%^ Vs 0.9%

^April 2014 to November 2014. NOTE: DGNHSFT no longer contract to CHKS Ltd for benchmarking information. The date range used is the latest included by CHKS from HES Data. These measures will not be available in the 2015/16 report.

**Specialties included in the surgical directorate changed during 2013/14 which has affected the figures compared to previous years and the peer group.*

#*The percentage rates for 2013/14 are for the full year and so are different to the partial year figures printed in last year's report.*

I would like to thank the consultant and his team for the excellent care I received. All his team were kind and respectful. The treatment and care was exceptional.

3.5 Our performance against key national priorities across the domains of the NHS outcomes framework

National targets and regulatory requirements	Trust 2009/10	Trust 2010/11	Trust 2011/12	Trust 2012/13	Trust 2013/14	Target 2014/15	National 2014/15	Trust 2014/15	Target Achieved/ Not Achieved
1. Access									
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	95.8%	97.03%	95.7%	96.1%	93.95%	**90%**	**88.6%**	**91.59%**	☺
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	99.1%	99.2%	99.2%	99.5%	99.18%	**95%**	**95.4%**	**98.71%**	☺
Maximum time of 18 weeks from point of referral to treatment (incomplete pathways)	N/A	N/A	N/A	98.1%	96.74%	**92%**	**93.2%**	**95.43%**	☺
A&E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	98.1%	98.8%	97.27%	95.4%	93.74%	**95%**	**93.6%**	**94.68%**	☹
A maximum wait of 62 days from urgent referral to treatment of all cancers	86.5%	87%	88%	88.7%	89%	**85%**	**83.4%**	**85.6%**	☺
All cancers: 62 day wait for first treatment from national screening service	N/A	99.6%	96.6%	99.4%	99.6%	**90%**	**93.2%**	**97.3%**	☺
All cancers: 31 day wait for second or subsequent treatment: surgery	N/A	99.6%	99.6%	99.2%	100%	**94%**	**95.7%**	**99.6%**	☺
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments	N/A	100%	100%	100%	100%	**98%**	**99.6%**	**100%**	☺
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	99.3%	99.8%	99.7%	99.5%	99.9%	**96%**	**97.7%**	**99.7%**	☺
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	98%	96.8%	97.2%	96.2%	97.5%	**93%**	**94.2%**	**97.1%**	☺
Two week maximum wait for symptomatic breast patients	69%	98.2%	99%	98.1%	98.2%	**93%**	**93.3%**	**96%**	☺
2. Outcomes									
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	N/A	Compliant	Compliant	Compliant	Compliant	-	Compliant	☺
Data Completeness for community services: Referral to treatment information#	N/A	N/A	N/A	97.3%	98.4%	**50%**	**+**	**99.6%**	☺
Data Completeness for community services: Referral information#	N/A	N/A	N/A	65.6%	64.6%	**50%**	**+**	**90.7%**	☺
Data Completeness for community services: Treatment activity information#	N/A	N/A	N/A	99.1%	100%	**50%**	**+**	**100%**	☺

N/A applies to targets not in place at that time
– applies to national figures not being appropriate
+ applies to national figures not available

☺ = Target achieved
☹ = Target not achieved
Latest monthly figure for March of the financial year

3.6 Glossary of terms

A&E	Accident and Emergency (also known as ED)
AAA	Abdominal Aortic Aneurysm
ADC	Action for Disabled People and Carers
BBC CRLN	Birmingham and Black Country Comprehensive Local Research Network
Bed Days	Unit used to calculate the availability and use of beds over time
BHF	British Heart Foundation
C. diff	Clostridium difficile (C. difficile)
CCG	Clinical Commissioning Group
CD4	Glycoprotein found on the service of immune cells
CEM	College of Emergency Medicine
CHKS Ltd	A national company that works with trusts and provides healthcare intelligence and quality improvement services
CNS	Clinical Nurse Specialist
COPD LES	Chronic Obstructive Pulmonary Disease Local Enhanced Services
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
DATIX	Company name of incident management system
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
EBMT	European Society for Blood and Marrow Transplantation
ED	Emergency Department (also known as A&E)
EGFR	Epidermal Growth Factor Receptor
ENT	Ear, Nose and Throat
ERCP	Endoscopic Retrograde Cholangio-Pancreatography
FCE	Full Consultant Episode (measure of a stay in hospital)
GP	General Practitioner
HASC	Health and Adult Social Care Scrutiny Committee
HAT	Healthcare Acquired Thrombosis
HCA	Healthcare Associated Infections
HDU	High Dependency Unit
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HIV	Human Immunodeficiency Virus
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
HTA	Human Tissue Authority

IBD	Irritable Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ISCT	International Society for Cellular Therapy
LINK	Local Involvement Network
MBC	Metropolitan Borough Council
MESS	Mandatory Enhanced Surveillance System
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRI	Magnetic Resonance Imaging
MRSA	Meticillin-resistant *Staphylococcus aureus*
MUST	Malnutrition Universal Screening Tool
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCI	Nursing Care Indicator
NICE	National Institute for Health and Care Excellence
NIHR	NHS National Institute for Health Research
NIV	Non Invasive Ventilation
NNAP	National Neonatal Audit Programme
NOF	Neck of Femur
NPSA	National Patient Safety Agency
NSL	The Trust's non-emergency patient transport provider from 01/04/2015
NVQ	National Vocational Qualification
OSC	Overview and Scrutiny Committee
PEAT	Patient Environment Action Teams
PFI	Private Finance Initiative
PROMs	Patient Reported Outcome Measures
RAG	Red/Amber/Green
ROSE	Rivaroxaban Observational Safety Evaluation
SHMI	Summary Hospital-level Mortality Indicator
SKIN	Surface, Keep Moving, Incontinence and Nutrition
SLT	Speech and Language Therapy
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TEAMM	Tackling Early Morbidity and Mortality in Myeloma
VTE	Venous Thromboembolism
WHO	World Health Organisation
WMAS	West Midlands Ambulance Service

Annex

Comment from Dudley MBC Overview and Scrutiny Committee (received 8/04/2015)

The Committee has a role in ensuring the effective planning, development and delivery of quality services across Dudley's patient population by holding system leaders accountable for their performance.

Members recently had occasion to review outcomes against 2014/15 priorities initially consulted on early 2014/15 along with improvement areas moving into 2015/16 and welcomed the opportunity to participate and express strong views through this process. Resultant issues and findings will be factored into the development of the committee's 2015/16 work plan.

The Committee is heartened by sustained commitment to patient experience supported by implementation of recommendations associated with the Committee's previous Dignity In Care review, Healthwatch collaboration and success in the outcomes of Friends and Family Test measures.

Continued focus on mortality tracking with the use of an associated innovative information technology tool and establishing zero tolerance approaches to pressure ulcers is also welcomed; members support the Trust's decision to continue mortality and pressure ulcer reduction as distinct priorities.

The document clearly demonstrates an organisation committed to continuous improvement across patient experience, clinical effectiveness and safety and overall the Trust should be commended on the range of improvements attained throughout 2014/15.

The Committee will remain watchful to ensure the Trust will continues maximise opportunities with system partners to secure further improvements for Dudley communities during 2015/16.

Comment from the Dudley Clinical Commissioning Group (received 2/4/2015)

The CCG is pleased to note the continued focus on quality by the Trust and there are many areas of improvement and good practice to be noted.

The work the Trust has done to gather patient experience data and the development of a patient experience 'app' to be launched in 2015 is commendable as this will provide another platform for patients and the public to share their views. The business cards and posters developed by the Trust to advise patients / public how to raise a concern, compliment or complaint is reassuring. The Trust is to be commended for having consistently received positive feedback from patients through the national "Friends and Family Test".

The CCG has undertaken two unannounced visits to the Trust's clinical areas, one in August 2014, when the visiting team found some areas of concern, which they told the Trust about and which have been dealt with promptly. A further visit was done in March 2015 and the visiting team concluded that no immediate patient safety risks were found, in fact the visiting team observed a range of good practice and passionate and interested staff entirely focused on giving the best possible care to patients.

The Trust has in place a robust mortality tracking system to enable each specialty to review in-hospital deaths. Most specialities are doing well with standard set by the Trust, however several are not and this is a cause of concern to the CCG although it must be noted that the Trust is not an outlier against national mortality indicators.

The Trust has worked hard to improve its performance against the A&E four-hour standard and is one of the best performing Trusts nationally in this area. In March 2015, a new Urgent Care Centre opened at Russells Hall Hospital. This was following a major public consultation by Dudley CCG regarding the redesign of urgent care across the borough with the support of both the Trust and Dudley Health and Wellbeing Board. This new facility is enabling the Trust to provide significant advancements in service and better co-ordinated care with the rest of the local health and social care system in Dudley.

The work on ensuring timely and accurate electronic discharge letters is on-going, following problems in December 2014; however, the Trust is making progress to remedy the situation working closely with GP members of the CCG.

The Trust is taking a significant amount of posts out of the organisation, the CCG has requested quality impact assessments for these from the Trust - at the time of writing this commentary none have been received. The CCG has been assured, however, that a robust process is in place to mitigate any risks to quality, led by the Trust Medical Director and Nurse Director.

The CCG and Trust use a broad range of objective indicators of quality, which together with wider intelligence is proving to be a robust system to assure the wider public of the quality of services. In reading this account the Trust appears to be very hospital centric - the CCG would like to see a greater emphasis on community provision, population focused services and outcomes based measures including further work on Patient Reported Outcome Measures.

Finally, the CCG will work with the Trust in ensuring that the people of Dudley are able to access services of the highest quality that are evidence based and ensure seamless care without organisational boundaries.

Paul Maubach

Chief Executive Officer

Comment from the Trust's Council of Governors (received 2/04/2015)

Governors have worked with the Trust and held the non-executive directors to account for the performance of the Board during a year of financial austerity with further financial pressures in the NHS and increasing demands on Trust services. We note the successful involvement of the Trust in many clinical audits and research trials, and the success of both hospital and community nurses and midwives in winning national awards.

Governors fully support the Chief Executive's Statement in Section 1 of this report and note, in particular, positive comments on the outcomes of the March 2014 Care Quality Commission inspection, the excellent progress with the majority of the Trust's 2014/15 Quality Priorities and the emphasis on quality of care and patient experience.

Governors have further embedded their involvement in Trust governance activity including Ward Walk Rounds with Trust directors and membership of Trust working groups for Patient Experience and for Quality and Safety, both of which report directly to Board Committees. Governors regularly meet executive and non-executive directors both in Council Committee meetings and in update/discussion sessions. Governors are kept well informed by the Board about all aspects of Trust activity and performance.

We are pleased to note the effectiveness of listening to patients as a fundamental part of improving quality at the Trust. A great deal of patient feedback is acquired and analysed carefully. Formal feedback is very positive. Improvements embedded made during the year include a revised complaints process, and re-organisation of the complaints and PALS provision. Trials of new patient food menus have been well-received. It should be noted that wards and staff receive numerous compliments, verbal and written, every year and that hospital inspectors found staff to be very caring.

Governors have met many patients, members of the public and community groups during the year and gained direct feedback about the quality of services and patient experience. Governors find that users' views of clinical treatment and the care provided by our nurses, doctors and other staff is very positive. This is reflected in the above average Friends and Family Test scores achieved by the Trust compared to national benchmarks.

In common with many trusts, failure to meet the A&E four hour target had been of concern for some time. It is very pleasing to note that measures to improve the flow of patients through the hospital have been very effective. The Trust has achieved among the best outcomes nationally in recent months and were very close to achieving the national target of 95 per cent in 2014/15. Governors have strongly supported the development of the new Urgent Care Centre at Russells Hall Hospital scheduled to open in April 2015. This should result in a more appropriate service for all patients and a reduction in waiting and treatment times.

Governors have also seen excellent working with our commissioners and other partners to ensure we continue to improve health services across Dudley. This includes projects such as working with the Dudley Clinical Commissioning Group and Dudley Metropolitan Borough Council to develop integrated care teams.

The process used to ratify the Trust's choice of Quality Priorities gives a wide range of patients, members, governors, staff and other interest groups the opportunity to be involved and to influence choice of priorities. While detail is given in section 2 of this report of the 2014/15 priorities, governors are pleased to note excellent progress and particularly the success in meeting targets for Infection Control, Nutrition, Hydration and Mortality. The Priority target measures for in-hospital call bell answering times and the slight decline in the community performance concerning patient awareness of raising concerns is disappointing. Governors are very pleased to see that the continued focus on pressure ulcers has resulted

in a commendable and dramatic decrease in avoidable pressure ulcers in hospital and the maintenance of very low numbers in the community. Equally the success of the continued focus on reducing hospital associated infections is notable. Commendably, the Trust has met all other key national priority targets.

During 2014/15 the Council of Governors carried out its own annual development review and in consultation with the Board of Directors reviewed the responsibilities of its committees. These will change somewhat in 2015/16 to give further emphasis to patient experience, the quality and safety of services and a renewed focus on membership engagement. These changes will ensure that governors have the information and assurance they need to hold the non-executive directors to account for the performance of the Board of Directors. Governors will maintain their focus on Trust governance and strategic direction.

In summary, the Trust operates under increasing pressure. The growing demands of an ageing population and efficiency measures have to be met while protecting the quality of services and care and safety of patients. That all staff demonstrate such high levels of care and commitment is to be commended. On behalf of patients, carers and the public, governors again wish to place on record their recognition and enormous appreciation of the commitment and excellent work done by staff at all levels in the Trust.

Comment from Healthwatch Dudley (received 2/4/2015)

Healthwatch Dudley can see that The Dudley Group NHS Foundation Trust has worked hard to meet quality improvement priorities as highlighted in the summary of their 2014/15 annual quality accounts.

We can see that progress has been made with capturing patient experiences and there have been a number of developments on the Patient Experience Group. Whilst we can see that the patient experience priority, with strands within the hospital and the community have not been fully achieved, we feel reassured that the Trust is committed to listening to the experiences of patients to improve services. It is important to us that driving improvement in these areas continues across the whole Trust looking forward.

Healthwatch Dudley feels that it is important for the Trust to continue to have a positive relationship with our organisation. This will help ensure that the views of patients and local people are listened to and taken into account, to improve patient experience across all areas of operation.

In 2015/16 we are looking forward to the introduction and development of services including:

- A review of appointment and discharge letters to ensure that patients receive information about who to contact if they are worried after treatment and how to raise a concern. We would welcome an opportunity to review this area in detail.
- The development and introduction of a new patient experience feedback app.
- Helping patients and hospital visitors to be better connected through the introduction of Wi-Fi across the sites.

Jayne Emery

Healthwatch Dudley Chief Officer

Statement of directors' responsibilities in respect of the quality report 2014/15

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2014 to March 2015
    - papers relating to Quality reported to the board over the period April 2014 to March 2015
    - feedback from commissioners dated 2/4/2015
    - feedback from governors dated 2/4/2015
    - feedback from the local Healthwatch organisation dated 2/4/2015
    - feedback from Overview and Scrutiny Committee dated 8/4/2015
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/4/2015
    - the latest national patient survey sampling patients from July 2014
    - the latest national staff survey dated 2014
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 31/3/2015
    - CQC Intelligent Monitoring Report dated December 2014
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the board

Signed **Date: 12th of May 2015**

David Badger
Chairman

Signed **Date: 12th of May 2015**

Paula Clark
Chief Executive

Independent Auditor's Report to the Council of Governors of The Dudley Group NHS Foundation Trust on the Quality Report

We have been engaged by the council of governors of The Dudley Group NHS Foundation Trust to perform an independent assurance engagement in respect of The Dudley Group NHS Foundation Trust's quality report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of The Dudley Group NHS Foundation Trust as a body, to assist the council of governors in reporting The Dudley Group NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Dudley Group NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week referral to treatment – incomplete pathway; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified below:
    - board minutes for the period April 2014 to March 2015;
    - papers relating to quality reported to the board over the period April 2014 to March 2015;
    - feedback from Commissioners, dated 02/04/2015;
    - feedback from governors, dated 02/04/2015;
    - feedback from local Healthwatch organisations, dated 02/04/2015;
    - feedback from Overview and Scrutiny Committee, dated 08/04/2015;
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/04/2015;
    - the national patient survey, dated 2014;
    - the national staff survey, dated 2014;
    - Care Quality Commission Intelligent Monitoring Report dated December 2014;

- the Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2015; and
- any other information included in our review.

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the '*NHS foundation trust annual reporting manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these

criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';

- the quality report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2014/15; and

- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Deloitte LLP
Chartered Accountants
Birmingham
21 May 2015

This leaflet can be made available in large print, audio version and in other languages, please call 0800 0730510

ਜੇਕਰ ਇਹ ਲੀਫ਼ਲੈੱਟ (ਛੋਟਾ ਇਸ਼ਤਿਹਾਰ) ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ (ਪੰਜਾਬੀ) ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰ ਕੇ ਪੇਸ਼ੰਟ ਇੱਨਫ਼ਰਮੇਸ਼ਨ ਕੋ-ਆੱਰਡੀਨੇਟਰ ਨਾਲ **0800 0730510** ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

यदि आपको यह दस्तावेज़ अपनी भाषा में चाहिये तो पेशन्ट इनफरमेशन को-आरडीनेटर को टैलीफ़ोन नम्बर **0800 0730510** पर फोन करें।

જો તમને આ પત્રિકા તમારી પોતાની ભાષા (ગુજરાતી)માં જોઈતી હોય, તો કૃપા કરીને પેશન્ટ ઈન્ફોર્મેશન કો-ઓર્ડિનેટરનો **0800 0730510** પર સંપર્ક કરો.

আপনি যদি এই প্রচারপত্রটি আপনার নিজের ভাষায় পেতে চান, তাহলে দয়া করে পেশেন্ট ইনফরমেশন কো-অর্ডিনেটারের সাথে **0800 0730510** এই নম্বরে যোগাযোগ করুন।

أذا كنت ترغب هذه الوريقة مترجمة بلغتك الاصلية (اللغة العربية) , فرجاء أتصل بمنسق المعلومات للمريض **Information Co-ordinator** على التلفون **0800 0730510**

حسب ضرورت اس لیف لٹ کو اپنی زبان (اردو) میں حاصل کرنے کے لئے براہ مہربانی ٹیلیفون نمبر **0800 0730510** پر پیشنٹ انفرمیشن کو-اورڈینیٹر (مریضوں کے لئے معلومات کی فراہمی کے سلسلے میں افسر) کے ساتھ رابطہ قائم کریں۔

Deloitte.

The Dudley Group NHS
NHS Foundation Trust

The Dudley Group NHS Foundation Trust

Findings and Recommendations from the 2014/15 NHS Quality Report External Assurance Review

Final report: 21st May 2015

Contents

This report sets out the findings from our work on the 2014/15 Quality Accounts.

We would like to take this opportunity to thank the management team for their assistance and co-operation during the course of our review.

Executive Summary

Executive summary

We have completed our Quality Report testing and are in a position to issue our limited assurance opinion

Status of our work

- The scope of our work is to support a "limited assurance" opinion, which is based upon procedures specified by Monitor in their "Detailed Guidance for External Assurance on Quality Reports 2014/15".
- We have received the Trust's final Quality Report and we will issue our final report to the Governors.
- We will be signing an unmodified opinion for inclusion in your 2014/15 Annual Report.

Summary of Quality Priorities

	2014/15	2013/14
Length of Quality Report	94 pages	96 pages
Quality Priorities	6	5
Future year Quality Priorities	5	6

Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in Monitor's Annual Reporting Manual ("ARM").
- Review the content of the Quality Report for consistency with various information sources specified in Monitor's detailed guidance, such as Board papers, the Trust's complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust is required this year to have 18 week referral-to-treatment waiting times as a publicly reported indicator, and has also selected 62 day cancer waits. The alternative was 28 day emergency readmissions.
  - For 2014/15, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected patient nutrition re-assessments.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the 18 week referral-to-treatment waiting times and 62 day cancer wait indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
- Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: 18 week referral-to-treatment waiting times, 62 day cancer wait and patient nutrition re-assessments.

Executive summary (continued)

We have not identified any significant issues from our work

Content and consistency review

Review content → Document review → Interviews → Form an opinion

We have completed our content and consistency review. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015, the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

	Overall conclusion
Content Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?	G
Consistency Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?	G

Performance indicator testing

Interviews → Identify potential risk areas → Detailed data testing → Identify improvement areas

Monitor requires Auditors to undertake detailed data testing on a sample basis of three indicators. We perform our testing against the six dimensions of data quality that Monitor specifies in its guidance. From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Guidance for External Assurance on Quality Reports 2014/15".

	18 week RTT	62 day cancer	Nutrition Re-assessments
Accuracy Is data recorded correctly and is it in line with the methodology.	G	G	G
Validity Has the data been produced in compliance with relevant requirements.	B	B	B
Reliability Has data been collected using a stable process in a consistent manner over a period of time.	G	G	G
Timeliness Is data captured as close to the associated event as possible and available for use within a reasonable time period.	G	G	G
Relevance Does all data used to generate the indicator meet eligibility requirements as defined by guidance.	B	G	G
Completeness Is all relevant information, as specific in the methodology, included in the calculation.	B	B	B
Recommendations identified?	Y	Y	Y
Overall Conclusion	B Unmodified Opinion	G Unmodified Opinion	G No opinion required

G No issues noted B Satisfactory – minor issues only A Requires improvement R Significant improvement required

Content and Consistency Review

Content and consistency review findings

The Quality Report meets regulatory requirements

Content of the Quality Report

We reviewed the content of the 2014/15 Quality Report against the content requirements set out in Monitor's 2014/15 Annual Reporting Manual (ARM).

Based on our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015, the content of the Quality Report is not in accordance with the 2014/15 ARM.

Consistency of the Quality Report

Monitor require Auditors to undertake a review of the content of the Quality report for consistency with the content of other sources of management information specified by Monitor in its "Detailed Guidance for External Assurance on the Quality Reports".

We reviewed the consistency of the Quality Report against this supporting information required by Monitor and:-

- We did not identify any significant matters specified in the supporting information which are not specified in the Quality Report.
- We did not identify any significant areas of the Quality Report that could not be confirmed back to supporting evidence.

Statement of Directors' Responsibilities

Monitor require NHS FTs to sign a Statement of Directors' Responsibilities in respect of the content of the quality report and the mandated indicators. The guidance requires these to be published in the Quality Report.

As part of our review, we have reviewed the Trust's "Statement of Directors' Responsibilities". The "Statement of Directors' Responsibilities" is an un-amended version of the pro-forma provided by Monitor.

Stakeholder Engagement

Monitor require Auditors to consider the processes which NHS FTs have undergone to engage with stakeholders.

The Trust has circulated the Quality Report to stakeholders and feedback has been received from Dudley MBC Overview and Scrutiny Committee, Dudley Healthwatch, Dudley CCG and the Trust's Council of Governors, as required by the ARM.

Performance Indicator Testing

18 week referral-to-treatment waiting times

Our testing has not identified any significant issues

	Trust reported performance	Target	Overall evaluation of work
2014/15	95.43%	>92%	B
2013/14	96.7%	>92%	Not Audited
2012/13	98.1%	>92%	Not Audited

G No issues noted B Satisfactory – minor issues only A Requires improvement R Significant improvement required

Indicator definition

Definition: "The percentage of patients on an incomplete pathway who have been waiting no more than 18 weeks, as a proportion of the total number of patients on incomplete pathways," reported as the average of each month end position through the year.

The NHS Constitution gives patients a legal right to start NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate to do so. This right is about improving patients' experience of the NHS – ensuring all patients receive high quality elective care without any unnecessary delay.

There are three 18 week Referral-To-Treatment (RTT) metrics:

- Admitted: The pathway ends (first definitive treatment) with the patient being admitted e.g. for surgery;
- Non-admitted: The pathway ends (first definitive treatment) with the patient not being admitted e.g. an outpatient attendance OR no treatment required; and
- Incomplete: The pathway has not ended and the patient is still waiting for treatment.

Our work has focused on the **incomplete 18 week RTT metric.**

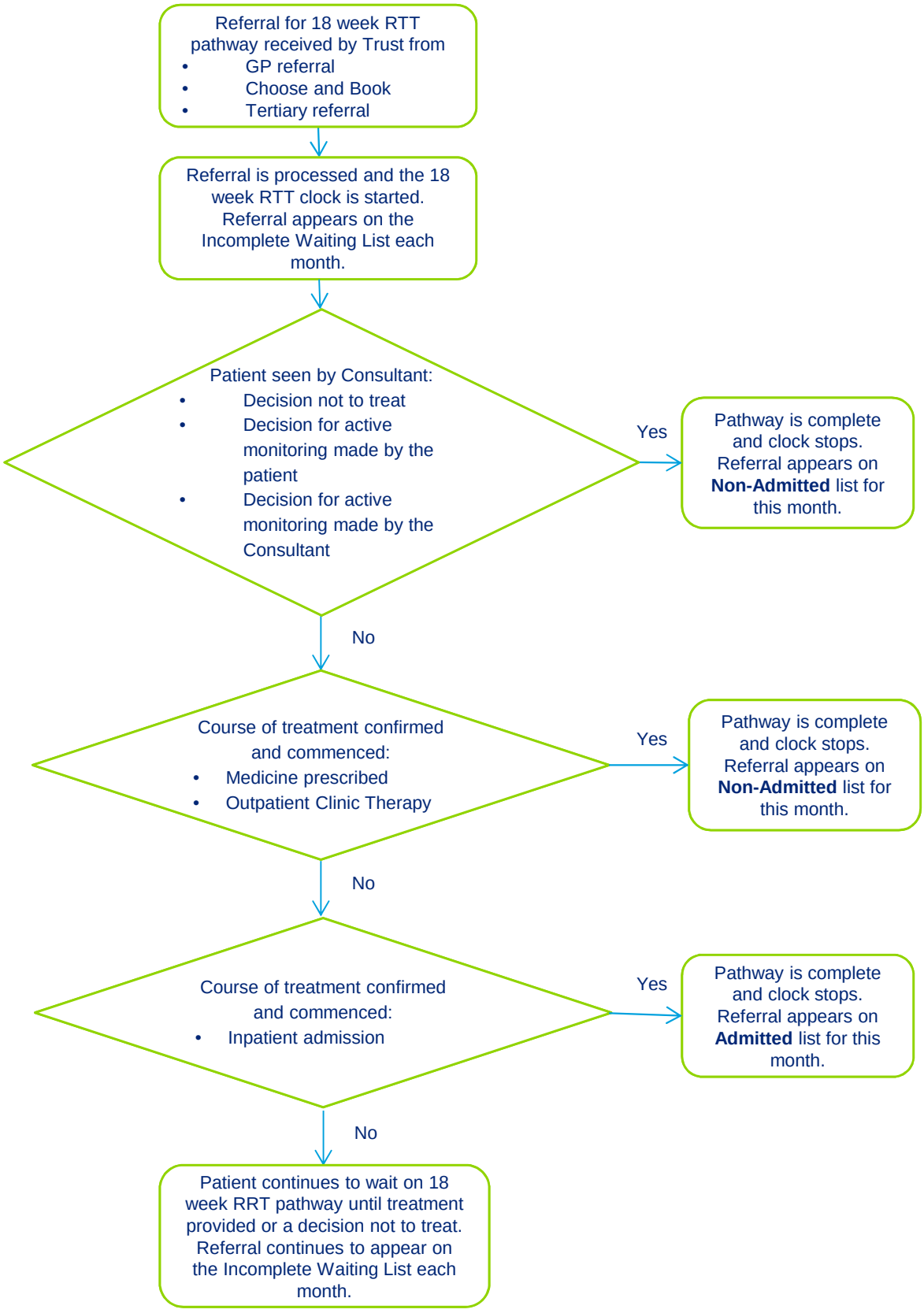
The national performance standard for the incomplete RTT metric (92%) was introduced in 2012.

For the first time, this year Monitor has specified that the 18 week RTT incomplete metric should be subject to testing as part of the Quality Report external assurance process for all acute FTs.

18 week referral-to-treatment waiting times

Our testing has not identified any significant issues

Indicator process



18 week referral-to-treatment waiting times

Our testing has not identified any significant issues

Approach

- We met with the Trust's lead for the 18 week RTT metric to understand the process from patient referral to the result being included in the Quality Report.
- The interview focused on understanding the processes involved. We discussed with management and used analytical procedures to identify whether there were any periods during the year or divisions within the Trust representing a greater risk that we should focus sample testing on. Risk areas were identified to be within specialties with the highest volume of patients waiting over 18 weeks, namely Trauma & Orthopaedics, Urology and Oral Surgery.
- We selected a sample of 40 from 1 April 2014 to 31 March 2015, following patient records through until treatment. 18 of the records selected were within the specialties identified as risk areas in the above paragraph.
- We agreed our sample of 40 to supporting documentation, including patient case notes as provided by the Trust.

Findings

Interviews

- Findings:
    - There is an agreed process in place for data collection. The Information team compiles weekly reports providing a snapshot of all incomplete pathways from the Patient Administration System (PAS). The monthly report is a combination of the weekly reports and presents the amalgamated incomplete wait list position for internal and external stakeholders.
    - Pathways over 40 weeks in length are highlighted for validation and reviewed by the RTT Training Manager for user errors (to feed into training requirements) or system glitches and identifies stakeholder / support service backlogs e.g. diagnostics.
    - The Directorate Manager with RTT responsibility reviews the weekly reports across all specialties for incompletes (outpatient and admitted) identifying long waiters, analysing the overall size of speciality waiting lists to consider if increases are in line with acceptable parameters, predicting the future incomplete picture by evaluating the patient's breach and 'To Come In' dates.
    - Feedback from interviews indicate that the Trust seeks to make sure that patients who are likely to breach receive treatment earlier where practical and appropriate. Where possible, theatre lists are expanded and additional clinics held to deal with spikes in demand.
    - The Directorate Manager chairs weekly RTT meetings with the Assistant Directorate Managers for each specialty to discuss issues and escalate where necessary.
    - Feedback from the Trust suggests that staff members take a proactive approach to errors within RTT data. Assistant Directorate Managers are responsible for reviewing various reports to ensure incomplete waiting lists are accurate (e.g. Missing Clinic Outcome Report, Open Pathway Report, Add to Wait List Report) and considering how to prevent these errors occurring in the future.
    - In particular, the Open Pathway report is run weekly and is used to review all RTT pathways over 14 weeks that do not appear on the incomplete RTT tracking list. It is possible for incomplete RTT pathways to appear on this report as a result of incorrect coding of an activity where no future activities are identified for the patient, such as no 'To Come In' date has been booked. The Trust investigates why these patients are not appearing on the RTT tracking lists and takes action as appropriate to rectify the issue.
    - The Trust looks to address the root cause of errors identified during validation through, for example, retraining, performance management, feedback to PAS supplier where system is not adhering to RTT regulations. Regular audit reviews are undertaken, with an external review being completed two years ago.

18 week referral-to-treatment waiting times

Our testing has not identified any significant issues

- Issues:
  - The RTT patients identified on the Open Pathway Report each month are not combined with the Trust's incomplete RTT reporting list at month end. Our sample testing identified a number of pathways which appear on this report, either at the start of, or during, the RTT pathway. These should be combined with the incomplete RTT list as part of month end reporting. **Recommendation 1: Performance Reporting**

Testing Approach

Our approach to testing was split into two phases:

1) We undertook testing of the clock start and stop dates and the validity of these events to assess whether these were recorded in line with national RTT guidance. As part of this, we also considered any validation undertaken by the Trust and its impact upon the clock start and stop dates.
2) We have also reviewed the RTT tracking lists (including the incomplete, and the two completed lists for admitted and non-admitted pathways) to assess whether, upon continuation or completion, patients appear on all appropriate RTT tracking lists.

Testing

- Findings:
  - The following errors were identified within the sample testing:
    - Clock start and validity testing: 0 (0%)
    - Clock stop and validity testing: 2 (5%)
    - 18 week breach testing: 6 (15%)
    - 18 week incomplete / completed RTT lists: 2 (5%)

- Issues:
  - There are 2 errors with the stop date. 1 of the errors had been validated, but the validated date was found to be an incorrect stop date. Testing identified an earlier stop date for the other error. **Recommendation 2: Staff Training**
  - There were 6 errors identified where a breach was reported but was found not to be a breach. In all 6 instances the stop had been validated by the Trust at a later date. **Recommendation 2: Staff Training**
  - There are 2 errors relating to the waiting lists. Of these:
    - 1 patient does not appear on the non-admitted completed list following a code relating to declined treatment. **Recommendation 3: Sample Audits**
    - 1 patient does not appear on the appropriate RTT tracking list due to incorrect coding. This was subsequently corrected in month, however they do not reappear on a RTT tracking list until the following month. **Recommendation 3: Sample Audits**

    In both cases our testing identified that the patients did not appear on the appropriate RTT lists due to the use of discrete weekly reports. The weekly reports only extract pathways with patient activity that has taken place in that week, and do not extract based on administrative activity. For example, the weekly report would extract a pathway that has a clinic appointment in that week period including any administrative updates applied within the week, but would not extract a pathway where validation of a previous patient activity was the only action in that week period. **Recommendation 4: Weekly and Monthly Reports**

18 week referral-to-treatment waiting times

Our testing has not identified any significant issues

Recalculation

- Findings:
  - The Trust has achieved performance of 95.43% against a nationally set target of 92%. This figure reconciles with the figure included in the Trust's final Quality Report.

- Issues: Not applicable

62 day cancer waiting times

Our testing has not identified any significant issues

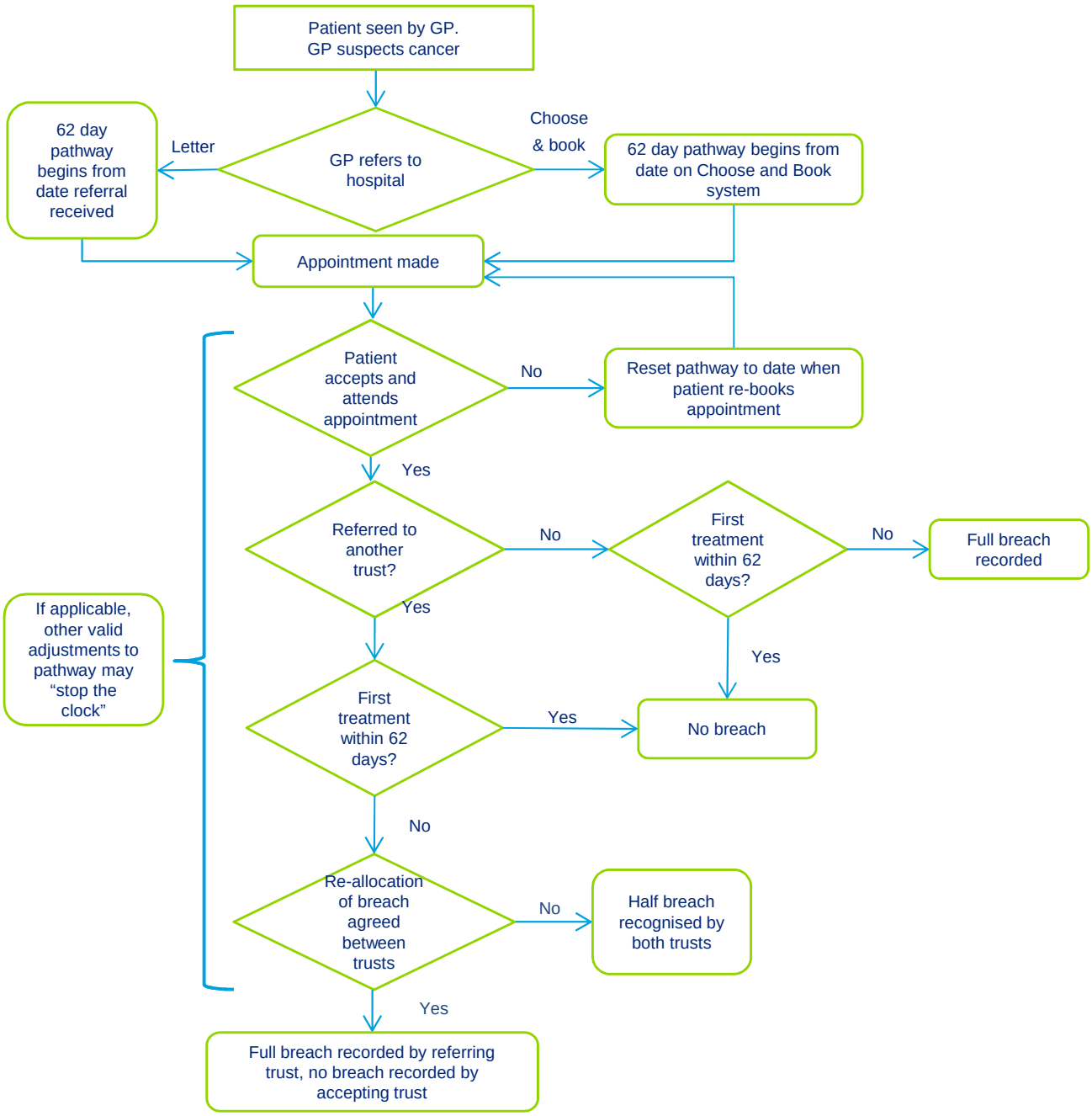
	Trust reported performance	Target	Overall evaluation of our work
2014/15	85.6%	85.0%	G
2013/14	89.0%	85.0%	G
2012/13	88.7%	85.0%	G

G No issues noted B Satisfactory – minor issues only A Requires improvement R Significant improvement required

Indicator definition and process

Definition: "Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer."

The NHS Cancer Plan set the goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons.



62 day cancer waiting times

Our testing has not identified any significant issues

Approach

- We met with the Trust's lead for 62 day cancer waits to understand the process from an urgent referral to the Trust to the result being included in the Quality Report.
- The interview focused on understanding the process involved. We discussed with management and used analytical procedures to focus on pathways which appear to be most at risk of error e.g. patients with manual adjustments and pathways close to the 62 day breach date.
- A recommendation made last year was for the Trust to consider having support in place to cover the Individual Tracking Meetings with each of the MDT co-ordinators in the event that the Assistant Cancer Services Manager is absent from work for any period of time. In response to this, the Trust has introduced a clear escalation process to the Cancer Services Manager.
- We selected a sample of 25 from 1 April 2014 to 31 March 2015 including in our sample a mixture of cases in breach and not in breach of the target. During our work, we found one error that impacted upon reported performance and therefore extended our sample by a further three.
- We agreed our sample of 28 to supporting documentation, including patient case notes as provided by the Trust.

Findings

Interviews

- Findings:
    - There is a established process in place for data collection, with use of the Somerset system to capture all information. MDT coordinators will continually track a patient's progress along the care pathway and escalate cases if they have not received a treatment date by day 42. The 42 day trigger is formally documented within the 'Cancer Waiting Times Breach Policy Guidelines and Escalation Policy'.
    - The data is validated by the Assistant Cancer Services Manager prior to upload on the national Open Exeter database. This validation process involves reconciling breach information on Somerset to admission and discharge information of the patient administration system.
    - A quarterly audit is undertaken to test 25 records against the requirements of the indicator. This has not identified any significant issues.
    - The Trust has individual tracking meetings with each MDT co-ordinator and the Assistant Cancer Services Manager to discuss their Priority Tracking List each week. The Assistant Cancer Services Manager is able to access the MDT co-ordinators tracking notes which are timed, dated and initialled to discuss in the meeting. In response to last year's recommendation, in the event that the Assistant Cancer Services Manager is absent, there is a clear escalation process in place to the Cancer Services Manager.
- Issues: Not applicable.

Testing

- Findings:
    - There were 3 errors identified within the sample testing undertaken as outlined below:
        - Date of Referral (Start Date): 0 (0%)
        - Date of First Treatment (Stop Date): 0 (0%)
        - Adjustments: 2 (8%)
        - 62 day breach testing: 1 (4%)
    - No further errors were identified during testing of the extended sample.

62 day cancer waiting times

Our testing has not identified any significant issues

- Issues:
  - In two instances, Rapid Access Administrators incorrectly recorded rescheduled appointments as DNAs, applying adjustments in situations that are not in line with national guidance. The reversal of these inappropriate adjustments during testing identified a breach of the indicator that had not been identified or reported by the Trust. **Recommendation 5: Staff Training**

Recalculation

- Findings:
  - The Trust has achieved performance of 85.6% against a nationally set target of 85%. This figure reconciles with the figure included in the Trust's final Quality Report.

- Issues: Not applicable

Local indicator: Nutrition re-assessments

Our testing has not identified any significant issues

	Trust reported performance	Target	Overall evaluation of our work
2014/15	92%	90%	G
2013/14	88%	90%	B
2012/13	Not Audited	Not Audited	Not Audited

G No issues noted B Satisfactory – minor issues only A Requires improvement R Significant improvement required

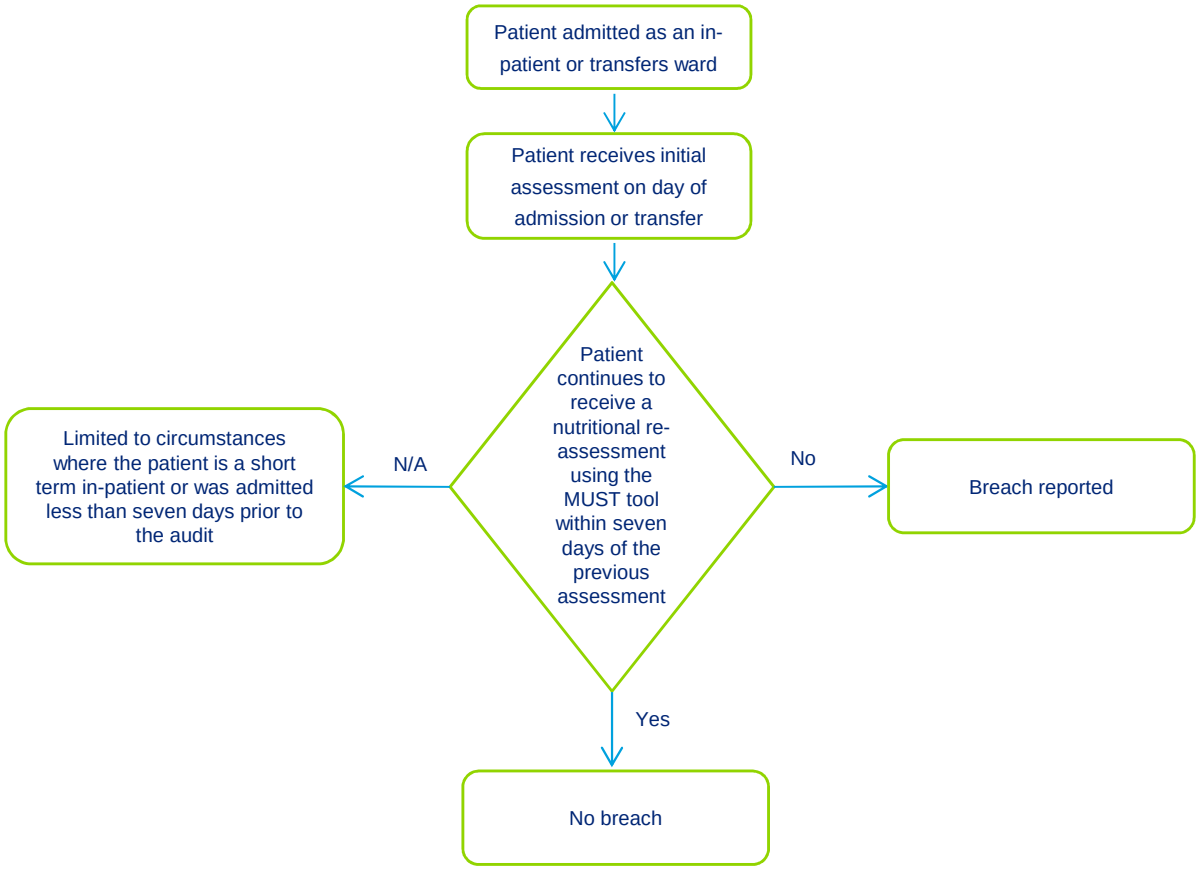
Indicator definition and process

Definition: The percentage of patients audited who have had a weekly re-assessment regarding their nutritional status through the Malnutrition Universal Screening Tool (MUST).

Numerator: The number of audited patients who have received a weekly re-assessment of their nutritional status through the MUST.

Denominator: The total number of patients audited via the Nursing Care Indicators.

The weekly re-assessment is audited as part of the Nursing Care Indicators (NCI) Audit on a monthly basis to ensure Patient Observation Charts are completed correctly and regularly.



Local indicator: Nutrition re-assessments

Our testing has not identified any significant issues

Approach

- We met with the Trust's Quality Project Lead to understand the process from auditing the use of the MUST as part of the wider Nursing Care Indicators (NCIs) to the overall performance being included in the Quality Report.
- Two recommendations were made last year for the Trust to consider as outlined below:
  - The Trust should consider amending the current process to include capture of the Hospital ID numbers of the patients included in the monthly audit of NCIs. The Trust has implemented this recommendation and now captures patient IDs during the audit.
  - The Trust should consider amending the current process of calculating performance for the Nutritional indicator to use the raw data across the year to calculate performance instead of taking an average of each month's performance. The Trust has implemented this recommendation and used this method to calculate the 2014/15 performance for this indicator.
- We selected a sample of 25 records from the period 1 April 2014 to 28 February 2015 to undertake testing.
- We tested the data recorded in the SNAP system back to individual patients' Observation Charts.

Findings

Interviews

- Findings:
  - Lead Nurses are responsible for the completion of the Nutrition re-assessment audit and are allocated by Matrons.
  - Each ward has 10 random patients selected each month which are then audited. The Lead Nurse will audit the Patient Observation Charts, assessing them against a predetermined list of questions, recording the results on a paper form before uploading them to the online SNAP system.
  - The question tested as part of the audit was 5.iii – "The patient is re-assessed weekly using the MUST Tool". The possible answers are "Yes", "No" or "N/A". "Yes" or "No" will be recorded if the selected patient has or has not received a re-assessment within 7 days of the previous assessment. "N/A" will be recorded if the selected patient is a short term inpatient or was admitted less than a week ago.
  - The Lead Nurse will check the Patient Observation Charts to see if the patient has had a weekly MUST re-assessment undertaken and record the appropriate answer on the paper form.
  - At the end of the audit, Lead Nurses complete a feedback report to advise the Lead Ward Nurse of any issues arising from the audit.
  - The Lead Nurse then has ten days within which to upload the results recorded on the paper forms to the online SNAP system. The system replicates the paper form for each question. If any questions are not answered, the system will alert the user and not let them continue to the next page.
  - If the audit has not been completed and uploaded by day ten, Lead Nurses are given notice of outstanding audits with day 14 given as the deadline. Audits outstanding post day 14 would be escalated to the Head of Nursing.
  - Once the data has been submitted, this is downloaded off the SNAP system by the clinical audit team and exported to an Excel spreadsheet. The spreadsheet is then configured to provide a RAG rating and percentage achievement for each question, section and for the overall NCI.
- Issues: Not applicable

Local indicator: Nutrition re-assessments

Our testing has not identified any significant issues

Testing

- In previous years, the results of the NCI audit were anonymised and could not be traced back to individual patients, therefore we were unable to test a sample against Patient Observation charts.
- In response to last year's recommendation, patient IDs are now captured. As a result, our approach to testing has altered and we have tested the data recorded in the SNAP system back to individual patients' Observation Charts.
- Findings:
    - There were 3 errors identified within the sample testing undertaken as outlined below:
        - Ward ID: 0 (0%)
        - Result of Question 5.iii: 3 (12%)
- Issues:
    - The errors identified during testing appear to be the result of local guidance relating to the NCI audit being misinterpreted, particularly around the appropriate recording of "N/A" during the audits.
    - Local guidance around the NCI audit may not be consistently interpreted by Lead Nurses. **Recommendation 6: Staff Training**

Recalculation

- Findings:
    - The Trust has achieved performance of 92% against a target of 90%. This figure reconciles with the figure included in the Trust's final Quality Report.

- Issues: Not applicable

Recommendations for Improvement

Recommendations for improvement

We have made the following recommendations as a result of our testing

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
18 week referral-to-treatment	**1) Performance Reporting** The Trust should consider combining the Incomplete RTT tracking list with the number of RTT patients identified on the Open Pathway Report prior to submitting its monthly return.	The recommendation of merging the Open Pathway Report with the Incomplete RTT month end report prior to submission is one that we would support, however, not until there is assurance that the Open Pathway Report has been fully validated. The Trust has been working on validating the Open Pathway report since November 2014 but more work is required before the report is robust enough to be used as part of the monthly RTT submission. Until this is done, the Trust would not be showing an accurate RTT incomplete position. **Responsible Officer:** Kevin Shine **Timeline:** 31/08/2015 **Process for updating Council of Governors:** Finance & Performance Committee	**High**
18 week referral-to-treatment	**2) Staff Training** The Trust should consider targeted training for and communication with departments or staff who are repeatedly found to incorrectly record activity outcomes or fail to appropriately stop the clock, in line with national RTT guidance.	Yes, this is already done as a result of validating the over 18 week records, but will be extended to include any erroneous actions. **Responsible Officer:** Karon Finlow **Timeline:** Monthly from 31/05/2015 **Process for updating Council of Governors:** Finance & Performance Committee	**High**
18 week referral-to-treatment	**3) Sample Audits** In line with best practice, the Trust should consider undertaking sample audits across RTT lists. Audits should focus on data quality across the RTT pathways, as well as data completeness to monitor whether patients are being transferred between RTT lists appropriately.	Yes, records are reviewed as a result of validating the over 18 week records, but will be extended to include a random selection of RTT pathways each month to ensure accuracy. **Responsible Officer:** Karon Finlow **Timeline:** Monthly from 31/05/2015 **Process for updating Council of Governors:** Finance & Performance Committee	**Medium**

Recommendations for improvement

We have made the following recommendations as a result of our testing

Indicator	Deloitte Recommendation	Management Response	Priority (H/M/L)
18 week referral-to-treatment	**4) Weekly and Monthly Reports** The Trust should consider using the weekly reports for their current review and validation purposes, but not to create the RTT lists for monthly submission. The Trust should consider using a full month extract to create the RTT lists in time for the submission deadline. This full month extract should be able to incorporate in-month validation and delayed entry of clinic outcomes.	The Information Department already produces a month end RTT report based on the weekly extracts together with a further month end report which looks for pathways that have had their outcome codes entered late, however, it does not currently look for pathways where a valid RTT status code was initially included in the weekly report but then subsequently changed with another valid RTT status code later in the month. Therefore, a new query needs to be created to look for these attendances where the RTT status code has been validated at a later date. **Responsible Officer:** Kevin Shine **Timeline:** 31/08/2015 **Process for updating Council of Governors:** Finance & Performance Committee	**Medium**
62 day cancer waits	**5) Staff Training** The Trust should consider providing training to the Rapid Access Administrators to ensure that rescheduled appointments are not incorrectly recorded as DNAs and inappropriate adjustments are not applied.	The Trust will organise training. All Rapid Access Administrators to receive update training on the management of DNAs. **Responsible Officer:** Jane Gritton **Timeline:** 31/05/2015 **Process for updating Council of Governors:** This will be undertaken as part of the quarterly reports on the Quality Account.	**Medium**
Nutrition re-assessments	**6) Staff Training** The Trust should consider providing refresher training for Lead Nurses that undertake the NCI audit to ensure local guidance around weekly re-assessments is consistently interpreted.	With the changes in some of the criteria of the NCIs, in October 2014 all Lead Nurses attended a training event. All Lead Nurses will be reminded of the rules and processes involved with the system to reduce the risk of error. **Responsible Officer:** Karen Broadhouse **Timeline:** 31/05/2015 **Process for updating Council of Governors:** This will be undertaken as part of the quarterly reports on the Quality Account.	**Medium**

Update on prior year recommendations

Our prior year recommendations have been addressed

Indicator	Deloitte Recommendation	Current year status
62 day cancer waits	**Absence Cover** The Trust should consider having support in place to cover the Individual Tracking Meetings with each of the MDT co-ordinators in the event that the Assistant Cancer Services Manager is absent from work for any period of time. **Responsible Officer:** Jane Whitehouse / Jane Gritton **Timeline:** May 2014	In the event that the Assistant Cancer Services Manager is absent, the Trust has implemented a clear escalation process to the Cancer Services Manager. This is in accordance with the Trust's Cancer Services Escalation Policy.
Nutrition re-assessments	**Audit Process** The Trust should consider amending the current process to include capture of the Hospital ID numbers of the patients included in the monthly audit of NCIs. **Responsible Officer:** Karen Broadhouse **Timeline:** June 2014	Monthly NCI audits now capture the Hospital ID numbers of the patients included in each audit. This was implemented from the audit in July 2014.
Nutrition re-assessments	**Recalculation** The Trust should consider amending the current process of calculating performance for the Nutritional indicator to use the raw data across the year to calculate performance instead of taking an average of each month's performance. **Responsible Officer:** Karen Broadhouse **Timeline:** May 2014	The Trust has implemented the recommendation and the calculation of performance has been amended. Raw data across the year is used to calculate annual performance instead of taking the average of each month's average performance.

Responsibility Statement

Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under Monitor's Audit Code to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

Other relevant communications

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.

We welcome the opportunity to discuss our report with you and receive your feedback.

Deloitte LLP
Chartered Accountants

21 May 2015

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name or this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose, but as made clear in our engagement letter dated 10 February 2014, only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

Appendices

Data quality

For evaluating the findings from our testing

Indicator definition and process

The volume and importance of non-financial performance information across the NHS has grown significantly in recent years. Performance reporting has emerged as a key tool used both internally and externally. Managers use information to monitor performance, regulators use it to gauge risk, commissioners use it to ensure their priorities are met, and governors, patients and the public use it to gain more information about their trust and to hold them to account.

Whilst the availability and use of non-financial performance information has developed quickly, the control frameworks used to produce and control such information has not been subject to the same level of rigour as that of financial information. On average a trust will receive information on 61 performance indicators on a monthly basis, but very few will be subject to independent review. This can result in a potential assurance gap.

In the table below we have prepared a summary of key considerations that each trust should be able to answer regarding their performance information. It can be used as an assurance tool to gauge the risk around accuracy and completeness of performance information.

Area	Overview	Key considerations
System	The accuracy of an indicator is influenced by the level of automated vs manual controls. In general, an automated system requiring minimal manual adjustment has a lower risk of error. However, this assumes that the system controls are operating as they are intended.	• Is the indicator generated from one system or the interaction of different systems? • How often are system controls reviewed to ensure they are appropriate and meet indicator definitions? • How quickly is data produced after the event? • Does data require manual adjustment prior to being reported as a performance indicator?
Governance	Accuracy and completeness of indicators are influenced by the 'tone at the top'. Good performance would mean clarity of responsibility for performance metrics, clear processes and procedures in place for each metric which are regularly updated, and quick and comprehensive action where concerns have been raised.	• Who is responsible for the quality and completeness of performance information at Board level? • If different individuals are responsible for different indicators, is it clear who is responsible for each? • Are there documented procedures and processes for each indicator and is this regularly updated? • If data quality concerns have been raised have they been addressed quickly and comprehensively?
Inputs	Some performance indicators rely on a wide variety of sources to produce the end metric. In general, the greater the number of separate sources of information, and the higher the volume of data, the greater the likelihood of error.	• What is the volume of inputs of each indicator on a daily / weekly / monthly basis? • How many different sources of data are there, and how do you know they all apply consistent? methodology in collecting and reporting the data? • What checks are in place to ensure the consistency and completeness of input data?
Complexity and skill	Some indicators require specific skills to identify, analyse and report performance. Some indicators have complex rules, which requires specialist consideration. If the complexity of these rules is not understood and applied correctly, there is a risk that indicators contain errors or are reporting incomplete information.	• If performance indicators have specific rules, is there regular training to ensure that all individuals involved understand these rules and apply them correctly? • Does the Trust have its own assurance systems in place to test compliance with such rules? • Has the Trust got the appropriate skill and level of resources to identify, analyse and report performance for complex indicators? • If national guidance is not clear, does the Trust have local guidance regarding process and procedures and is this shared with appropriate individuals?

Data quality responsibilities

The new False or Misleading Information offence applies to this year's Quality Accounts

New legal responsibilities over data quality

From 1 April 2015, health providers are subject to the False or Misleading Information ("FOMI") offence, introduced in response to issues over data quality in the NHS. The FOMI offence applies to:

- specified information which trusts already report regularly to the Health and Social Care Information Centre; and
- the contents of the Quality Accounts.

The FOMI offence is a two stage offence:

- firstly, a NHS or private sector provider organisation is guilty of the offence if it provides information that is false or misleading whether intentionally or through negligence i.e. this is a strict liability offence where intent is not relevant to the offence being committed.
- secondly, if a provider has committed and offence, it is possible that a director or other senior manager or other individual playing such a role may be personally guilty of an equivalent of the FOMI offence as well.

The potential penalties for providers include fines, a requirement to take specific action to remedy failures in data reporting, or to publicise that the offences have been committed and corrected data. For an individual, penalties can be an unlimited fine or up to 2 years in jail.

Providers and individuals are able to make a defence that they reported information having taken "took all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information"– however it is currently unclear what would be interpreted as "reasonable" in this context. In practise, there is likely to be significant discretion exercised in determining whether to mount a prosecution.

Deloitte view

Over the course of the year, we have updated the Trust on the potential implications of the offence and have discussed with management the findings from our Quality Accounts work in the context of the offence. We have recommended additional wording to make clear the inherent limitations of recording and reporting some metrics. The Trust has incorporated some of this within the Quality Report in order to present reported data in the appropriate context.

The scope of the FOMI offence is wide ranging, and covers many more indicators and data sets than are considered in our Quality Accounts data testing of three indicators, or than Internal Audit are able to cover in their data work each year. In order to be able to demonstrate across all reported metrics that they have taken "all reasonable steps and exercised all due diligence to prevent the provision of false or misleading information", providers are ultimately reliant upon the quality of their systems for data recording and information reporting.

However, accurately reported data is not just a compliance requirement – it is a prerequisite for creating an insight driven organisation. A lack of accurate, complete and timely data can increase operational and financial risk. Failure to govern and use data effectively can lead to poor patient experiences and reputational damage. Data issues can also undermine a Trust's ability to run an efficient service, as key information that should influence decision making is not available or accurate.

To support boards in considering their use of data, our latest NHS Briefing on Data Quality highlights areas of good practice for Trusts to consider in improving how they govern and use data. Key questions for Trust boards to consider include:

- Is there a risk that your reported data is not accurate or that you are making decisions on unreliable data?
- What sources of assurance has the Board sought around the quality of data? Do you place too much reliance on the mandatory external data governance reviews to assure data quality?
- Is there an opportunity to improve patient outcomes, patient experience, operational efficiency and financial performance of your Trust by using data in a more sophisticated way?
- Has your Trust adequately identified the costs and benefits associated with a data governance effort?
- Does your Trust have in place a system of Data Governance designed to address data quality concerns and enable more effective data usage?
- Is your data governance effort owned at a sufficiently senior level and is the Board aware of data governance issues and concerns?
- Has your Trust set out its analytics and information vision and strategy?
- Is your analytics and information strategy aligned to other Trust strategies?
- Does your Trust have the analytics capacity, capability and technology to exploit its data assets effectively?

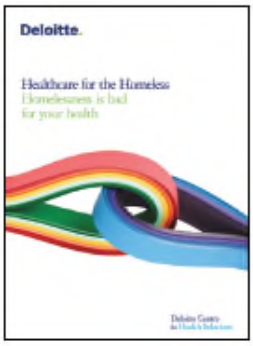
Events and publications

Our events and publications to support the Trust

Deloitte UK Centre for Health Solutions

The Deloitte Centre for Health Solutions generates insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry. Working closely with other centres in the Deloitte network, including our US centre in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors; health providers and purchasers; and consumers and suppliers.

Deloitte Centre for Health Solutions



Recent reports include:

- Connected Health;
- Healthcare and Life Science Predictions 2020;
- Better care for frail older people;
- Guideposts Dementia Information Prescription, in partnership with the Guideposts Trust; and
- Working differently to provide early diagnosis.

Upcoming studies include End of Life Care, and the Cost of Compliance.

For access to our latest studies and opinion pieces, please sign up to receive our weekly blog at http://blogs.deloitte.co.uk/health/ or email centreforhealthsolutions@deloitte.co.uk:

NHS Briefings and publications for the Trust

We provide the Trust through the year with publications and access to webinars and information on accounting requirements, including our “Stay Tuned Online” accounting update sessions.

We regularly publish NHS Briefings designed to disseminate our insights on topical issues within the NHS in general, and Foundation Trusts in particular. They focus on current issues facing the sector and ask questions to help readers assess if the issue is being appropriately addressed at their Trust.

Briefings have covered a range of topics including Data Quality, The Dalton Review: Implications for providers, Joined up QIPP, Patient Administration Systems, Effective Boards, the Evolving Role of Governors, Narrative Reporting, Quality Accounts requirements, Human Resources, Mergers & Acquisitions in the NHS, Transforming Community Services, and the challenges of Monitor’s Quality Governance framework.

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Board of Directors on 2 July 2015

TITLE:	**Corporate Risk Register and Assurance Report**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVES ALL			

Attached is the Corporate Risk Register and accompanying Assurance Analysis that was presented to the Risk and Assurance Group on the 16th June.

Corporate Risk Register

The Corporate Risk Register records the Trust's key risks linked to each of the Trust's six objectives. The Register includes those key risks to the Trust's objectives as recorded with the Trust's annual plan (these are seen as the top down risks), it also includes those risks that have been escalated from the Trust's Divisions / Directorates (these are seen as bottom up risks). Attached to the Corporate Risk Register analysis is a list of the key Division / Directorate risks which they are managing and have been agreed do not need escalating.

The Risk and Assurance group met on the 16 June to review the Corporate Risk Analysis along with the Divisional Risk Registers. The Group on reviewing the information presented to them determined that four risks should be added to the Corporate Risk register, two of these were risks being escalated from Divisional / Directorate Risk Registers.

Below is a summary of the changes to the Corporate Risk Register

- Two risks have increased since last year, but recognizing that whilst the risks are similar to those last year they are not identical. The Executive has reconsidered the likelihood of failing the cancer target (linked to risk COR079) higher based on recent past performance and a greater understanding of the control environment and for the second risk (COR077) the Executive has reconsidered the impact of the second tranche of workforce reductions as posing a higher risk than the delivery of the first.

- There are eight new risks, which is to be anticipated, as the Trust has revised its annual plan and objectives.

- There are four risks that have been escalated from the Divisions as they have a corporate wide potential impact.

- There are also two risks that have reduced (COR080 and COR081) which are linked to the delivery of the Trust's CIP and its long term financial sustainability. One risk has been archived (COR044) and will be replaced by a new better defined risk for the next meeting.

Corporate Risk Assurance Register

Supporting the Corporate Risk Register is an Assurance Register which records the details of the assurances received to date, noting that this records the origin of the assurance, e.g. operational management through to an external source. As this assurance is collated across the

year management and the Board will be able to see the relative strength of assurance against each risk underpinning each objective. This register as it becomes populated across the year will be reported the Risk and Assurance Group and Audit Committee.

Attached is the analysis of this register which reflects that for the first two months of the year for three of the six objectives assurances still need to be registered. Given the timing in the year and the roll out of the Trust's enhanced processes it should be noted that this does not mean the Executive are not assured just that the assurance has yet to be registered. For the other objectives there is one negative assurance against one of the risks within each of those three objectives, each of these negative assurances confirm the control weaknesses that have driven the score registered for that risk so no change to those recorded risk scores are planned.

It is intended that the assurance register and the gaps is assurance will be reported to the appropriate board committee with the key responsibility for the stated Trust Objective to allow them to review their cycle of business to close these gaps within the year.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		

Action for the Board

To note the Trust's corporate risks as at the end of May.

To approve that corporate risk assurance register will be circulated to relevant Board Committees to further enhance the Trust's risk management process by focusing attention on the securing of expected assurances within the year.

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK REGISTER – JUNE 2015

Risk Dashboard – rolling risk score trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
					09/09/14	09/12/14	17/03/15	05/06/15						
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer) *	20	20	20	15	20					↑	8
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	25	25	16	16	16					→	8
	DG	COR084	Failure to embed the improvements from our last CQC inspection	12			new	12						8
S02	MD	COR072	The Trust does not consistently send discharge information to GP	20	20	20	20	20					→	4
	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	8	15	15	15					→	10
	CN	COR085	Failure to maintain the delivery of the safer staffing levels in relation to ward nurse staffing	20	esc	20	20	20					→	15
	CN	COR081	Nurse / Midwifery revalidation fails	12			new	16						8
	CN	COR082	Failure to deliver the significantly reduced C.Diff target of just 29 cases within 2015/16	20			new	20						10
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16			new	16						8
	CN	COR087	The number of grade 3 and 4 pressure ulcers potentially increase	12			esc	12						12
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20			new	20						15
	DF	COR084	IT Strategy does not deliver	16			new	16						16
	MD	COR044	The need for a medical workforce plan that is fit for purpose	12	new	12	12	arc						4
S04	CHR	COR077	Workforce reduction programme will adverselty affect patient care and trust performance	20		esc	9	16					↑	9
	DN	TBC***	Inadequate nurse staffing levels	16			esc	16						
	MD	TBC***	Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director may result in a failure to properly discharge the duties of Responsible Officer for Medical Revalidation and the Trusts' function as a Designated Body.	8			new	8						4
S05	DG	COR088	Failure of DATIX system to support the business	16			esc	16						6

The Dudley Group NHS
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Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
					09/09/14	09/12/14	17/03/15	05/06/15						
	DF	TBC***	The IT DR arranegments are not effective	20			new	20						12
	DSP	COR080	Failure to deliver our CIP programme **	20	20	20	20	12					↓	9
	COO	TBC***	Ineffective Business Continity Plans	20			esc	20						10
SO6	DF	COR061	Failure to maintian financial sustainability	20	20	20	20	16					↓	5

* merged from three previous risks – prior period is highest risk score from each of the three indicators
** a similar risk was in the prior year (COR065) so this has been used for the past trend
*** a specific risk reference has to be allocated by the system

Key for Risk Lead	
CE	Chief Executive
MD	Medical Director
CN	Chief Nurse
DF	Director of Finance and Information
COO	Chief Operating officer
DSP	Director of Strategy and Performance
DG	Director of Governance
CHR	Chief HR Advisor

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

Key for risk	
New	New risk identifed
Esc	Risk esculated from lower division / directorate etc
De-esc	Risk de-esculated to the lower division / directorate to manage
Arc	Risk no longer valid

NOTE when a risk is esculated it is recalibrated against the impact and liklihood at a corporate level and vice versa when a risk is de-esculated to the division / directorate. Therefore a risk at a divisonal level scoring 20 (4 liklihood x 5 impact) may score on a 12 (4 liklihood x 3 impact) as a corporate level.

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DIVISIONAL / DITECTORATE KEY RISKS – JUNE 2015

Division	ID	Risk Description	Current Score						Trend	Target Risk Score
			30/04 /15	31/05 /15						
Medicine and Community	DO16	Radiology capacity is insufficient to provide a safe, robust, fit for purpose service that meets the needs of the Trust. This could potentially delay diagnostic imaging and reporting, thus impacting on the quality of patient care	15	15						10
	DMC002	Failure to control Directorate overspend	20	16						4
	DMC006	Dudley Group NHS Foundation Trust is not meeting the needs of patients at the end of their life and is therefore providing a poor quality service (as shown with the failure of 6 out of 7 KPIs associated with The National Care of the Dying Audit for Hospitals)	20	16						4
	new	There is a risk that a Haematology and Blood Transfusion service cannot be maintained at The Dudley Group NHS Foundation Trust due to poor retention and recruitment of qualified staff which will adversely impact on patient care.	new	15						new
	new	There is a risk that a Clinical Biochemistry service cannot be maintained at The Dudley Group NHS Foundation Trust due to poor retention and recruitment of qualified staff which will adversely impact on patient care.	new	15						new
Surgery	NP035	Lack of peadiatric medical workforce capacity to meet service demainds, service standards and recommendations	16	16						9
	SUV005	Limited outpaitent elective theatre in Urology.	15	15						12
	SUV006	The Trust is unable to guarentee the availaibity of BCG supplies for treatment of high risk non muscle invasive bladder cancer	15	15						12
	OSS006	The demand for the Paediatric Orthopeadic Service currently exceeds the capacity we are able to provide	15	15						10
Nursing	N013	Catering trolleys are taken into the 4 bedded bays on peediatric ward	16	16						4
	N009	Staffing estbalishment level on B2 does not support full care requirments for demientia / acutely confused patients	15	15						6
	N020	Paediatric Speech and Language Therapy Dysphasia Service	15	15						6
Corp Depts	new	Insufficient resources in the Governance Team does not support the organisation	new	16						4
	ST001	Lack of progress on major service and cost improvement change leadign to delays in qulaity and efficency gains. Skill levels of Lean Practicioners not up to the level required to lead major change projects	16	16						12
	FI003	In the event of one or more primary system failures, current IT DR may be insuffucent	15	15						6
	FE004	Failure to estbalish accountability for the prevention of legionella within PFI buildings	15	15						10

The Dudley Group NHS
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CORPORATE RISK ASSURANCE ANALYSIS – APRIL TO END OF MAY 2015

The following report provides information on the assurances registered in respect to key controls mitigating the corporate risks within each of the Trust's six strategic objectives.

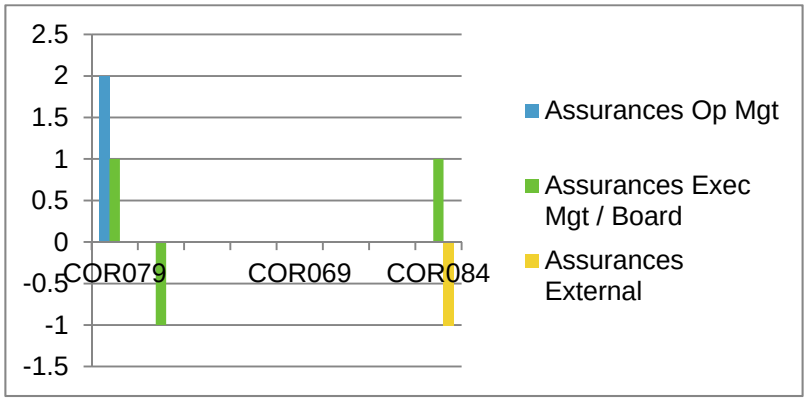
The assurances received are analysed over their source from level 1 (those received from operational management), level 2 (those received from executive management or a board committee) to level 3 (those provided by an external source). Whilst most expected assurances will come from operational management it is key to give relevant weight to those from levels 2 and 3 when assessing the robustness of management's view of the control environment.

Note that the risks highlighted in **RED** are seen as those principal risks within each strategic objective and they form the Trust's Assurance Framework and thus are given further scrutiny by the Board.

Strategic Objective 1 - Deliver a great patient experience

Extract from the Corporate Risk Register

Strat Obj	ID	Inherent risk score	Current Score	Target Risk Score
			16/06/15	
SO1	COR079	20	20	8
	COR069	25	16	8
	COR084	12	12	9



COR079 has a risk rating of 20, which is at the same level as its uncontrolled risk level thus reflecting that the Executive Team is not confident on the strength of the control environment. This is supported by the negative operational assurance received in relation to the Cancer targets.

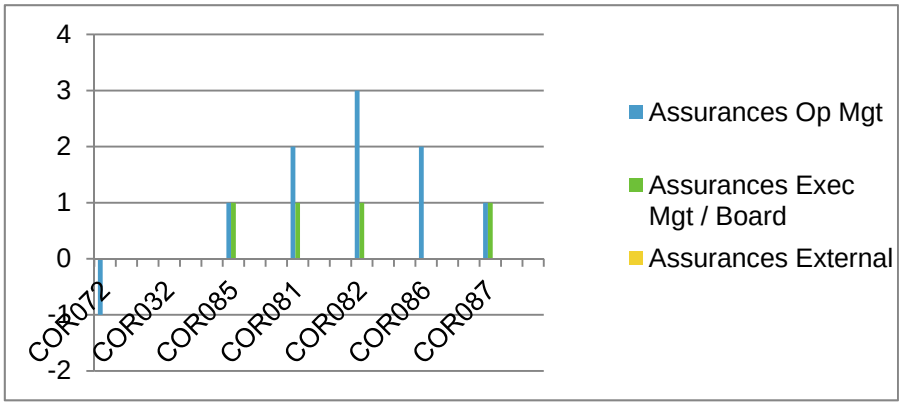
COR069 has a current risk rating of 16 against an uncontrolled risk of 25 yet no assurance over these controls has been received.

COR084 has only received one positive executive management assurance at this time, but there are elevated risks within the CQC intelligent monitoring report therefore these have been treated as negative assurance until these are resolved.

Strategic Objective 2 - Safe and caring services

Extract from the Corporate Risk Register

Strat Obj	ID	Inherent risk score	Current Score 16/06/15	Target Risk Score
S02	COR072	20	20	4
	COR032	15	15	10
	COR085	20	20	15
	COR081	16	16	8
	COR082	20	20	10
	COR086	16	16	8
	COR087	12	12	12



COR072 has received a negative operational management assurance which confirms weak controls which supports the risk rating of 20.

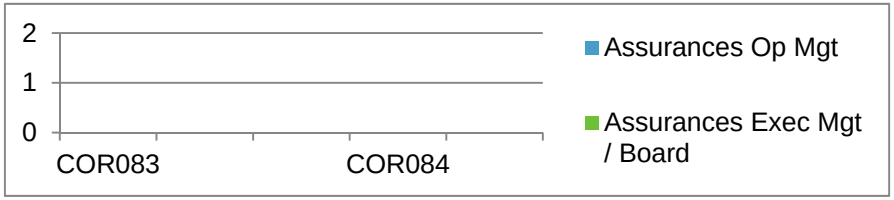
COR032 has a current risk rating of 15 against an uncontrolled risk of 15 however no assurance over the controls in this area has been registered.

All other risks within this objective have received positive assurance over the controls mitigating these.

Strategic Objective 3 - Drive service improvement, innovation & transformation

Extract from the Corporate Risk

Strat Obj	ID	Inherent risk score	Current Score 16/06/15	Target Risk Score
SO3	COR083	20	20	15
	COR084	16	16	16

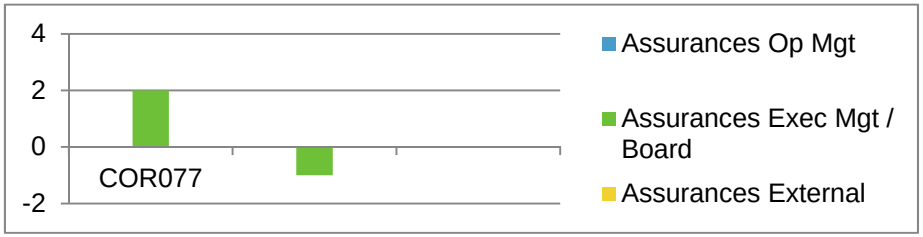


To date, no assurances have been registered in respect of these risks.

Strategic Objective 4 - Be the place people chose to work

Extract from the Corporate Risk Register (note this excludes the one new and escalated risk to be registered on the underlying system)

Strat Obj	ID	Inherent risk score	Current Score 16/06/15	Target Risk Score
SO4	COR077	20	18	9

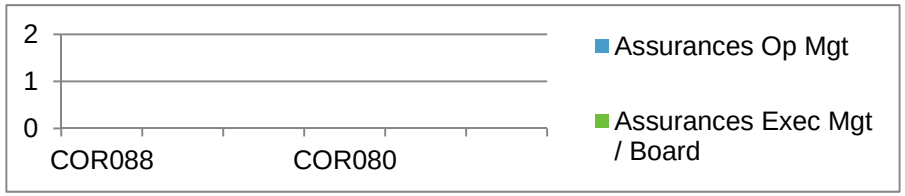


Whilst three assurances have been received, one of these confirmed the degree of risk (not well established controls) regarding the deliverability of the future workforce revisions and thus the risk ranking of 18 remains appropriate.

Strategic Objective 5 - Make the best use of what we have

Extract from the Corporate Risk Register (note this excludes the one new and escalated risk to be registered on the underlying system)

Strat Obj	ID	Inherent risk score	Current Score 16/06/15	Target Risk Score
SO5	COR088	16	16	6
	COR080	20	12	9

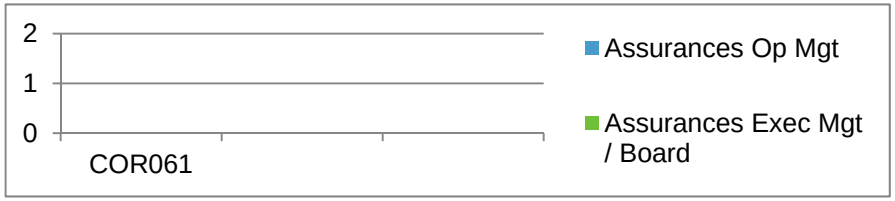


To date, no assurances have been registered in respect of these risks.

Strategic Objective 6 - Plan for a viable future

Extract from the Corporate Risk Register

Strat Obj	ID	Inherent risk score	Current Score 16/06/15	Target Risk Score
SO4	COR061	20	16	5



To date, no assurances have been registered in respect of this risk.

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FULL CORPORATE RISK REGISTER

Risk Ref	Risk	Risk Start 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)]	The Trust does not consistently send discharge information to GP	12/06/2014	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. 4. 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. 5. In order for discharge summaries to appear in Soarian, a folder in the Keystone system is searched and documents copied to Soarian. 6. 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. 7. Multiple individuals complete the TTO letter, with no clear final sign-off process.	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. 5. Documents in the Keystone folder appear in Soarian. 6. Staff should then reclose the admission so that any future admissions are generated correctly. 7. 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 a expiry date on TTOs – approx 48 hours. 12. There must be a robust audit process around discharge letters	2. If the patient has an open episode in JAC, the message will not be processed resulting in no discharge being created 3. The JAC to Keystone interface is not actively monitored. The Keystone system is used to send discharge summaries to GPs 4. This requires resources from the Trust to match patients across both systems 5. 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 6. Staff are able to override the closed admission in JAC by manually opening a spell previously closed by OASIS 8. The drug list on JAC has not been updated for 7 years, meaning not all drugs can be picked accurately 9. Patient's medication and diagnosis may change during that time, but this will not be included on the TTO 10. When Pharmacy	2. It is not easy to monitor the JAC system for open episodes where a patient has been discharged in OASIS. 3. 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 4. 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. 5. Documents belonging to Incompatible GPs are not created in the Keystone folder and they do not get sent to GPs or Soarian, however, delays in updating the	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 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 6. Create a new set of processes that only permit a select group of users to reopen correctly closed spells 8. Display urgent message on the Hub 9. Review TTO process to ensure it is clinically safe	30/06/2014	4	1	4

Risk Ref	Risk	Risk Start 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
				8. Not all drugs can be included on JAC from the picklist. 9. 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. 10. There are many prescribing errors on TTOs which have to be corrected in Pharmacy. 11. The GP list of emails on Keystone is not up to date. 12. Dudley CCG monitors receipt of discharge summaries twice yearly, to monitor contract standard target.					updates a TTO, there is no process for a further sign-off by the doctor 11. Letters not sent electronically to GP. A copy of the letter is not stored for future reference	national spine continue to cause some issues where GPs have changed 6. 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. 9. Nursing staff currently only check the TTOs against TTO letter; not the	8. Trust database and drug list on the JAC to be updated with the local formulary 11. Gen Practitioner email address to be updated 11. Develop a framework that ensures incompatible letters are saved				

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Risk Ref	Risk	Risk Start 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
COR079	Failure to continue to deliver the key contractual/monitor delivery targets (18 weeks/ED/Cancer etc)	05/05/2015	S01: Deliver a great patient experience	1. Capacity monitoring undertaken. 2. Daily reviews of discharges. 3. LoS monitoring. 4. Monitoring of patients on in-patient lists. 5. Monitoring of theatre productivity. 6. Divisional and Corporate Performance Dashboards. 7. Robust breach analysis and rectification tracking.	5	4	20	1. Divisional Performance Review Meetings. 1. Divisional performance reporting to Board.	1. Increase in diagnostic testing. 5. Potential improvement for improved productivity in theatres.		1. To develop a Business Case to support an increase in diagnostic testing to manage the greater demands. 5. To continue with the Theatre staffing review to support greater productivity.		4	2	8
COR082	Failure to deliver the significantly reduced C. Diff target of just 29 cases within 2015/16	06/05/2015	S02: Safe and caring services	1. The Trust's incidences of C. Diff have continued to reduce year on year which along with the assurances received across last year support that the Trust has an effectively designed system of internal control within this area, supported by Infection Control Team review, hygiene and infection control training and rigorous surveillance. 2. CCG and Trust RCA meeting to apportion lapses in care. 3. Monthly Saving Lives Audit of Infection Control practices.	5	4	20	1. Infection Control Team Review. 1. Report to Board. 2. Reports to Board monthly. 3. Reported to CQSPE and CQRM.	2. Terms of Reference to group need to be revisited to ensure fit for purpose. 3. Some ward areas failing to achieve 'green' rating.		2. To improve the review of cases to identify which relate to lapses of case (those rightly attributable to the Trust). 3. To review Saving Lives audits and escalate areas of non-compliance. 2. Review of Terms of Reference.	31/08/2015	5	2	10

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Risk Ref	Risk	Risk Start 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
COR083	Failure to have a workforce/infrastructure that supports the delivery of 7-day working	06/05/2015	S03: Drive service improvements, innovation and transformation		5	4	20		1. Do not have a plan that defines the steps to be taken.		1. To define what is meant by 7-day working and an action plan to address gaps. 1. To develop a Business Case to support an increase in diagnostic testing to manage the greater demands.		5	3	15
COR085	Failure to maintain the delivery of the safer staffing levels in relation to ward nurse staffing	06/05/2015	S02: Safe and caring services	1. Graduate nurses recruited twice a year. 2. Established Staff Bank provide temporary cover. 3. Agency cover. 4. International Recruitment campaigns. 5. Implementing Allocate Roster system. 6. Vacancies advertised on NHS Jobs. 7. Established Agency frameworks.	5	4	20	1. Graduate Programme competencies. 2. Weekly Staff Bank Stats Report. 3. Weekly Staff Bank Stats Report. 5. Report to Finance and Performance Committee on Allocate implementation plan.	1. Numbers of graduate nurses not always known in advance. 2. Size of Staff Bank limited. 3. Agencies do not always supply the agreed request. 4. Numbers of experienced nurses (both in UK and internationally) available is depleted due to UK-wide recruitment. 5. Wards not yet fully compliant with Allocate system to optimise roster. 6. Numbers of experienced nurses (both in UK and internationally) available is depleted due to UK-wide recruitment.	5. Regular reporting from Allocate on shift fill rates.	1. Work with Universities to participate in Open Days. 2/3. Publicise the Staff Bank within Trust Recruitment events. 5. Centralisation of the Rostering Team to support the benefits from the continued implementation of the Allocate Rostering System.	30/09/2015	5	2	10

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Risk Ref	Risk	Risk Start 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	Failure to maintain financially sustainable	16/05/2014	S06: Plan for a viable future	1. Our developed five year plan is being developed with key measurable milestones that are supported by a series of performance management control processes embedded within the Trust's Divisions/Directorates .	4	4	16	1. Finance Report to F & P. 1. Reports to Board on Strategic Plan development. 1. Feedback from Monitor in respect of Trust delivery against Monitor undertakings.	1. No formal project/discussions have been launched. 1. No agreement on the process of timeframe has been reached.		1. There are a number of local heath economy system opportunities that we plan to engage with to support our 5 year plan these include continuing to work with the Black Country Alliance on the shape of acute services across the main providers and to take an active role with the partnership Board in respect of the Dudley Vanguard project supporting our community services aspirations. 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. Schemes 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. In addition work is underway with local commissioners and	30/04/2015	4	2	8

Risk Ref	Risk	Risk Start 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
											providers in Dudley to establish a pattern of services to be delivered in a 5 and 10 year period,				
COR069	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	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. Capacity and Demand review to establish future demand and required capacity (including Cardiology CT). 3. Plan to replace or expand equipment needed based on Capacity and Demand review.	31/03/2015	4	3	12

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Risk Ref	Risk	Risk Start 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
COR086	Patients' nutritional needs are not fully met during their hospital stay	06/05/2015	S02: Safe and caring services	1. Nutritional assessment included in nursing assessment. 2. Fluid bundles included in intentional rounding. 3. Referral to Dietician when MUAC score is low. 4. Nutritional supplements prescribed when necessary. 5. Nutritional assessments displayed on boards behind the patients beds. 6. Malnutrition and identification guideline.	4	4	16	1. NCI Audits reported to Matrons Group and to CQSPE.	1. Nutritional assessment not always completed. 2. Fluid Bundles not always completed. 3. Referral to Dietician not always made. 4. Nutritional supplements not always administered. 5. Boards no not always display accurate information. 6. Guideline is not always adhered to.		1. Awareness to be raised via training sessions on Nutrition. 2. Intentional Rounding to be re-launched. 3. Lead Nurses and Matrons to be informed of all patients who were referred to Dieticians late. 4. Provision of Oral Nutritional Supplements in the acute setting document to be developed. 5. Audit of information on bed boards to be completed. 6. Malnutrition and identification guideline to be re-launched Trust-wide.	31/07/2015	4	2	8

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Risk Ref	Risk	Risk Start 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
COR088	Failure of DATIX System to support the business	05/11/2014	S02: Safe and caring services	1. Daily checks regarding data integrity and contract reporting requirements. 2. Check and challenge of data between Corporate Governance and Divisional Governance staff.	4	4	16	1. Management review and reporting to CQSPE.	1. Configuration of the system is sub-optimal.	2. Divisional confidence in data reporting.	1. To recruit to pivotal team member posts (Patient Safety Manager and Datix Business Intelligence Officer). 2. To rebuild the database with IT technical support and then relaunch DATIX into the Trust. 3. Deliver improvement actions from 2014/15 Internal Audit reviews. 4. Improve reporting capabilities and support to Divisions.	30/09/2015	3	0	0
COR089	IT Strategy does not deliver	06/05/2015	S05: Make the best use of what we have	1. Clinical Senate (Consultant-led design focus) and IT Steering Group (Project-led delivery-led) are in place for project Governance and to support clinical engagement. 2. IT (CIO, CCIO) have a monthly slot at Directors to ensure issues, all Directors are aware of any issues. 3. Resources are identified in advance and agreed with Operational Directorates through TME.	4	4	16	1. IT Steering Group ToR and attendance review to ensure correct focus mandated by Executive Directors. 1. Agreed mechanism required for accounting for Clinicians' time. 2. IT reporting lines review. 3. Resources scheduled by Operational Directorate.	1. Meeting attendance for IT Steering Group is poor and not prioritised by Directorates. 1. Sustaining Clinical attendance for the IT Senate over a 2 year project lifecycle with no payment mechanism. 1. IT Steering group is 3 levels removed from board which impacts the decision process. 2. IT still views as a Technology delivery rather than a transformation enabler. 3. Allocated resources still rely on consultant “good will” and not mandated.		Complete review of IT Governance and reporting. Deliver Action Plan as defined in IT Strategy Risk Mitigation Tracker.	30/06/2015	4	4	16

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Risk Ref	Risk	Risk Start 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)	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	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

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Risk Ref	Risk	Risk Start 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
COR077	Workforce Reduction Schemes are not aligned to the skills required for service delivery	25/02/2015	S04: Be the place people choose to work	1. Revised vacancy management process (VAR). 2. QIA process for assessment of risk for all posts being recommended for approval. 3. Active re-deployment process for 'At Risk' staff to retain skills and experience. 4. Staff Appraisal process. 5. Sickness and Training Data Review by HR, Managers, relevant Executive together with return to work interviews. 6. Learn lessons from Phase One of the Workforce Reduction Programme and adjustments made to approach e.g. voluntary redundancies will not be offered or only sought from areas that are definitely affected. 7. Ward-based nurses at Band 5 and 6 and Band 2 clinical support staff excluded from reductions. 8. Annual workforce plans, that correlate with the Trust financial plans are submitted to W Midlands workforce planning hub each year.	3	4	12	1. Meets weekly, decisions and rational for them are noted. 2. QIA process reported to Workforce and Staff Engagement Committee. 4. % compliance rates reported to Finance and Performance Committee and Workforce and Staff Engagement Committee. 5. Workforce KPI's e.g. sickness and training reported to Board, Finance and Performance and Workforce and Staff Engagement Committee.	1. VAR process does not include admin Bank/Agency or interims. 2. Lack of benchmarking metrics about expected standards of productivity e.g. ratio of medical secretaries to consultants. 8. No detailed departmental workforce plans on which to base decisions.	4. Performance ratings from appraisal process not yet reported on to a Committee.	1. VAR process adapted to include admin Bank/Agency and interims. 2. Detailed divisional and departmental workforce plans produced, that are interactive and refreshed regularly. 3. Initial indications of areas for further workforce reductions identified and submitted to Directors. 4. Performance ratings from appraisal process reported on to Workforce and Staff Engagement Committee. 5. Standard/comparable metrics identified for common areas of activity such as medical secretaries, PA's, common administrative roles.	31/12/2015	3	3	9

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Risk Ref	Risk	Risk Start 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
COR080	Failure to deliver our 2015/16 CIP Programme	06/05/2015	S05: Make the best use of what we have	1. Operation of a rigid PMO structure to properly assess each saving opportunity, requiring completion of PID with key milestones and a QIA. 2. Formal review and challenge of delivery at Divisional Performance Meetings/Transformational; Executive and at Trust Management Executive (TME). 3. Increased budget manager accountability to ensure rectification plans are prepared for overspending budgets. 4. F & E effect of workforce reduction impact in 2015/16 to value of £7.5m.	4	3	12	1. Transformation Executive Reports and minutes. 1. Proposal in place to commission cover. 2. TME Minutes. 2. Transformation and Finance Reports to F & P. 2. Transformation Report to Board. 2. F & P Report to Board on assurance received on CIP delivery. 3. Performance Management and Review process. 4. Reduction in budgets and posts tracked.	1. Consistent use of the designed PID's in particular in respect of savings profile. 1. Capacity in PMO not available to support delivery.	1. Cover not yet achieved.	1. To continue to have the Transformational Executive Meetings focus on identification and rectification of missing information. 1. Undertake further idea generation to identify further schemes. 1. Commission PMO cover.	31/08/2015	3	3	9

The Dudley Group NHS
NHS Foundation Trust

Risk Ref	Risk	Risk Start 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
COR081	Nurse/Midwifery Revalidation fails	15/04/2015	S02: Safe and caring services	1. Co-ordinating Group set up within Trust. 2. NMC requirements on what evidence staff need to revalidate are available supported by attendance at Regional Meetings to understand issues. 3. ESR database. 4. Training and communications plan in place commencing 12th May. 5. Appraisal system in place as a basis for checking evidence.	4	3	12	1. Notes from meetings. 1. Progress Reports to Board. 2. Co-ordinating group have assessed the provisional requirements and these have been incorporated into its communications and training.	2. These requirements are provisional and final requirements will only be available in November 2015. 2. No revalidation policy in place. 2. Appraisal Policy needs updating. 2. No templates for revalidation in place. 3. Not all staff have a revalidation date in ESR. 3. Need to use ESR as central repository of confirmation and monitoring of revalidation system. 5. Not 100% coverage, Bank Staff not covered at all.	5. Monitoring system to be established to allow regular reporting.	Engagement with managers outside the Nursing Division to raise their understanding of the requirements for re-validation from 2016/17. 2. Incorporate final requirements into Trust's systems and processes once available in November. 2. Write and update required policies using provisional information initially. 2. Complete templates and get agreement for Trust-wide use. Commence use. 3c. Set up sub-group on data integrity and flows. 3b. Ensure data in ESR and NMC same. 4. Agree training plan and start training. 4/3a. Ongoing communication to all relevant managers and staff. 5. Ensure 100% appraisals in place.	31/01/2016	4	2	8

The Dudley Group NHS
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Risk Ref	Risk	Risk Start 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
COR084	Failure to embed the improvements from our last CQC Inspection	06/05/2015	S01: Deliver a great patient experience	1. Action mapping undertaken and CEO sign off January 2015. 2. Patient level walkrounds are undertaken.	4	3	12	1. Report presented to the Board in January2015 in respect of action taken - confirmed actions closed. 1. WMQRS and DCCG visits to the Trust - reported no concerns regarding CQC domains. 2 . Outcomes of these are reported to the CEO and the Quality and Safety Group - show low level actions that could improve patient experience but no non-compliance with CQC domain areas identified.	3. Divisions do not undertake any form of self-assessment or peer review for compliance - reliance on NCI audits and primary control/assurance. 4. Corporate Governance Team not undertaken any reviews.	1. Further follow up assessment of actions taken being undertaken in May 2015. 3. No reporting from Divisions on level of CQC compliance. 4. No review of actions remaining in place by Governance Team.	3/4. To develop the framework for undertaken a series of self-assessment potentially utilising an improved Board to Ward Patient Safety Visits. 3/4. To roll out the assessments. 1. Provide enhanced assurance to the Board via CQPSE on outcomes of above.	31/12/2015	3	2	6

The Dudley Group NHS
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Risk Ref	Risk	Risk Start 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
COR087 (N004)	Grade 3 and 4 Pressure Ulcers potentially can increase	19/08/2014	S01: Deliver a great patient experience	1. Framework to report pressure ulcers. 2. Skin Bundles implemented for all patients as appropriate in hospital and community 2-4 hourly as necessary. 2. Fluid and nutritional requirements managed for all patients. 3. Pressure Ulcer Group meets weekly to review Hospital and Community incidents. 4. Grade 3 and 4 Pressure Ulcers investigated as Serious Incidents and reviewed at Pressure Ulcer Group. 5. New pressure relieving mattresses provided for all beds and trolleys. 6. Pressure Ulcer Management included on Induction and Mandatory Training. 7. Verification of all Grade 3 and Grade 4 Pressure Ulcers completed within 48 hours by a senior nurse or Tissue Viability Team. 8. NICE Guidance recommends that all Grade 3 and 4 Pressure Ulcers are photographed.	4	3	12	1. Patient Safety Express identifies prevalence of pressure ulcers monthly. 1. Framework to monitor progress of pressure ulcers against CQUIN targets to reduce the incident of Grade 3 and 4 Pressure Ulcers. 2. Pressure Ulcer Documentation Audit. 2. Audit of Quality Accounts. 2. Nursing Care Indicators. 3. Monthly update provided to Quality and Safety Group. 4. Action Log from Pressure Ulcer Group. 4. Action Plans from RCA investigations. 5. Mattress Audits completed twice a year. 6. Compliance monitored via training records.	1. There are some delays in Pressure Ulcers being reported. 2. Not all staff are trained in Pressure Ulcer Management. 4. Quality of RCA investigations needs to be improved. 4. Some delays in completion of RCA investigations. 8. Not all Grade 3 and 4 Pressure Ulcers are photographed.		1. Process to escalate delays in reporting pressure ulcers to the Deputy Director of Nursing to ensure that action is taken by Matrons and Heads of Nursing to address delay to be developed. 2. Process to audit pressure ulcer documentation quarterly to be developed. 3. Pressure Ulcer RCA Training to be provided for hospital and community staff. 4. Process for all Grade 3 and 4 Pressure Ulcers to be photographed to be developed.	30/06/2015	4	3	12

The Dudley Group NHS
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Risk Ref	Risk	Risk Start 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
COR090	Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director may result in a failure to properly discharge the duties of Responsible Officer for Medical Revalidation and the Trust's function as a Designated Body - (RISK LEAD: Teekai Beach)	08/06/2015	S01: Deliver a great patient experience	1. The Responsible Officer and Medical Director is supported by a trained Revalidation Lead who is able to support decision-making around recommendations to revalidate and identify any potential conflicts. 2. The Board has agreed to support the separation of the role of Responsible Officer and Medical Director, and a suitable candidate has been identified.	4	2	8	1. All recommendations to revalidate and to defer doctors have been accepted by the General Medical Council (GMC). 2. The plan to separate roles is reflected in the Responsible Officer's appraisal. 2. The candidate has undertaken and completed approved Responsible Officer Training.	1. The Revalidation Lead is not an alternative Responsible Officer (and therefore can only support and make recommendations on behalf of the Responsible Officer) whose statutory duty it remains to recommend doctors for revalidation. 2. Operational pressures have prevented the candidate for the role of Responsible Officer from commencing the role. 2. The Trust is in deficit and has been unable to provide additional financial resource to support the plans.	1. Should a conflict of interest arise, there is no internal policy or process in place to govern the Trust's response. 2. There is a greater potential for conflict of interest if the Responsible Officer is an internal appointment.	1. Amend the existing Medical Appraisal Policy to formalise the process and any triggers for making an application to appoint an alternative Responsible Officer should the specific situation arise where the Responsible Officer has a conflict of interest. 2. Agreement of appropriate time/PAs for Deputy Medical Director (Surgery) to undertake role of Responsible Officer. 2. Appointment of Deputy Medical Director as Responsible Officer.	30/09/2016	4	1	4

Enclosure 12

The Dudley Gr
NHS Foundation Trust

Paper for submission to Board of Directors on 02/07/2015

TITLE:	**RESEARCH & DEVELOPMENT**		
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 thr ough to SO6 (research s eeks to im prove 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 2ND JULY 2015

RESEARCH & DEVELOPMENT REPORT

Summary

Finance

Research & Development's (R&D) core funding allocation from the Clinical Research Network: West Midlands (CRN WM) for the financial year 2015/2016 is £571,730, an increase of £35,014 from FY 2014/2015.

We have also been granted an additional £39,603 in the first round of CRN WM 2015/16 strategic funding bids; £20,000 from the Department of Health as in previous years; £29,000 'flow through funding' from the National Institute for Health Research (NIHR) in recognition of our commercial performance in the last financial year. The funding received will be used to further develop our research capabilities in accordance with national guidelines issued by the NIHR.

Recruitment

In the financial year 2014/2015, 1827 patients gave consent to participate in NIHR supported research studies, just short of our challenging target of 1861 participants. This local success is not reflected in our end of year report (see appendix 1) which reports a total of 1740 participants consented. We are, however, satisfied with our 93% amber rating (we were 7% short of our target for the year) which puts Dudley in a favourable light when compared to similar local Trusts, who fared less well. The accruals discrepancy is due to the time point at which the study centre, often based outside the West Midlands area, uploads our recruitment totals to the national database. We have no control over this timescale; it is an issue experienced by all Trusts within CRN WM.

Activity

National Institute for Health Research portfolio studies only:

Number of recruiting studies as of 12/06/2015: 110 comprising 94 academic (a) and 16 commercial (c).

Closed studies still collecting data: 73 (a) 31 (c).

Recruiting non NIHR studies: 20 (a); 3 (c)

Publications for 2014 calendar year: 180 – this figure includes conference posters and articles

Publications for 2015 calendar year: 75 to date

Hidden benefits of research

We are considering ways in which we can present in this report how research benefits the health economy and work is on-going. Of the trials logged above, there are 33 where drug is funded or partially funded and three where devices are provided free. In the future we will integrate an assessment of the monetary value of this into trial set up. Often the drugs are expensive and are pass through, so the monetary benefit is to the wider health economy. We have reached out to the research lead at the CCG to explore ways of working together.

Education and Training

The online Good Clinical Practice training package provided by NIHR is popular among Dudley research staff. Dudley employees continue to attend courses held in the Clinical Education Centre and further afield. Two members of the R&D administrative team attended the annual NHS R&D Forum in Manchester. Research active staff are completing an increasing number of study specific face-to-face and online training sessions so as to be fully conversant with research protocols, radiology and histopathology reporting requirements and data collection tools.

Research Governance Implementation

A total of 31 studies were assessed by the protocol review sub-committee between 01/12/2014 and 08/06/2015.

Reported Serious Adverse Events (SAE) for the period 10/12/2014 – 12/06/2015:

Oncology: 3
Haematology: 14
Chemical Pathology: 12
Dermatology: 3
Stroke 3

15 of these SAEs are thought to be drug related (2 in Dermatology; 1 in Stroke; 2 in Oncology; 10 in Haematology), one of which is a suspected unexpected adverse reaction (SUSAR).

(SAE is any event (related or not) to the treatment given in the trial; for example an emergency hospital admission whilst in a trial will be an SAE, regardless of the reason for admission. During cancer treatment, for example, hospital admissions are not unusual whether the patient is in a trial or not.)

Staffing

R&D's contribution to staffing reductions this year is £79,000 – equivalent to the budget R&D has received from the Trust since 1999. All the funds that R&D receive now are from the CRN and commercial trials.

We are currently experiencing a number of staff changes, particularly in the Oncology nurse team:

- The 1.00 WTE Senior Oncology Research Sister leaves DGH in late June. Her employer, Royal Wolverhampton Hospitals NHS Trust, is recruiting her replacement.

- A 1.00 WTE Oncology Research Nurse is on long term sick leave; the third 1.00 WTE Oncology Research Nurse will take maternity leave in September. We are seeking to place an advertisement to cover this post.

- Our 0.5 WTE dispensary trials Pharmacist left the Trust in May. Her successor comes into post in mid August. In the meantime we have appointed 1 WTE band 5 technician to assist with the smooth running of dispensary based trials.

- A 1.00 WTE Research Support Officer left the Trust in February. His successor commences on 20/07/2015.

- A new Radiology Department research lead is to be identified by the Department, replacing Dr Kambiz Maleki.

- The CRN Strategic research fund granted in April 2015 has been used to increase Generic Research Nurse support.

- The NIHR flow through funding has been used to increase Dermatology Research Nurse Support.

- Dr Barr has been successful in gaining £90,000 of commercial grants to support his existing research team of 3.00 WTE nurses and 1.00 WTE band 2 administration staff.

Good Clinical Laboratory Practice inspection

The May 2015 accreditation inspection was successful; the Research Laboratory will be re-inspected in May 2017.

Issues

There are three issues at the time of writing:

- The first is to ensure that we have adequate research nurse cover within the Oncology team. We are working with our General Manager and the CRN WM Cancer Service Delivery Manager to ensure that this happens as swiftly as possible; patients are currently not being entered into Oncology trials.

- The second issue relates to the completion of Siemens-generated paperwork required for Siemens MES to undertake safety checks of equipment loaned to the Trust for specific research studies. A number of equipment suppliers have refused to sign the required Siemens FHC608 form. An information sheet has been developed by R&D to explain the relationship between the PFI partners; this has partially helped. One equipment supplier still refuses to sign, a situation that will effectively prevent recruitment to a new commercial study.

- Research staff continue to experience delays in receiving the medical notes they request from Medical Records. While it is important that notes are always prioritized for patient care, the failure to deliver notes to data managers and research nurses has an effect on study timelines and ultimately on income received by the Trust for research activity.

Recommendations

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

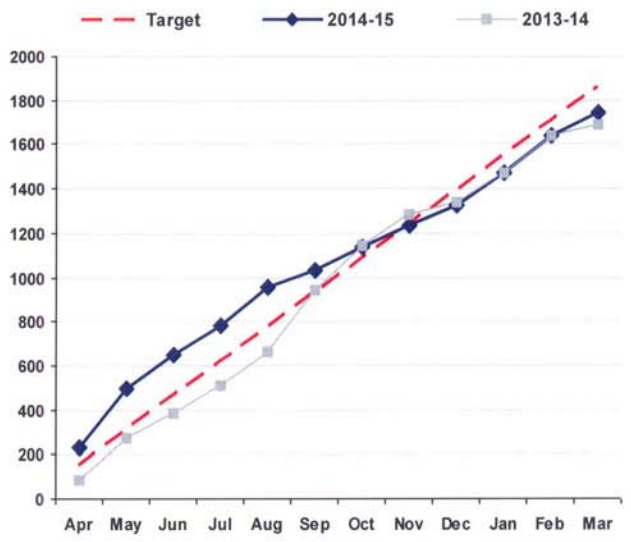
HLO 1: Increase the number of participants recruited into NIHR CRN Portfolio studies

Measure: Number of recruits to NIHR Portfolio Studies in 2014-15, as a percentage of agreed target

Pro rata target	1861	Your Rating	>= 100%
Recruits to date	1740	93%	>= 90%
			< 90%

Recruitment data as provided by CRN Coordinating Centre on 04/05/2015

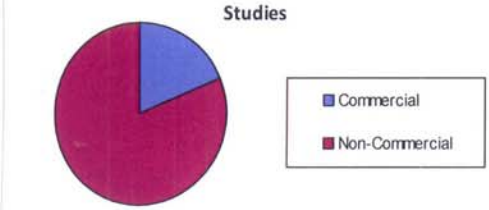
	This year Target	This year Recruitment	Last year
Apr	155	233	84
May	310	497	275
Jun	465	651	383
Jul	620	782	511
Aug	775	953	662
Sep	931	1031	940
Oct	1086	1136	1146
Nov	1241	1230	1281
Dec	1396	1325	1340
Jan	1551	1469	1472
Feb	1706	1635	1635
Mar	1861	1740	1684

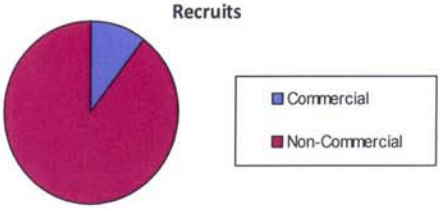


Due to the average delay in studies uploading data, it is recommended to look back 1-2 months for a more accurate picture.

Summary of the studies that have reported recruitment, 2014-15 to date only.

	Studies		Recruits	
Commercial	18	19%	186	11%
Non-Commercial	77	81%	1554	89%
	95		**1740**	





Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 2 July 2015

TITLE	**Performance Report May 2015**		
AUTHOR	**Paul Taylor Director of Finance and Information**	**PRESENTER**	**Jonathan Fellows F & P Committee Chairman**
CORPORATE OBJECTIVE: SG06 Enabling Objective			
SUMMARY OF KEY ISSUES: • **Trust continues to forecast a year end overspending of £3.7m but monthly performance has been good and an improvement in the forecast position may be possible for Month 3** • **A business case for investment in the IT Datacentre has been recommended to Board** • **An action plan to resolve the deteriorating position on the 62 day cancer waiting time target was discussed with the Medical Division** • **A payment of £1.3m to ATOS was approved**			
RISKS	**Risk Register**	**Risk Score Y**	**Details: Risk to achievement of the overall financial target for the year**
COMPLIANCE	**CQC**	**Y**	**Details: CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.**
	NHSLA	**N**	
	Monitor	**Y**	**Details: The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS)**

			at Q4, but 3 for Finance for the forthcoming 12 months. The Trust remains on monthly monitoring by Monitor. **Monitor has notified the Trust that it is no longer investigating A&E performance in the Trust** **Monitor has confirmed that the Trust is in breach of its authorisation conditions regarding future financial sustainability. Undertakings have been signed by Trust to resolve this position**
	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

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance & Performance Committee	25 June 2015	Jonathan Fellows	yes	

Declarations of Interest Made

None

Assurances Received

- That the IT system performance continues to perform well
- That a plan is being developed to address the recent shortfall in performance in the 62 day cancer waiting times target
- That the Surgical Division was performing well on financial, activity and performance targets
- That appropriate progress was being made to improve the booking of elective patients within the Trust using the Choose and Book 3methodology
- That the Income and expenditure position of the Trust continues to perform at a level better than the plan with a year to date deficit at month 2 of £906,000, which is £1.7m better than plan.
- That the balance sheet and cash position of the Trust is better than plan after 2 months of the financial year
- That the performance of the Trust against agreed national targets continues to be good, apart from the area of cancer waiting times – where there is an action plan to improve
- That workforce key performance indicators were reviewed
- That progress with the 2015-16 and 2016-17 Cost Improvement Programme that has been made so far, and the additional steps needed to secure the full £16.7m savings

Decisions Made / Items Approved

- Agreed that a payment be made to ATOS of £1.395m in respect of the IT services provided in 2014
- To recommend approval to the Board of the Dudley Clinical Services Limited accounts
- To ask Workforce Committee to review the turnover rate of Trust staff to see if there were any concerns

Actions to come back to Committee
• **To follow up progress on the cancer waiting times action plan** • **Further work in the light of the Carter Review of Operational Productivity for NHS Providers**
Items referred to the Board for decision or action
• **It is recommended that an investment of £1.092m capital is made in a new IT datacentre, to allow for a greater resilience in the IT systems of the Trust (separate Board paper refers)**