The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 2nd April, 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 5th March 2015	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 5th March 2015	Enclosure 2	D Badger	To Action	9.30
5.	**Patient Story** - Including feedback from February patient story		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D Mcmahon	To Note & Discuss	10.00
	7.2 Nurse Staffing Report	Enclosure 5	D Mcmahon	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	D Wulff	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 Corporate Risk Register	Enclosure 8	G Palethorpe	To Note	10.40
	7.6 Board Assurance Framework	Enclosure 9	G Palethorpe	To Note	10.50
	7.7 Quality Accounts Targets 2015/16	Enclosure 10	D Mcmahon	To Note & Approve	11.00
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 11	J Fellows	To Note & Discuss	11.10

9.	**Date of Next Board of Directors Meeting** 9.30am 7th May, 2015, Clinical Education Centre		D Badger		11.20
10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		D Badger		11.20

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 5th March, 2015 at 9:30am in the Clinical Education Centre.

Present:

David Badger, Chairman
Richard Miner, Non Executive Director
Jonathan Fellows, Non Executive Director
Denise McMahon, Nursing Director
Paul Taylor, Director of Finance and Information
Ann Becke, Non Executive Director
Paul Harrison, Medical Director

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Julie Cotterill, Associate Director of Governance/Board Secretary
Anne Baines, Director of Strategy and Performance
Jon Scott, Chief Operating Advisor
Julie Bacon, Chief HR Advisor
Glen Palethorpe, Associate Director of Governance/Board Secretary Designate

15/023 Note of Apologies and Welcome

Apologies were received from Paula Clark, Doug Wulff and David Bland.

15/024 Declarations of Interest

There were no declarations of interest.

15/025 Announcements

None to note.

15/026 Minutes of the previous Board meeting held on 5th February, 2015 (Enclosure 1)

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

15/027 Action Sheet, 5th February 2015 (Enclosure 2)

15/027.1 New Heated Trolleys

Mr Fellows, Chair of the Finance and Performance Committee, confirmed that there was no further news from Interserve FM regarding the arrival of the new heated trolleys. The item will remain on the action sheet.

15/027.2 Nurse Staffing Report

A letter had been prepared for the Chairman to send to the Chairman of Health Education England, but it had not as yet been sent until further discussions had taken place with the Chief Executive. The item will remain on the action sheet.

Chairman to discuss draft letter to the Chairman of Health Education England with the Chief Executive.

All other items appearing on the action sheet were noted to be complete, for update at a future Board meeting or appeared on the Board agenda.

15/028 Patient Story

The Chief Operating Advisor presented the patient story which was a PALS concern raised as a result of a delayed discharge.

The issue was around a series of patient assessments and disagreement regarding the patients' needs by multiple agencies.

The Chairman asked how the process could be streamlined when multiple agencies are involved. The Chief Operating Advisor stated that there is an issue around the number of assessments undertaken and this is a constant concern.

The Board noted that there is also an issue with associated costs relating to spot purchasing for intermediate care beds.

The Chairman noted the patient story and asked for a report to be presented to the Finance and Performance Committee relating to the cost of intermediate care beds. The Chief Operating Advisor confirmed that at the West Midlands Quality Review Service feedback the previous day the WMQRS team had recommended the streamlining of processes by third parties.

A report to be presented to the Finance and Performance Committee relating to the cost incurred by the Trust for intermediate care beds.

15/029 Chief Executive's Overview Report (Enclosure 3)

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

- **Friends and Family Test Performance:** Good performance for inpatients and ED being above the national average.

- **ED Performance and Four Hour Wait Target:** Performance continues to be very good. The quarterly position to date is 95.33%. February performance was 96.6% and the Trust is on track to meet the quarterly target. The Urgent Care Centre opens in shadow form from Monday, 9th March, between 10am and 10pm. The Centre will fully open on 1st April, 2015.

- **Nursing Professional Referrals:** The Board noted the active cases.

- **Caldicott Guardian:** The Deputy Chief Executive was pleased to confirm the appointment of Dr Jeff Neilson as Caldicott Guardian from 1st March, 2015, taking over the role from Mr Roger Callender. The Board expressed its thanks to Mr Callender for his contribution to improving patient confidentiality over the last 15 years.

- **Monitor Visit:** Members of the Board were meeting with Monitor the following day. Feedback from the meeting will be shared with Board members after the meeting.

- **CCG Unannounced:** The Board noted that a team from the CCG had arrived at the Trust that morning to undertake an unannounced visit. Feeback will be shared with Board members when available.

The Chairman noted the report and noted the pleasing performance for Friends and Family and ED. The Chairman voiced his heartfelt thanks to the work of Mr Roger Callender for his great diligence during his time as Caldicott Guardian.

15/030 Patient Safety and Quality

15/030.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Nursing Director presented the Infection Prevention and Control Exception Report given as Enclosure 4, including the following points to note:

MRSA: No cases to report.

C.Diff: There was a peak in January with 6 cases. The Board noted that there has been an increased trend in the local health economy. It was pleasing to note that there had been no cases of cross infection seen within the Trust. The Board noted that target for next year was only 26 cases as discussed at the previous meeting.

Norovirus: Being experienced in several other local organisations and schools, but only one case noted to date within the Trust.

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

The Chairman noted the report and confirmed that the Board can take strong assurance around the management of norovirus.

15/030.2 Nurse Staffing Report (Enclosure 5)

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

The Board noted that there had been 59 shifts during the month that had required management.

There was one red shift noted. This related to a night shift on A2 and was as a result of failure by agency nurses. The Chairman asked about the agency nurse that refused to look after 12 patients. The Nursing Director confirmed that the issue has been raised with the nursing agency.

The Chairman asked if there had been any incidents during the red night shift. The Nursing Director confirmed that there were no incidents.

The Nursing Director confirmed that new guidance had been received on how nurse staffing is reported and this now includes reporting the amount of direct patient contact time undertaken by nurses. The Chief Operating Advisor asked if Monitor had confirmed this requirement. The Nursing Director confirmed that the request was from NHS England and not from Monitor.

Mr Fellows, Non Executive Director, suggested that if the Trust is being RAG rated for sickness absence and mandatory training it needs to ensure that information is properly recorded. The Director of Strategy and Performance confirmed that a piece of work was being undertaken to look at this area.

The Medical Director stated that this is the latest in a series of requests for data. Mr Fellows, Non Executive Director, suggested that the Board should consider a written response to NHS England.

The Chairman noted the staffing report for January 2015, noted the red case with concern, but also noted the actions taken to minimise risk. The Chairman confirmed that the Trust will write to NHS England expressing the Board's concerns around reporting. The Chairman noted the work in relation to mandatory training and appraisals.

The Board to raise its concerns around nurse staffing reporting with NHS England.

15/030.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)

The Director of Governance/Board Secretary presented the CQSPE Committee Exception Report, given as Enclosure 6. The Board noted the following key areas:

- Learning Disability Strategy: A number of actions were now in green and good assurance was received by the Committee.

- Quality Dashboard: The Committee noted that two indicators were red for November: Smoking in Pregnancy and TAL appointment bookings within 4 days.

- Mortality Quarterly Report: The Committee noted the progress against existing action plans and the SHMI position.

The Chairman raised TAL appointments and whether the Finance and Performance Committee had considered the action plan. Mr Fellows, Non Executive Director, confirmed that the Finance and Performance Committee will continue to monitor the position.

The Finance and Performance Committee to monitor the position with TAL appointment bookings.

The Chairman noted the report.

15/030.4 Audit Committee Exception Report (Enclosure 7)

Mr Miner, Committee Chair, presented the Audit Committee Exception Report, given as Enclosure 7.

Assurances had been received against all concerns and will be monitored by the Committee.

The Board noted the amber/red rating by Baker Tilly for Childrens Services.

A further 46 additional clinical audits were approved by the Committee to be included in the 2014-15 clinical audit plan.

The Committee was looking at whether the Risk and Audit Committee could be better integrated into the Audit Committee.

The Committee received the 2014-15 quarter three losses and special payments report. There were no excessive amounts and the position will be monitored by the Committee

The Board noted the position by external audit around the issue of the Trust being a going concern and the value for money element of the audit opinion. The Director of Finance and Information suggested that the Trust should ask Monitor to confirm its position to the Auditors.

The Chairman noted the report and the actions taken as a result of audit concerns.

15/030.5 Complaints Report (Enclosure 8)

The Associate Director of Governance/Board Secretary, presented the Complaints Report, given as Enclosure 8.

The Board noted the position at Quarter 3, including 30% less complaints in the quarter, with 64 in total. All complaints had been acknowledged within 3 working days.

The Director of Goverance/Board Secretary confirmed that responding to complaints remains a challenge for the team.

19 meetings had been undertaken with complainants within the quarter and a summary of key issue was shown on page 3 of the report. The majority of complaints were around clinical care and no specific trends or themes were noted.

Two complaints received during quarter 3 were assessed as 'high risk' and are still being investigated.

Four inquests were held and concluded during the quarter with no adverse conclusion for the organisation.

The Ombudsman accepted one new complaint for further investigation. A decision is awaited.

The Chairman noted the report and noted the positive way in which the organisation now collects information and learns from complaints. The Director of Strategy and Performance asked about trends and whether 92 complaints in Q2 was unusual. The Associate Director of Governance/Board Secretary thought the number was unusually high but confirmed that there were no clear reasons for the increase.

15/030.6 Quality Accounts Report (Enclosure 9)

The Nursing Director presented the Quality Accounts Report given as Enclosure 9.

The Board received the Quarter 3 report and noted that the Trust was on plan to meet all priorities.

The Nursing Director confirmed that the Trust was on target to start the process for next year's Quality Accounts.

The Chairman asked about the reasonableness of the call bell response time priority area. The Nursing Director confirmed that the Trust is testing this on 5 wards with a response time of 30 seconds. Mrs Becke, Non Executive Director, commented that there is a distinction between answering the bell and meeting the patients' needs.

Mr Fellows, Non Executive Director, asked if Infection Control will be included in next year's accounts. The Nursing Director confirmed that it will be and the Trust will also consider measuring infections by whether there was a lapse in care and not based entirely on the C.Diff target. A paper will be presented to the next Board meeting.

The Chairman noted the report and the work around call bell response times.

15/031 Finance

15/031.1 Finance and Performance Report (Enclosure 10)

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Report, given as Enclosure 10.

The Board noted that this was the fourth consecutive month that the Trust had performed better than plan and was now back on track to meet its original deficit of £6.7m. Mr Fellows commented that there was little likelihood of much more improvement on this positon

The Board noted the RTT waiting time pressures but that major RTT and Cancer targets were being met.

Mr Fellows stated that it was disappointing to note the relatively little progress made by PFI partners around the new menus and heated trolleys. The Board noted that Interserve FM are also looking to exclude Trust staff from the Restaurant who are not purchasing food.

Progress is continuing on IT and systems and the Trust is working to map all processes.

The Board noted that the timetable for the Monitor Plan had been pushed back.

Mrs Becke, Non Executive Director, suggested that representatives from Interserve FM are invited back to a future Board meeting. The Chairman confirmed that he is meeting with a Summit representative on 17th April and will explore issues at this meeting and if he does not receive a positive response will then invite representatives back to the Board.

The Director of Finance and Information raised the 2015-16 tariff arrangements and advantages of the enhanced tariff option, he confirmed that he had responded to Monitor by the 4th March deadline.

The Chief Operating Officer commented that there appeared to be an error on the Monitor Governance Targets and Indicators for the 4 hour wait target.

The Chairman noted the report and noted that the Trust was now back at its original deficit target. He confirmed that the Trust continues to meet performance targets in difficult circumstances and it is important to recognise the work from the Trust leadership team and all staff. He confirmed that he will raise working relationships with Sandy Bremner, Summit representative of their meeting on 17th April. The Board placed on record that it gave its full support to the response to Monitor on the enhanced tariff. The Chairman noted that the ED figure in the Monitor Governance Targets required checking for accuracy.

15/032 Any Other Business

15/032.1 West Midlands Quality Review Service (WMQRS) Visit

The Chief Operating Advisor confirmed that the WMQRS fed back to the Trust Management Team the previous afternoon. A draft report on the visit will follow. The team had identified an immediate concern around safeguarding in the acute care flow. The Chief Operating Advisor confirmed that he will provide further details during the private element of the Board meeting.

The Chairman confirmed that this was the Associate Director of Governance/Board Secretary's last meeting. He passed on the Board's thanks for her massive contribution around the Board table and throughout the Trust. The Chairman wished her well for the future.

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

15/033 Date of Next Meeting

The next Board meeting will be held on Thursday, 2nd April, 2015, at 9.30am in the Clinical Education Centre.

Signed …….

Date ……..

Enclosure 2

The Dudley Group NHS
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Action Sheet
Minutes of the Board of Directors Public Session
Held on 5th March 2015

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/103	Action Sheet	New menus to come online at the end of February 2015. The new heated trolleys will not be available at the end of January as requested at the November Board meeting due to limitations in the PFI contract.	RG	5/3/15	Interserve have withdrawn from all catering negotiations. The Trust Representative is seeking clarification on this recent development.
15/017	Patient Story	The Chairman asked for an update on the issues raised in the patient story at a future meeting. A letter should be sent to the patient in response to issues raised in the patient story on behalf of the Board.	LA LA	2/4/15 5/3/15	On Agenda Done
15/019.2	Nurse Staffing Report	Chairman to write to the Chairman of Health Education England regarding the national agency nursing staff position resulting from nurse shortages.	C	5/3/15	Update provided at the March Board
15/030.3	Clinical Quality, Safety, Patient Experience Committee Exception Report	The Finance and Performance Committee to monitor the position with TAL appointment bookings.	JF	26/3/15	Done
15/027.2	Action Sheet - Nurse Staffing Report	Chairman to discuss draft letter to the Chairman of Health Education England with the Chief Executive.	C	2/4/15	
15/028	Patient Story	A report to be presented to the Finance and Performance Committee relating to the costs incurred by the Trust for intermediate care beds.	JS	30/4/15	
15/030.2	Nurse Staffing Report	The Board to raise its concerns around nurse staffing reporting with NHS England.	DM/C	7/5/15	

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 Meeting
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. Dr Neilson to consider presenting an update on the Trust's Research and Development activities to Dudley CCG.	PH JN	2/7/15 2/7/15	

Enclosure 3

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 2nd April 2015

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Test Performance
- CCG Unannounced Visit Report
- Workforce reduction programme

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive Update – 2nd April 2015

FFT rollout to Community, Day Case, Outpatient areas and Children's areas– provisional update March 2015

Community – The first national return was submitted in February 2015. In February we received a total of 31 responses with 93.55% of respondents indicating they would be extremely likely or likely to recommend the service they had used to friends and family. We are working with the Community managers to improve the response rates. National benchmarking data is not available at this time.

Area	Total number of responses	Percentage recommended
Community Inpatient Services	0	**0**
Community Nursing Services	23	**91.30**
Rehabilitation & Therapy Services	7	**100.00**
Specialist Services	1	**100.00**
Children & Family Services	0	
Community Healthcare Other	0	
Total	**31**	**93.55**

We have also rolled out FFT to Day Case, Outpatient departments and our Children's inpatient areas with the first data submission in May 2015.

Inpatient FFT (01.03.15 – 22.03.15 provisional)
The Trust continues to benchmark well both nationally and regionally. The latest published NHS England figures are for January 2015 show The Dudley Group scored 97% (maintained from the start of quarter 2) against the national average of 94%.
The provisional response rate for March (01.03.15 – 22.03.15) shows a significant increase to 47% (compared to 31% for February 2015) across our inpatient areas.

A&E FFT (01.03.15 – 22.03.15 provisional)
The Trust continues to score well and is in the top 20% of Trusts with those who say they are extremely likely or likely to recommend A&E to friends and family. The latest published NHS England figures for January 2015 show The Dudley Group scored 94% against the national average of 88%.
The provisional response rate for March 2015 shows a decrease to 27% compared to 43% for February 2015.

Inpatient and A&E	**Q1**	**Q2**	**Q3**	**March**
Date range	01.04.14	01.07.14	01.10.14	01.03.15
	30.06.14	30.09.14	31.12.14	22.03.15
Number of eligible inpatients	5860	5987	5669	915
Number of respondents	1646	1577	1756	427
Ward FFT NPS	84	80.8	84	
Ward FFT percentage recommended score		97%	97%	98%
Ward footfall	28%	26%	31%	47%
Number of eligible A&E patients	13542	13970	12545	1820
Number of respondents	2459	3141	2709	494
A&E FFT NPS	57	67.7	56	
A&E FFT percentage recommended score		90%	83%	94%
A&E footfall	18%	22%	22%	27%
TRUST FFT Score (A&E/Inpatient)	68	72	67	92%
TRUST footfall	21%	24%	25%	33%

The Dudley Group NHS
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Maternity FFT results (01.03.15 – 15.03.15 provisional)

The combined response rate is 26% for the month to date which is slightly up on the figure for February 2015 of 25%.

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.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar 1st-15th
Maternity - Antenatal NPS	64	80	78	79	66	71	71	69	89			
recommended score in percentage							98%	97%	100%	98%	99%	100%
Response rate	14%	18%	13%	21%	19%	26%	16%	15%	11%	19%	33%	15%
Maternity - Birth NPS	62	85	83	90	94	98	87	91	89			
recommended score in percentage							98%	100%	99%	99%	97%	98%
Response rate	44%	33%	34%	30%	23%	24%	14%	30%	27%	18%	38%	38%
Maternity - Postnatal ward NPS	57	85	79	87	94	96	83	87	87			
recommended score in percentage							98%	100%	98%	99%	99%	98%
Response rate	43%	31%	32%	29%	23%	24%	14%	31%	27%	18%	38%	38%
Maternity - Postnatal community NPS	86	90	85	85	85	76	70	82	100			
recommended score in percentage							100%	100%	100%	100%	100%	100%
Response rate	16%	9%	15%	13%	12%	11%	8%	10%	6%	13%	11%	13%

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

CCG Unannounced Visit Report:

Dudley Clinical Commissioning Group (CCG) undertook an unannounced visit to The Dudley Group NHS Foundation Trust (DGFT) on Thursday 5 March 2015. The visit was conducted as a component part of the routine quality surveillance of commissioned services as part of an integrated quality assurance framework consisting of hard data, soft intelligence, KPI analysis and the need to 'go and look / show me'. The visiting team were on site for five hours and visited eleven clinical areas.

The visiting team were very positive with what they saw and did not identify any areas of concern. They reported to us:

- There is a strong culture of good leadership across the clinical areas.
- Clinical areas were calm and welcoming environments, uncluttered and clean
- Staff were responsive and approachable and keen to share their views.
- Patients were complimentary about the care they received.
- Staff were happy and proud to work for the organisation.
- Observed compliance with hand hygiene and PPE.
- Motivated staff who want to make a difference.
- The wellbeing support workers are a fantastic development and are making a real difference.
- Staff would be happy to have a relative cared for on their ward.
- Staff are happy to raise concerns and know how to do this.
- Staff care about their patients, each other and value the teamwork philosophy.

- One area was flagged as being at odds with what the visiting team had seen elsewhere and this was to do with equipment being stored on a second floor corridor.

The CCG team felt that the Trust appeared well organised with a strong focus on quality. All the staff met were very helpful to the visiting team should be congratulated on their commitment to both the Trust and to the delivery of good patient care.

Without exception patients were happy with their level of care; examples of comments captured from both patients and the "thank you" cards that were displayed on wards are detailed below:

- "I have been treated like royalty"
- "I have been in this hospital ten times in as many years and would not go anywhere else, despite others trying to get me there"
- "I would recommend the staff who have looked after me here 110%"
- "Nothing is too much trouble"
- "They make me feel like a duchess"
- "Marvellous staff – nothing too much trouble"

All the staff involved should be rightly proud of the findings as a testament to their hard work and dedication to our patients.

Workforce Reduction Programme:

The 45 day collective consultation period ended on 18th March 2015. All 35 staff taking voluntary redundancy are leaving the Trusts employment by 31st March 2015, apart from two exceptions who have a later leaving date for operational reasons.

A further 29 staff are At Risk of compulsory redundancy, the majority of whom will be issued with their notice letter by 31st March 2015. No more than 6 of these staff will be made compulsory redundant with pay in lieu of notice, so that they can leave on 31st March 2015. The remainder will work their notice period and there is a strong indication that several will be redeployed to other jobs within the Trust, thereby mitigating their redundancy.

It is now expected that the final total for all redundancies will not exceed 60 for the financial year 2014/15.

Enclosure 4

The Dudley Group NHS
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Paper for submission to the Board of Directors on 2nd April 2015 - PUBLIC

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

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

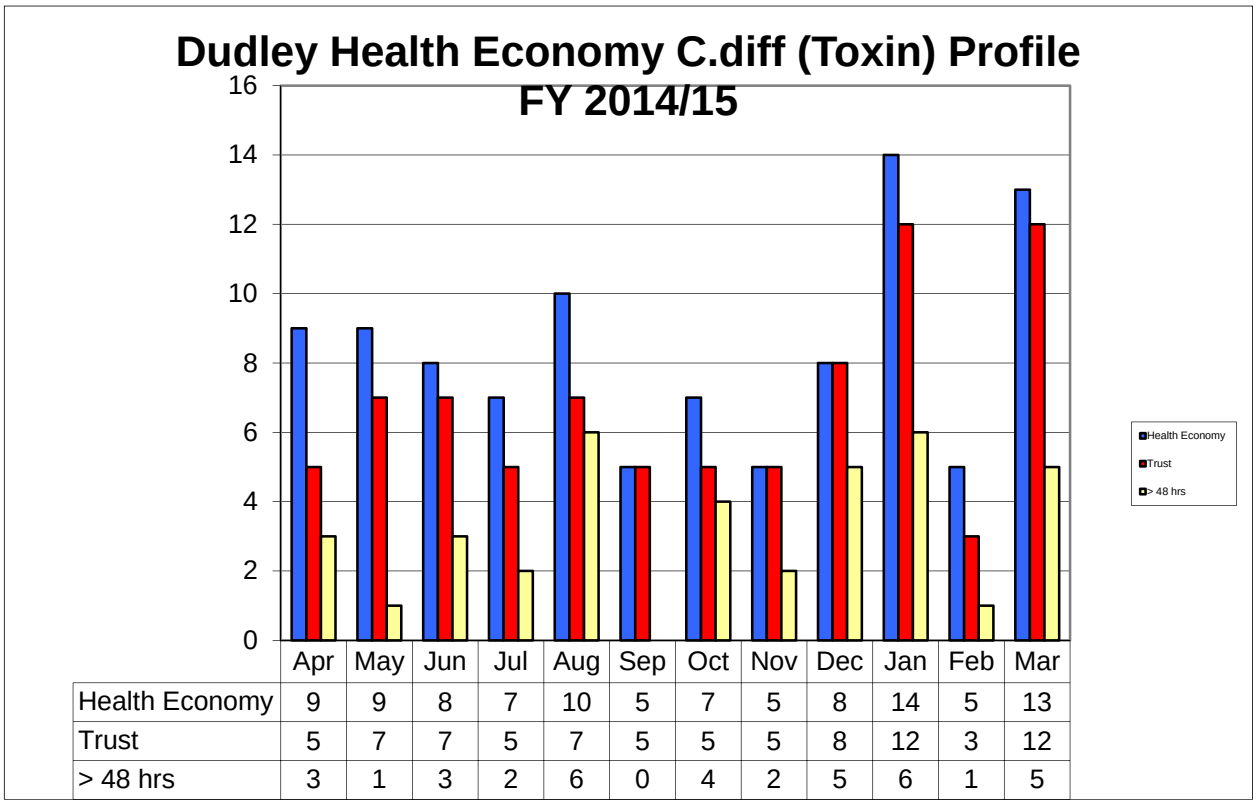
Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

Summary:

Clostridium Difficile – The target for 2014/15 is 48 cases, equivalent to 20.5 CDI cases per 100,000 bed days. At the time of writing (24/3/15) we have 5 post 48 hour cases recorded in March 2015. The Trust has achieved an annual number of cases of 38 (to date) against an end of year target of 48 cases.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	9	9	8	7	10	5	7	5	8	14	5	13
Trust	5	7	7	5	7	5	5	5	8	12	3	12
> 48 hrs	3	1	3	2	6	0	4	2	5	6	1	5

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], has commenced. To date 32 cases have been reviewed with the CCG of which 25 were determined as being associated with lapses in care. The main themes identified are: poor documentation, issues related to antibiotic prescribing, delayed sample collection and poor environmental scores.

There has been a period of increased incidence on Ward C3. The 72 hour meeting has been held, RCAs are in progress and ribotyping results are awaited.

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

Norovirus - no further cases.

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

Reference

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

Enclosure 5

The Dudley Group NHS
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Paper for submission to the Board of Directors on 2nd April 2015

TITLE:	**Monthly Nurse/Midwife Staffing Position – February 2015**		
AUTHOR:	Denise McMahon Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:

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

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

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

SUMMARY OF KEY ISSUES:

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 February 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 32 which is a reduction from the last few months. 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

February 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.

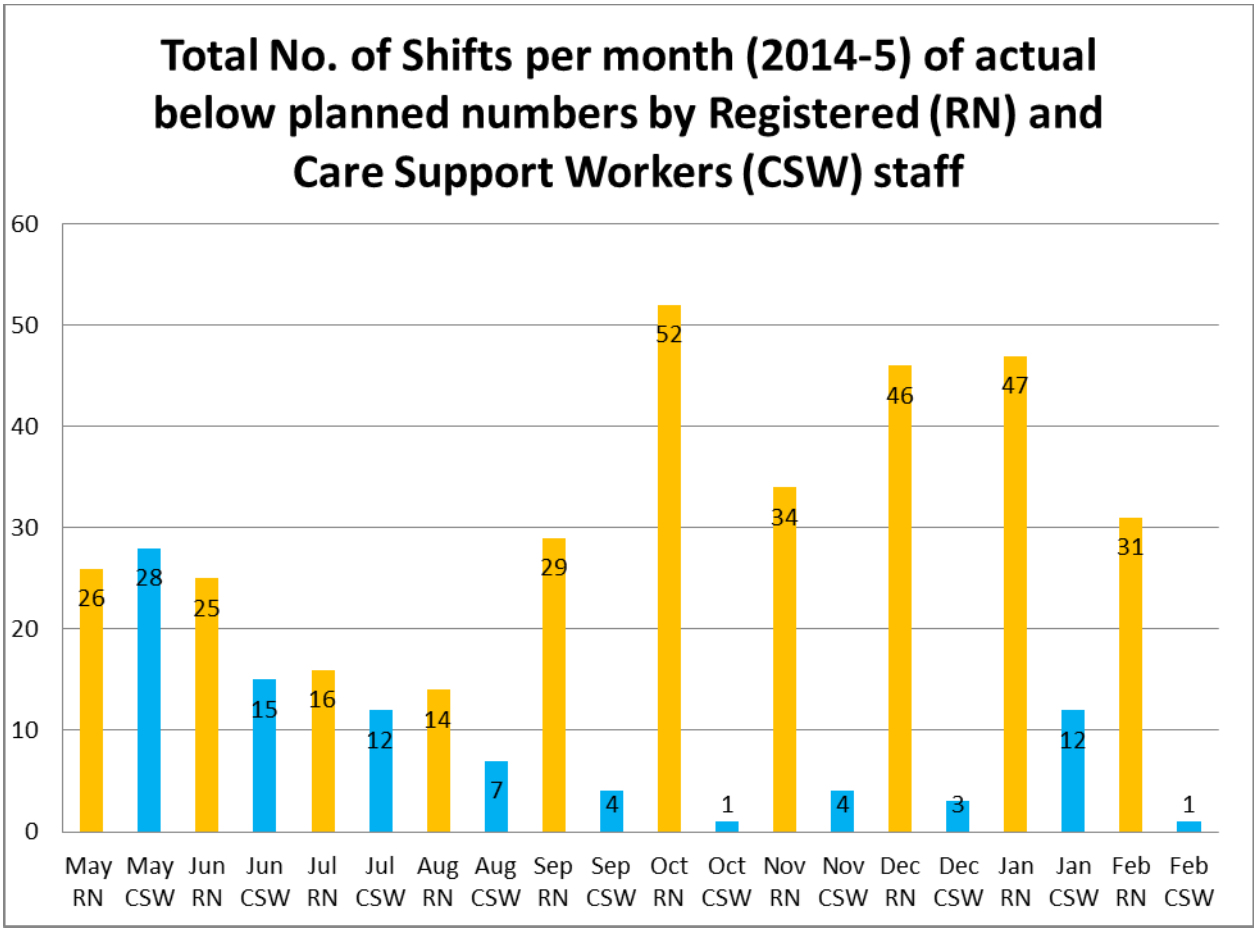
Following a shift, the nurse in charge completes a monthly form indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed, for the patients on that day. Each month the completed form for every ward is sent to the Nursing Directorate 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 32. This compares to 59 in January, 49 in December, 38 in November, 53 in October and 33 in September (see accompanying graph below). The number has reduced considerably this month and, again, is 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.



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 FEBRUARY 2015

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	1	RN	Sickness/Vacancy	Similar to last month, due to the number of vacancies, the staff on A1 have been working closely alongside the staff on ward A3 to ensure the safe delivery of care on both wards. For this one night shift, both the bank and agency were unable to fill. Staff from A3 assisted.
A3	2	RN	Vacancy	As stated above, a staff member assisted on A1 for one of these shifts. On the other shift, both the lead nurse and Matron assisted.
A4	1	RN	Vacancy/Short Term Sickness	The bank and agency were unable to fill but with a ratio of 1:12 on this night shift and with assistance from a support worker from another ward the area remained safe.
B1	3	RN	Vacancy/Staff sickness	The bank was unable to fill but with ratios of 1:9 x 2 and 1:10, with discharges planned and with a full complement of support staff the staffing levels remained safe.
B3	7	RN	Sickness, vacancy and maternity leave	When requested, the bank and agency were unable to fill and on one occasion an agency nurse did not turn up. On one occasion staff from B2 assisted. On one shift admissions were stopped.
B4	6	RN	Short and long term sickness. Vacancy and emergency unpaid leave.	On all occasions requested the bank was unable to fill. With the patients present and ratios of 1:9-9.6 the ward remained safe.
B6	1	RN	Long term sickness	The bank was unable to assist with this one night shift. The situation was escalated to the bed managers and for some of the night the ward was closed to assist staff.
C7	1	RN	Sickness	The ward was such that the remaining staff were able to arrange their work to provide safe care
C8	2 1	RN CSW	Vacancy/sickness	The bank was unable to fill the two registered shifts when requested and on one of these occasions the lead nurse from a different ward assisted to provide safe care. On a further occasion, there were six CSWs as planned but additional CSW support was requested due to the dependency of the patients. This was unavailable but work was distributed to take this into account.
Maternity	7	RM	High maternity leave and sickness absence	On all five shortfall occasions bank unable to fill. There were two further occasions when the actual staffing was as planned but due to unanticipated workload occurring through the condition of the women, midwives were taken from other areas such as the low risk birth area and antenatal rooms.

Feb-15

SHIFT

WARD	STAFF	1		2		3		4		5		6		7		8		9		10	
		D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg																				
	Unreg																				
WARD A2	Reg																				
	Unreg																				
WARD A3	Reg																				
	Unreg																				
WARD A4	Reg																				
	Unreg																				
WARD B1	Reg	4/3		4/2																	
	Unreg																				
WARD B2 HIP	Reg																				
	Unreg																				
WARD B2 TRAUMA	Reg																				
	Unreg																				
WARD B3	Reg	6/5												6/5							
	Unreg																				
WARD B4	Reg	6/5												6/5							
	Unreg																				
WARD B5	Reg																				
	Unreg																				
WARD B6	Reg								2/1												
	Unreg																				
WARD C1	Reg																				
	Unreg																				
WARD C2***	Reg																				
	Unreg																				
WARD C3	Reg																				
	Unreg																				
WARD C4	Reg																				
	Unreg																				
WARD C5	Reg																				
	Unreg																				
WARD C6	Reg																				
	Unreg																				
WARD C7	Reg															5/4					
	Unreg																				
WARD C8	Reg																				
	Unreg																				
CCU	Reg																				
	Unreg																				
PCCU	Reg																				
	Unreg																				
EAU	Reg																				
	Unreg																				
MHDU	Reg																				
	Unreg																				
CRITICAL CARE*	Reg																				
	Unreg																				
NEONATAL**	Reg																				
MATERNITY ****	Reg								15/14		15/14		15/14								
	Unreg																				

WARD	STAFF	11		12		13		14		15		16		17		18		19		20	
		D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg								3/1												
	Unreg																				
WARD A2	Reg																				
	Unreg																				
WARD A3	Reg								4/2												
	Unreg																				
WARD A4	Reg														3/1						
	Unreg																				
WARD B1	Reg									4/3											
	Unreg																				
WARD B2 HIP	Reg																				
	Unreg																				
WARD B2 TRAUMA	Reg																				
	Unreg																				
WARD B3	Reg							6/4		6/5				6/5							
	Unreg																				
WARD B4	Reg									6/5						6/5					
	Unreg																				
WARD B5	Reg																				
	Unreg																				
WARD B6	Reg																				
	Unreg																				
WARD C1	Reg																				
	Unreg																				
WARD C2***	Reg																				
	Unreg																				
WARD C3	Reg																				
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WARD C5	Reg																				
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WARD C6	Reg																				
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WARD C7	Reg																				
	Unreg																				
WARD C8	Reg							4/3													
	Unreg																				
CCU	Reg																				
	Unreg																				
PCCU	Reg																				
	Unreg																				
EAU	Reg																				
	Unreg																				
MHDU	Reg																				
	Unreg																				
CRITICAL CARE*	Reg																				
	Unreg																				
NEONATAL**	Reg																				
MATERNITY ****	Reg								15/12								15/14				
	Unreg																				

WARD	STAFF	21		22		23		24		25		26		27		28		29		30		31	
		D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg																						
	Unreg																						
WARD A2	Reg																						
	Unreg																						
WARD A3	Reg													5/2									
	Unreg																						
WARD A4	Reg																						
	Unreg																						
WARD B1	Reg																						
	Unreg																						
WARD B2 HIP	Reg																						
	Unreg																						
WARD B2 TRAUMA	Reg																						
	Unreg																						
WARD B3	Reg	6/5														6/4							
	Unreg																						
WARD B4	Reg	6/5		6/5																			
	Unreg																						
WARD B5	Reg																						
	Unreg																						
WARD B6	Reg																						
	Unreg																						
WARD C1	Reg																						
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WARD C8	Reg											4/3											
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MHDU	Reg																						
	Unreg																						
CRITICAL CARE*	Reg																						
	Unreg																						
NEONATAL**	Reg																						
MATERNITY ****	Reg																						
	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

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 6

Paper for submission to the Board on 5th March 2015

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 12th March 2015		
AUTHOR:	Glen Palethorpe Associate Director of Governance / Board Secretary	**PRESENTER:**	Doug Wulff (NED) CQSPE Committee Chair
CORPORATE OBJECTIVES: SGO1: Quality, Safety & Service Transformation, Reputation, SGO2: Patient Experience SGO5: Staff Commitment			

SUMMARY OF KEY ISSUES

National Care of the Dying Audit for Hospitals, England – May 2013 – update on Trust Action Plan
The Committee received an update on the Trust's action plan developed from the previous National Care of the Dying Audit. The Committee discussed the progress made with the Palliative Medicine Consultant and noted the progress. During the discussion of the progress being made it was determined that the narrative against one of the actions did not reflect fully the actual progress made. As part of the discussion it was agreed that more regular reporting from the End of Life Working Group would be beneficial and it was agreed that this group would be brought inside the regular reporting to this Committee.

Quality Dashboard for Month 10 (January) 2014/2015 – The Committee received a breakdown of the quality KPIs and specifically noted:

- ***C diff* –** Whilst in January there had been one more case than the Trust's monthly target the total incident of 32 remains inside the original target of 42 cases.
- **Maternity KPIs -** The performance for both KPIs were inside their targets for the month of January.
- **Stroke -** the 'Stroke - Swallowing Screen within 4 hours of clock start' target continued to be achieved in January as did the 'Stroke – Suspected TIA Scanned within 24 hours of presentation'.
- **TAL Appointment booking within 4 days –** There had been a 5% improvement in performance against this target, with an increase to 46.2% however this was still below the 80% target.
- **Saving Lives: Reducing Ventilation Associated Pneumonia -** the Trust was in the red at 72%, which was in part due to the low overall levels, seven cases for which 4 were outside the target. Each case is looked at to determine what action is needed.
- **VTE Assessment -** this was above target.
- **NHS Choices -** Dupuytrens contracture was outside the acceptable range, whilst this indicator had been removed last year it had been reinstated for this month. This had been removed from the list of Clinical Indicators, however, two had been added: Gallbladder Surgery and Osteoporosis.
- **Never Events –** There remained no never events in this quarter

The Committee **noted** the quality dashboard for the month of January 2014.

Mortality Quarterly Report – The Committee received the report showing the Trust's mortality position which continued to show the Trust's Summary Hospital Mortality Indicator (SHMI) remained within the expected range. The report also provided assurance in respect of case note audits undertaken in respect of two Dr Foster Unit alerts which showed no cause for concern.

The Committee **agreed** with the Deputy Medical Director's proposal to write to the CQC informing them of the action taken by the Trust and the outcome of the Trust's internal review in respect of the two alerts.

Policy Group Recommendations – A schedule of procedures received and reviewed by the Policy Group was received, the Policy Group agreed with the updates.

The Committee **ratified** the schedule of updated procedures policies.

Serious Incident Monitoring Report – There were 26 new SIRIs reported in February, of which 8 were general incidents and 18 were pressure ulcer incidents (7 Community Acquired and 11 Hospital Acquired).

- **Breakdown of Open Serious Incident -** there were 170 open serious incidents of which 64 RCA investigations were in progress, 39 were recommended for closure following receipt of assurance that actions had been taken, and 67 are awaiting assurance that all actions had been completed. The Committee noted that of these 67 43 had passed the originally agreed timescales. Actions which had breached completion dates would be discussed at Divisional meetings.
- **Incident Trends -** there had been no increased trends of Serious Incidents reported in areas of the Trust, however Falls remained a frequent incident type and was discussed at Divisional Meetings.

- **Compliance with CCG Contractual Arrangements -** there were no breaches in the 2 days from identification of the incident and reporting on STEIS and no breaches in completion of an RCA investigation report within the 45 day timescale.
- **Trust Red Incident Matrix -** whilst these incidents did not meet external serious incident reporting requirements the Trust view these as significant i.e they are judged as of major and catastrophic severity grading (4 and 5) for each of these a 72 hour meeting was convened to discuss these incidents. No increase in the type / trend of these incidents was identified.

The Committee **noted** the current position and **supported** the recommended closure of 39 Serious Incidents.

Quality & Safety Group (17 February 2015) summary report and minutes-
The Committee received the minutes from this group with a summary report which highlighted the following:

- **Nurse Care Indicators –** These had been refined for both Community and the Hospital with a process of peer review added.
- **Staffing –** Graduates can now take their first job in the Community.
- **Pressure Ulcers –** The Group received an update from the pressure ulcer group that monitors action in respect of pressure ulcers. The group also received information on the learning from the RCAs undertaken in respect of pressure ulcers and how the improvement from this learning was being built into regular audits / reviews. .
- **Nutrition Group -** The Group received an update on the various initiatives on going in the Trust to ensure patient nutritional needs were being met and the nursing care indicators that measure this area of performance remained high. There is a National Nutrition day in March and the Trust is planning activities to raise awareness.
- **Education update -** 16 CSWs started the Novice course in January, with a further 25 applicants commencing in April 2015. 24 graduate nurses were due to commence in February and 9 internationals were due to commence February. Eight additional internationals will be interviewed by Skype.

The Committee **noted** the summary of the Quality and Safety Group meeting held on 17 February

Reporting groups terms of reference review
The Committee received a report in respect of the six groups that report to this Committee. It was agreed when these Groups where established that they would review their terms of reference after the first year. Two of the groups proposed slight amendments to their Terms of Reference, the Patient Experience Group and Infection Prevention and Control Forum. One group, the End of Life Steering Group had not met, albeit as discussed earlier an End of Life Working Group was meeting. The remaining three proposed no changes (the Quality and Safety Group, Internal Safeguarding Group and Trust's Children's Services Group)

It was agreed that the revised Terms of Reference in respect of the Patient Experience Group was **approved** however the Terms of Reference in respect of the Infection Prevention and Control Forum was referred back to the Group for update as it referred to out of date membership and the quoracy seemed complicated. As noted above the Committee asked that the end of life working group be brought into the normal reporting processes.

IMPLICATIONS OF PAPER:

RISK	Y		**Risk Description:** Committee reports ref to the risk register
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Outcome 1 - Respecting & Involving people, 4 – Care & welfare of people, 7 – Safeguarding, 16 – Assessing & monitoring quality of service
	NHSLA	Y	**Details:** Risk management arrangements e.g. safeguarding
	Monitor	Y	**Details:** Ability to meet national targets and priorities
	Equality Assured	Y	**Details:** Better health outcomes for all Improved patient access and experience
	Other	Y	**Details:** Quality Report/Accounts

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 12th March 2015 and refer to the full minutes for further details.

The Clinical Quality, Safety & Patient Experience Committee was established to provide assurance to the Board on Clinical Quality and Safety standards, (including Clinical Effectiveness, Patient Safety and Patient Experience). It sets clear quality performance expectations and ensures the development and delivery of high quality care and continuous improvements through innovation and the use of levers such as CQUINS. It identifies and advises on quality improvement priorities and the organisational learning from these and monitors compliance with Health Standards ensuring the Trust fulfils its obligations with regard to the Health Act (2009) and Monitor in the production of an Annual Quality Account and Report.

Enclosure 7

The Dudley Gr
NHS Foundation Trust

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

TITLE:	**Workforce and Staff Engagement Committee**		
AUTHOR:	**Julie Bacon; Chief HR Advisor**	**PRESENTER**	**Ann Becke Non Executive Director**
CORPORATE OBJECTIVE: SGO5. Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude			

SUMMARY OF KEY ISSUES:

The Workforce and Staff Engagement Committee met on 24th February 2014.

Appointment of a additional Non-Executive Directors
Mr Milner had been appointed as a non-executive director on the Committee and Mr Wulff as clinical non-executive director. An open invitation is made to all non-executive directors.

Annual Review of the Diversity Management Group
The Committee received a report from the group and accepted its recommendations that included the group be disbanded and future assurance is achieved via regular reports directly to the Workforce and Staff Engagement Committee.

Workforce KPI's
The committee received a report on workforce KPI's. The Committee noted that the Sickness Absence Policy has been updated. Mandatory Training compliance was discussed and it was agreed that a report on the potential impact of adopting the Skills for Health 8 core topics for mandatory training would be brought to a future meeting.

Workforce Strategy
The majority of the meeting was taken up with a presentation and discussion on the proposed Trust People Plan / Workforce Strategy and the proposed work-streams, shown below. This strategy and plan will be produced for final discussion at the May 2015 meeting.

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

ACTION REQUIRED OF 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 Board of Directors – 2 April 2015

TITLE:	**Corporate Risk Register**		
AUTHOR:	Glen Palethorpe Associate Director of Governance and Board Secretary	**PRESENTER:**	Glen Palethorpe Associate Director of Governance and Board Secretary

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

In addition to the operational risk registers (reported to Risk and Assurance Group) the Directors are currently managing 17 corporate risks, of which 5 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified again reported to the Risk and Assurance Group.

1new risk has been added to the register since the previous report, 1 risk has been escalated to the corporate register from the relevant operational risk register, 1 risk has been mitigated in part but remains on the register and 2 risks have been mitigated to an acceptable level and have been archived or superseded.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF THE BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD:

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

CORPORATE RISK REGISTER

In addition to the operational risk registers (reported to the Risk and Assurance Group) the Directors are currently managing 17 corporate risks, of which 5 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified. The risk scores are as follows:

Risk Score	Number of Risks
20	5
16	2
15	4
12	2
10	2
9	2

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

RISK REGISTER MOVEMENT

1 new risk (COR 077 on page 16) has been added to the Corporate Risk Register between 1 January 2015 and end of February 2015.

1 risk (COR 071 on page 11) has reduced from a score of 20 to 15 in this reporting period.

1 risk (ST 002 on page 12) has been escalated from the operational risk register to the Corporate Risk Register

2 risks have been removed from the Corporate Risk Register since the previous report (December 2014) as these are in effect included within other risks within the register. These are summarised below:

Director lead	Risk Summary	Date
Director of Strategy and Transformation	The inability to release the Guest Hospital to enable its lease for other healthcare uses to bring income into the Trust, in line with the agreed actions within the 5 year strategic plan. (included elsewhere in the CRR)	February 2015
Director of Strategy and Transformation	The Black Country Alliance does not deliver solutions that supports the future clinical and financial sustainability of the Trust. (included elsewhere in the CRR)	February 2015

PENDING NEW RISKS

Presently there are pending risks to be added to the Corporate Risk Register, these will be linked to the developing 2015/16 business plan in particular the financial risks.

Corporate Risk Register – end of February 2015

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR061 **Director Lead: Director of Finance** **Initial Risk Score 20**	The Trust must ensure that it remains financially viable over a 5 year time period. At present, there is no indication that either growth, exit or redesign of our major service lines over the next 5 years, will deliver the financial efficiencies required to mitigate the projected financial deficit over that time period. Monitor have already notified the Trust it is in breach of its authorization conditions in respect of financial sustainability and have agreed a number of legal undertakings with the Trust which are designed to put this right. We are currently at risk of being put into "special measures" by Monitor, and the administration of the Trust taken out of its hand if these undertakings are not met during 2015-16	16/05/2014 **Last Review Date: February 2015**	6. To deliver an infrastructure that supports delivery.	1. Beyond the initial 7 specialities examined, conduct a service line options appraisal for all services, to ensure optimum service mix is recommended to the Board of Directors. 2. Formal monthly monitoring at F&P Committee and Board	4	5	20	1. Board Workshop and Private Board papers on 5-year plan. 2. F&P and Board reports	1. Time pressure means the depth of review; analysis and engagement for the remaining specialities won't be as deep as those done for the initial major services. Plan to complete the more in-depth review as part of new Divisional arrangements during Q2 and Q3 2014/15, in advance of detailed APR scrutiny from Monitor.		1. Revise the approach to the Cost Improvement Programme 2015-16 and 2016-17 to include a greater emphasis on cost reduction not income growth. Scheme to be worked up in detail as part of the Operational Planning 2015-16 process in conjunction with Divisions. 1. Black Country Trust Finance Directors to arrange facilitated planning session(s) with respect to radical, sub-regional service configuration options and associated financial monitoring 1. In addition, work is underway with local commissioners and providers in Dudley to establish a pattern of services to be delivered in a 5 to 10 year period, which will include some operational efficiencies and better use of facilities.	30/04/2015	4	3	12
COR065	The current Trust plan of a £6.7m deficit is	27/05/2014	6. To deliver an infrastructure	1. Development of rigid PMO structure to properly assess	4	5	20	1. Bi-weekly meetings with managers to run through key		1. Some central schemes not fully owned by	1. Focus on saving cost schemes reinforced through	31/03/2015	3	4	12

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Director Lead: Director of Finance **Initial Risk Score 20**	predicated on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to deliver this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years	**Last Review Date: February 2015**	that supports delivery.	each saving opportunity, requiring completion of PID with key milestones and a QIA. 1. Weekly/Bi-Weekly PAR meetings held with Performance Director /Operations Director and Chief Executive to offer significant challenge to project leads. Further escalation where necessary. 2. Development of a Turnaround Programme designed to ensure that saving/efficiency opportunities are maximised without detriment to quality/patient care. Wider debate with Monitor/CCG/Area Team at round table sessions. 3. Increased budget manager accountability to ensure rectification plans are prepared for overspending budgets. 4. Devolution of income to directorates to create greater ownership and accountability. 5. Drive to reduce run rate including medical staffing exercise and formal announcement of reduction of 400 posts over 2 years. Stricter control on vacancies in lieu of this.				milestones. Completion of CIP tracker showing PID and QIA. CIP Update report to Directors, F&P, Board. 1. Escalation meetings now include Director of Ops/Chief Executive; Dashboard available on Hub. 1. F&P Committee and Board reports 2. Turnaround plan/reports to Directors, F&P, TME and Board. 2. Reports continue to be presented to above on a monthly basis; however, Month 7 position shows an adverse variance of £1.981m and projected year-end forecast of £8.705m. 3. Development of controls framework. 3. Re-launch of Budget Manager responsibility policy. 3. Discussions held with Budget Managers. 3. Rectification plans for overspends in excess of £50k. 4.Monitoing of income levels 5. Additional winter pressure income received to provide finances to keep beds open.	5. Inability to achieve required savings due to other pressures, i.e. increased emergency activity resulting in inability to close beds.	Directorates. 2. Poor detail presented to QIA panels - requiring deferral of support by MD/DN. 3. New management structure has resulted in doubts about accountability for overspends.	PAR meeting and escalation processes. 2. Board require sign-off of 2015/16 Plan by December. Workforce Efficiencies medical staff - agency reduction and programme to look at post. Increased drive on outpatient efficiency involving specific specialties of greatest impact.				
COR072 [FI002	The JAC, a medicines	12/06/2014	1. To become	1. Users are trained to use	4	5	20	1. Users must be trained to	1. If the patient has an	1. It is not easy to monitor	1. Meet with JAC to identify	**30/06/2014**	4	1	4

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(IT009)] **Director Lead: Director of Finance** **Initial Risk Score 20**	management system, since 2008, to generate an electronic discharge summary containing details of patients' diagnosis and discharge medication. However, a discharge summary is not always being sent to the GP or to Soarian and sometimes the messaging between systems is not processed correctly. Key issue is that discharge writing process is not delivering.	**Last Review Date: February 2015**	well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	both Soarian and JAC. 2. An admission and discharge message is sent from OASIS to JAC when the patient is either admitted or discharged. 3. The Trust is able to generate the current bed state from OASIS and is then able to manually match this to the ward list in JAC in order to be able to close open episodes which would prevent an OASIS admission message being processed. 4. In order for discharge summaries to appear in Soarian, a folder in the Keystone system is searched and documents copied to Soarian. 5. Admission and discharge on OASIS does not always correspond to admission and discharge on JAC. This happens very frequently in some areas with high throughput, such as EAU or Day Case Units. 6. Multiple individuals				use Soarian and JAC before they are issued with a log-in. 2. The OASIS to JAC interface is monitored by Siemens. 4. Documents in the Keystone folder appear in Soarian. 5. Staff should then reclose the admission so that any future admissions are generated correctly. 6. A new sign-off procedure	open episode in JAC, the message will not be processed resulting in no discharge being created 2. The JAC to Keystone interface is not actively monitored. The Keystone system is used to send discharge summaries to GPs 3. This requires resources from the Trust to match patients across both systems 4. There are a number of incompatible GP practices in Keystone, therefore these do not generate a discharge summary document and such will not appear in Soarian 5. Staff are able to override the closed admission in JAC by manually opening a spell previously closed by OASIS	the JAC system for open episodes where a patient has been discharged in OASIS. 2. Because the system is not actively monitored, the Trust is unaware when a discharge message is not sent and a GP does not receive the electronic discharge summary 3. This is not actively monitored, therefore discharge summaries that have failed the automated messaging are not sent to the GP and Soarian. Often the GP telephones the Trust to request a discharge letter, this is often not reported. 4. Documents belonging to Incompatible GPs are not created in the Keystone folder and are not sent to GPs or Soarian, however, delays in updating the national spine continue to cause some issues where GPs have changed 5. Staff do not close reopened admission spells on JAC until the patient is readmitted. By closing the original spell a new summary will be created and sent electronically which is now out of date.	and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed 2. Meet with Indigo4 to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed 3. Create a new set of processes to actively monitor JAC and Keystone error messages 4. Develop of Joint Audit between the CCG and The Dudley Group NHSF Trust 5. Reference files across the Trust to be updated 6. Create a new set of				

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

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COR059 **Director Lead: Director of Operations** **Initial Risk Score 16** **Increased to 20 November 2014**	The capital development cost of the UCC exceed that available to the Trust. The financial consequence of the planned reduction in ED activity causes financial pressure	15/05/2014 **Last Review Date: February 2015**	6. To deliver an infrastructure that supports delivery.	1. Urgent Care Project Group (Involves senior staff from DCCG as equal partners in planning the development and its finances). 2. Project group examining 4 different estates options and will plan that client brief for new facility can be economically met within capital envelope set aside. Variation process has begun under PFI project agreement rules. Consistent capital development fees will be applied. 3. Completion of Business Case for capital and revenue elements to be developed.	5	4	20	1. Urgent Care Project Group Minutes discuss key financial issues. 1. DCCG Board Minutes support project. 1. 2-year operational plans (DCCG and DGFT) support project. 1. Project Board re-focus jointly project managed by external organisation. 1. Finance and Performance Committee Minutes. 2. DGFT investment committee notes. 2. Contract variation audit trail. 2. Project plan and milestones includes Summit discussions. 3. DGFT investment committee minutes. 3. Project Board Minutes. 3. Business Case.	1. No final agreement in place. 2. Approval process by Summit Healthcare not within DGFT control. 3. Business Case not yet produced for approval.	1/2. No agreed budget and cost 2. OBC incomplete 3. Business Case is delayed.	1/2. Contract negotiation with DCCG including consideration of risk share arrangement and/or local tariff on both ED attendance and AEC/SAU/EAU assessment activity, better reflecting re-designed service. 2. Production of OBC 3. Presentation of business case for capital revenue. 3. Agreement of capital and revenue consequences of UCC provisions on DGFT with DCCG.	30/06/2015	5	2	10
COR076 **Director Lead: Director of Nursing** **Initial Risk Score 20**	The Registered Nursing (RN) staffing levels do not meet Safe Staffing for Nursing in Adult Patient Wards in Acute Hospitals NICE/Guidance	28/11/2014 **Last**	6. To deliver an infrastructure that supports delivery.	1. Identified nurse rostering system across all wards (Allocate). 2. Process embedded to monitor staffing levels daily, includes: - Daily review by Lead Nurses - Staff ratios displayed on Huddle Boards and discussed at Huddle Board Meetings.	5	4	20	1.Progress and completion reported to Finance and Performance Committee. 2. Daily e-mails of Lead Nurses review of staffing levels - requesting Bank. 2. Monthly report to the Board of Directors. 2. Weekly Agency Stats report. 2. Report to Finance and Performance.	6. Shortfall in the number of nurses to recruit within the catchment area.		6. Planning to recruit from India and the Phillipines but current Home Office issues. Continue to work with 'TTM' search agency to view new markets. Currently looking at Scandinavia.	31/10/2015	5	3	15

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		reviewed February 2015		3. Process embedded for managing prospective staff levels short and long term. 4. Trust has an integral Staff Bank to provide staffing cover. 4. Agency framework used if Bank cannot supply. 5. Monthly report to the Board of Directors and to Finance and Performance of Trust compliance to Safe Staffing Ratios (NICE). 6. Framework for graduate nurse and intermittent recruitment of nurses to achieve NICE staffing ratio.				3. Monthly report to the Board of Directors. 3. Weekly Agency Stats report. 3. Report to Finance and Performance. 4. Monthly report to the Board of Directors. 4. Report to Finance and Performance. 5. Monthly report to the Board of Directors and then our public website. 5. Report to Finance and Performance. 6. 6-monthly Safer Nursing Care Tool (SNCT) nursing staffing assessment reported to Board and on public website.						
COR069 **Director Lead: Director of Operations** **Initial Risk Score 25** **Reduced to 16 Sept 2014**	The Diagnostic standard is at risk if: the demand rises to a level above capacity, resulting in breaches to the Diagnostic standard	31/08/2014 **Last Review Date: February 2015**	2. To provide the best possible patient experience	1. Daily monitoring. 2. Divisional Plan to increase capacity to meet current demand.	4	4	16	1. Daily information reports. 1. Performance Review Meetings. 1. Finance and Performance Meeting. 2. Finance and Assurance Committee paper.	1. None. 2. None.	1. None. 2. None.	2. Plan to ensure recruitment of sufficient qualified staff. 2. Capacity and Demand review to establish future demand and required capacity. 2. Plan to replace or expand equipment needed based on Capacity and Demand review.	31/03/2015	4	3	12
COR073 **Director Lead: Director of Strategy and Transformation**	The Black Country Review of acute services does not deliver a solution that supports the future clinical and financial	05/11/2014	6. To deliver an infrastructure that supports delivery.	1. The Review has been raised with Monitor who have agreed the facilitate discussions.	4	4	16	1/2/3. Progress reported at the Board of Directors.	1. No formal project/discussions have been launched. 2. No agreement on the process of timeframe has been reached.		1/2. Dialogue with CCG, Area Team and other providers to get agreement and initiate a formal project.	31/03/2015	4	3	12

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Initial Risk Score 16	sustainability of the Trust	**Last Review Date: February 2015**		2. Informal discussion have taken place between three of the Chief Executives. 3. This is on the Board of Directors Agenda and discussed during reviews of the strategic objectives for implementation in 2016/17.											
COR063 **Director Lead: Director of Finance** **Initial Risk Score 15**	The current NHS contract enables the Trust to earn additional income up to 2.5% (£6.1m) to meet specified quality targets. The Trust budget assumes that the quality targets will be achieved in full. Hence, any shortfall against any of the schemes will result in a real financial consequence to the Trust's income position which could seriously compromise financial plans	27/05/2014 **Last Review Date: February 2015**	6. To deliver an infrastructure that supports delivery.	1. Separate CQUIN Exception Report scheduled in for quarterly discussion at F&P Committee. 2. CQUIN report incorporated into monthly reporting dashboard and covered in Directorate Performance Review Meetings. 3. All CQUIN schemes have a Lead Manager and nominated Executive Lead. Progress reports reviewed monthly with the Director of Operations with Exception Reports required for red rated schemes. 4. Exceptions flagged in CQUIN report and responsible officer required to report to F&P Committee. 5. Letter to CCG requesting current CQUIN for electronic discharge letters be set aside due to problems with JAC and need to revert to paper referrals.	3	5	15	1. Reports F&P Committee. 2. Dashboards and Performance Review Meetings. 3. Progress report collected on a monthly basis from Lead Manager. Exception Reports for red rated schemes. 4. August F&P Committee received exception reports for Pressure Ulcers, Dementia and Discharge Letters. 4. August financial position assumes risk of 10% (£0.6m). October financial position assumes risk of 15% (£0.9m).	5. Some CQUIN targets/milestones not fully agreed or remain unclear.	5. Awaiting CCG response to Trust proposal to set aside discharge summary CQUIN.	Divisional performance meetings focus on financial delivery against CQUINs 5. Agreement being sought to set aside discharge letter CQUIN.	31/3/2015	2	5	10

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COR064 **Director Lead: Director of Finance** **Initial Risk Score 15**	The current NHS contract allows the CCG to invoke penalties for sub-standard performance/failure to meet key targets. The Trust budget makes no allowance for any deduction. Hence, if contract penalties are enacted, there is real financial consequence to the Trust's income position which could seriously compromise financial plans	27/05/2014 **Last Review Date: February 2015**	6. To deliver an infrastructure that supports delivery.	1. Regular monthly monitoring of Performance Reports and exposure to penalties to Directors, F&P Committee and Board. 2. Corporate and Departmental dashboards in place for monitoring. 3. Breach analysis and Directorate reporting regime in place for investigation of target failures giving rise to penalties. 4. Plans linked to ECIST recommendations in operation 5. Letter from Director of Operations setting out Trust stance that fines cannot be invoked due to CCG failure to manage demand. 6, Agreement reached with CCG not to invoke fines for RTT from July to November in line with National Guidance	3	5	15	1. Reports to Directors, F&P Committee and Board. 2. Dashboards. 3. Action plans reported to F&P with reasons for failure and action to improve. Issues debated at Directorate Performance Reviews. 4 ED 4-hour target achieved in July/August. RTT overall 90% target achieved throughout the year but currently being fined on individual specialties. Ambulance turnaround find reduced to £40K in July. 5. CCG are to discuss Director of Operations letter at their September F&P Committee. Likely outcome is that CCG will maintain contractual requirement to enact fines but will seek to agree a reimbursement mechanism linked to behavioral "strings". Outcome remains that the CCG reject the Trust argument regarding fines but maintain willingness to agree reinvestment based on behavioral incentives.	5. Seek to negotiate repatriation of contract penalties with CCG.	5. CCG invoiced for Q1 fines totaling £464K, split £219K ambulance handover, £130K A&E, £115K RTT. 5. CCG also questioning reimbursement of 13/14 fines, stipulating that Trust did not deliver on all of requirements amounting to £275K. The 2 specific issues have been challenged (Discharge by 1pm and twice daily consultant ward rounds) by the Trust. This will be discussed at the September CCG F&P Committee. CCG have requested discussion between Medical Director and counterpart at Area Team to agree issue. Trust view is that this has occurred with a favorable outcome.	5. Agree with CCG mitigating reasons for not invoking fines or alternatively agree acceptable rationale for the payback of imposed contract penalties.	31/12/2014	3	5	15

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COR032 (OP097) **Director Lead: Director of Operations** **Initial Risk Score 15**	The Trust is required to have an up to date plan to manage major incidents and business continuity so that the Trust can deliver care to patients when a major incident is declared and continue to deliver patient care in the event of a serious outage or disruption to key services - (RISK LEAD: Karen Hanson)	01/12/2011 **Last Review Date: February 2015**	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). Reinstated emergency planning group.	5	3	15	1. IFM Reports and business continuity. 1. RCA Reports following business continuity incidents. 2. Clinical Quality and Patient Experience Committee Reports. 2. Table top exercise held testing BCP.	1. There are gaps in the BCP especially in relation to IT failure. 2. Delivery of actions.	1. 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.	31/3/2015	5	2	10
COR071 **Director Lead: Director of Operations** **Initial Risk Score 20** **Risk increased to 25 Nov 2014** **Risk decreased to 20 Dec 2014** **Risk decreased to 15 Feb 2015**	The ED 4 hour standard is at risk if: the level of emergency attendance or admission activity is higher than contracted activity or; there is an increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input, resulting in high numbers of 4 hour breaches within ED, a below 95% performance and the implementation of fines	31/08/2014	2. To provide the best possible patient experience **Last Review Date: February 2015**	1. Live capacity monitoring. 2. Capacity meetings with CCG. 3. Daily reviews of delayed discharges. 4. Length of Stay monitoring. 5. Agreement of recurrent funding for Winter plan schemes.	5	3	15	1. Four times daily multi divisional capacity meeting. 1. Daily information reports 1. Performance Review meetings 1. Finance and Performance meeting 2. Urgent Care Working Group 2. Winter Plan 3. Delayed discharge reporting 3. Delayed discharge meetings 3. Capacity team monitoring and escalation 3. Policies on delays including Choice 4. Ward and speciality reporting 4. Review against peers 4. Length of Stay working group 4. Winter plan 4. Previous pilot of Frail Elderly Unit 5. Agreement that the Winter funding will be made recurrent has taken place at SRG	1. None. 2. CCG implemented plan (including Better Care Fund) to manage activity. 2. Lack of on-site Urgent Care Centre. 3. Adherence to agreement on numbers of accepted delayed discharges. 3. Activation of fining protocol. 4. None. 5. UCWG and SRG to agree which Winter schemes will be made recurrent.	1. None. 2. Delivery of UCWG plans in past. 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand. 4. Accepted and agreed plan for sustained Frail Elderly Unit. 5. UCWG to determine which schemes proved to be most effective.	2. Establish actions by CCG to reduce attendances and admissions at DGH in line with contract and BCF plans 2. Open commissioned Urgent Care Centre 4. Inclusion of WIC figures into DGH overall performance	31/03/2015	5	2	10
COR067	The current Trust plans assume the receipt of £4m transitional support from Dudley CCG.	22/08/2014	6. To deliver an infrastructure that supports delivery.	1. Joint funded post across Trust/CCG and regular SDIP Steering Group Meetings.	4	3	12	1. Update of SDIP presented at monthly contract review. Separate SDIP Steering Group Meetings on a monthly basis.	1. Need to ensure that actions are agreed for each area between October and December,	1. Scoping meetings need to occur by the end of September for each of the requirements: SDIP, CAB, Elderly Care pathways	1/2. Schedule to be prepared setting out what needs to happen for each item in order to	31/03/2015	2	2	4

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Director Lead: Director of Finance Initial Risk Score 12	Whilst this has now been approved by the CCG Board, payment is linked to compliance with certain conditions and is therefore not guaranteed. The four conditions focus on greater transparency, implementation of the Service Delivery & Implementation Plan (SDIP), improving referral practice and establishing a comprehensive elderly care pathway)	Last Review Date: February 2015		2. CCG letter discussed at CLT and agreed that meetings would occur by the end of September to agree the scope of each requirement to enable the release of the first tranche of £1m. The second tranche of £1.5m will be released in December subject to the agreement of actions arising from the scoping meetings.				2. Of the first tranche of money, £900k has been agreed and paid. The outstanding £100k is subject to the outcome of a Capita report setting out the progress made on the Urgent Care Centre. The second tranche linked to actions is not due until December.	2. System to manage delivery of the four conditions to enable quarterly progress reports to be submitted to the CCG and ensure full payment of £4m.	and greater transparency (Finance, Estates, Workforce and Patient Experience). 2. Final tranche of £1.5m will be released in March, subject to delivery of actions.	increase the likelihood of achieving the agreed actions. A Director lead will be allocated to each item to ensure these are progressed.				
ST002 **Director Lead: Director of Strategy and Transformation** Initial Risk Score 12	Delivery of the turnaround plan negatively impacting upon the patient experience, quality of care and patient safety.	09/06/2014 Esculated from operational risk register February 2015	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1/2 Quality Impact Assessment (QIA) process in place that assesses the impact of a Cost Improvement Programme (CIP) 3/4 Weekly Performance Assurance Review (PAR) meetings	3	4	12	1 Established process continues from 2013/14 Cost Improvement Programme during which no detriment to patient experience or quality of care occurred. 2 Quality Impact Assessment (QIA) embedded within the Project Initiation Document (PID) and produced when projects enter planning phase 2 QIA procedure in place returning incomplete QIA to project lead for full completion 2 Reassessment of schemes done periodically post implementation where appropriate 3 Monthly turnaround performance report Completion of action log to demonstrate progress against outstanding actions. 4 Regular review of attendees and meeting frequency to encourage attendance 4 Action log published on the hub to be visible to remind attendees of actions	1 incomplete documentation meaning a decision cannot be made by the panel 2 Prospective completion of a QIA could result in risks not fully being identified 3 Poor attendance at meetings 4 Actions not completed by Leads		1/2/3/4 Review of project governance 1/2/3/4 Clinical lead for each project to be agreed that will be accountable for the delivery of the agreed quality indicators	31/7/2015	3	2	6

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								required for completion 4 Complaints, Friends and Family monitoring in place							

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COR068 **Director Lead: Director of Operations** **Initial Risk Score 20** **Reduced to 10 Sept 2014**	The RTT standard is at risk if: the level of emergency attendance or admission activity rises or; the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or; the theatre capacity and productivity is insufficient to meet demands, resulting in cancelled elective patients, breaches to the RTT standard and reduced income.	31/08/2014 **Last Review Date: February 2015**	2. To provide the best possible patient experience	1. Live capacity monitoring 2. Capacity meetings with CCG 3. Daily reviews of delayed discharges 4. Length of Stay monitoring 5. Monitoring of patients on inpatient lists 6. Theatre productivity 7. Continued delivery of performance above required level	5	2	10	1. Four times daily multi divisional capacity meeting. 1. Daily information reports 1. Performance Review meetings 1. Finance and Performance meeting 2. Urgent Care Working Group 2. Winter Plan 3. Delayed discharge reporting 3. Delayed discharge meetings 3. Capacity team monitoring and escalation 3. Policies on delays including Choice 4. Ward and specialty reporting 4. Review against peers 4. Length of Stay working group 4. Winter plan 4. Previous pilot of Frail Elderly Unit 5. Weekly PTL meetings 5. Monitoring reports 5. Performance Review meetings 5. Finance and Performance Meeting 5. Review of waiting list management 6. Theatre productivity reports 6. Theatre productivity meetings 6. Consultant leave policy 7. Trust Board Performance Report	1. None 2. CCG plan to manage activity 2. Lack of on-site Urgent Care Centre 3. Adherence to agreement on numbers of accepted delayed discharges	1. None 2. Delivery of UCWG plans in past 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand 4. Accepted and agreed plan for sustained Frail Elderly Unit 5. None 6. Consultant leave planning and impact on theatre activity management 7. None	1. Agree Frail Elderly Unit plan to reduce LOS and create capacity 2. Implement Winter Plan internally and gain action from partners for wider Winter Plan 3. Agree response by partners to delayed discharge pressure and implement section 2 & 5 sanctions 4. Establish actions by CCG to reduce attendances and admissions at DGH 5. Open commissioned Urgent Care Centre 6. Ensure priority of elective patients is kept high within Capacity meetings 7. Agree plan for annual activity including managing consultant leave appropriately 7 Develop plan to use A1 over summer time to reduce waiting list	30/04/2015	5	1	5

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR070 **Director Lead: Director of Operations** **Initial Risk Score 20** **Reduced to 10 Sept 2014**	The Cancer standard is at risk if: the level of emergency attendance or admission activity rises or; the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or; the theatre capacity is insufficient to meet demands, resulting in breaches to the cancer standard	31/08/2014 **Last Review Date: February 2015**	2. To provide the best possible patient experience	1. Live capacity monitoring. 2. Capacity Meetings with CCG. 3. Daily reviews of delayed discharges. 4. Length of Stay monitoring. 5. Monitoring of patients on inpatient lists. 6. Theatre productivity. 7. Continued delivery of performance above required level show that mitigating actions are mitigating risk.	5	2	10	1. Four times daily multi divisional capacity meeting. 1. Daily information reports. 1. Performance Review meetings. 1. Finance and Performance meeting. 2. Urgent Care Working Group. 2. Winter Plan. 3. Delayed discharge reporting. 3. Delayed discharge meetings. 3. Capacity team monitoring and escalation. 4. Ward and specialty reporting. 4. Review against peers. 4. Length of Stay working group. 4. Winter plan. 4. Previous pilot of Frail Elderly Unit. 5. Weekly PTL meetings. 5. Monitoring reports. 5. Performance Review meetings. 5. Finance and Performance Meeting. 5. Review of waiting list management. 6. Theatre productivity reports. 6. Theatre productivity meetings. 6. Consultant leave policy. 7. Trust Board Performance Report.	1. None. 2. CCG plan to manage activity. 2. Lack of on-site Urgent Care Centre. 3. Adherence to agreement on numbers of accepted delayed discharges.	1. None. 2. Delivery of UCWG plans in past. 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand. 4. Accepted and agreed plan for sustained Frail Elderly Unit. 5. None. 6. Consultant leave planning and impact on theatre activity management. 7. None.	1. Agree Frail Elderly Unit plan to reduce LOS and create capacity. 2. Implement Winter Plan internally and gain action from partners for wider Winter Plan. 3. Agree response by partners to delayed discharge pressure and implement Section 2 & 5 sanctions. 4. Establish actions by CCG to reduce attendances and admissions at DGH. 5. Open commissioned Urgent Care Centre. 6. Ensure priority of cancer patients is kept high within Capacity Meetings. 7. Agree plan for annual activity including managing consultant leave appropriately.	31/03/2015	5	2	10

Risk Ref	Risk	Risk Start Date Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR077 **Director Lead: Head of HR** **Initial Risk Score 20**	Workforce Reduction Programme will adversely affect patient care and Trust performance by removing essential skills and reducing the capacity of the workforce.	25/02/2015 **NEW RISK**	2. To provide the best possible patient experience	1. Manager, division support and business case approval required for voluntary redundancies 2. Active redeployment process for At Risk staff to retain skills and experience 3. New directorate / division structures that re-allocate work from removed posts to other roles	3	3	9	1. QIA process for voluntary and compulsory redundancies 2. 1) At risk/redeployment procedure, 2) 4-week trail period for redeployed staff in new role, 3) Redeployed staff must have the essential capabilities for the job	1. Lack of consistency when calculating savings 3. Not all changed roles will have new job descriptions or be job evaluated. This might result in grading claims	1. No QIA process for removed vacancies 3. Lack of an over-arching workforce plan to complare against	1/3. Development of a Trust-wide 5-year workforce plan, including medical staffing 2/3. Development of a Trust-wide workforce resourcing plan, identifying skills shortages and sources of workforce supply	31/12/2015	2	2	4
COR044 **Director Lead: Medical Director** **Initial Risk Score 12** **Reduced to 9 May 2014**	The need for a 'Medical Workforce Plan' - a fit-for-purpose workforce is needed to meet service needs - (RISK LEAD: Dr Whallett)	03/01/2013 **Last Review Date: February 2015**	6. To deliver an infrastructure that supports delivery.	1. Appointment of Trust junior and middle grade medical staff to support specialty rotas. 2. Locums to cover 'gaps' in rotas. 3. Ad hoc Trust appointed posts in individual departments. 4. We are beginning to explore the roles of non-medical staff performing the duties traditionally performed by doctors.	3	3	9	1. A business case for Junior and Middle Grade Trust doctors based upon the needs of departments working together rather than in isolation was approved and recruited to. 2. Rotations are staggered with deanery posts so that times of 'changeover' do not coincide. 3. Rotas are less hard pressed leading, so there is more flexibility if there any 'gaps' in the rota. Therefore EWTD less likely to be breached. 4. 'Spreading the load' with existing doctors reduces stress hard pressed areas. Junior doctor satisfaction is important in external QA such as deanery visits, JEST, GMC trainee's surveys etc. 4. Posts to be under the educational stewardship of a new 'Junior Trust Doctor Tutor' post.	1. Some of the Trust posts are still not recruited to. 2. Locums are expensive, unreliable, of lower quality and have no commitment to the organisation. 3. Ad hoc Trust appointed posts are difficult to fill, difficult to fill with quality and a considerable drain on departments to appoint in isolation with other departments in the hospital (e.g. shortlisting, interviewing etc). 4. The recruitment of non-medical alternatives – e.g. surgical nurse practitioners, Physician's assistants, has not been rolled out to its full potential. 4. No process for overseeing education and training of locum and ad hoc post holders. 4. Little flexibility in the system if a doctor leaves a deanery rotation early (e.g. maternity leave, obtains consultant job, illness etc).	1. Assessment of the impact of the Trust doctors has not yet been completed, as the post holders are not yet in post: 1. To analyse reduction of locum spend which we presume to reduce over time. 2. To ensure a steady stream of high quality candidates for posts, and retain them. 3. To ensure adequate appraisal and training of post holders, and revalidation if necessary. 4. This requires the assurance of available educational and clinical supervisors, clinical skills, IT and mandatory training. 4. Processes to be established for any doctors who run into difficulty.	1. Implementation of a Trust Programme for Junior and Middle Grade Trust Doctors. a) To recruit high quality, consistent junior and middle tier In-house training schemes that supplements the deanery trainees. b) Review how we can use existing funded posts, and also to offset the money currently spent on locum posts. The rotations could be viewed in isolation. 2. Develop a further rotation to offset pressures in the Anaesthetic service. This will work to the same principles. a) Review programme and extend to other departments i proven beneficial. . 4. To explore the role of Physicians assistants for other departments where posts may be threatened or where there is demand. ACTION IS ON-GOING.	31/07/2015	2	2	4

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd April 2015

TITLE:	**Board Assurance Framework – as at end of February 2015**		
AUTHOR:	**Glen Palethorpe Associate Director of Governance and Board Secretary**	**PRESENTER**	**Glen Palethorpe Associate Director of Governance and Board Secretary**

CORPORATE OBJECTIVES: ALL

SUMMARY OF KEY ISSUES:

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

This report identifies the Trust Assurance Framework and specifically:

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

In addition to the operational risk registers (reported to Risk and Assurance Group) the Directors are currently managing 17 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (5 risks in total). The report shows the assurance to date of the effectiveness of the management and control of these risks. Action plans are in place, or being developed to address any gaps in control or assurance identified at this time.

It should be noted that as the Trust's 2015/16 plan is drafted then the identified strategic risks to the delivery of the agreed objectives supporting the Trust's vision will be used to formulate the 2051/16 Assurance Framework.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD:

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

THE DUDLEY GROUP NHS FOUNDATION TRUST
BOARD ASSURANCE FRAMEWORK – RISKS SCORING 20 AND 25 as at February 2015

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR072 **Director Lead: Medical Director** **Current Risk Score 20** **Target Mitigated Risk Score 4**	The JAC, a medicines management system, since 2008, to generate an electronic discharge summary containing details of patients' diagnosis, and discharge medication.	NHSLA - Standard 4 CQC Outcome 6	1.Users are trained to use both Soarian and JAC	1.review of access by systems administrator. 1 Training monitored by line managers	1.July 2014 new training programme now in place 1 staff training monitored by managers			Meet with JAC to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072	However a discharge summary is not always being sent to the GP or to Soarian and sometimes the messaging between systems is not processed correctly. Key issue is that discharge writing process is not delivering	NHSLA - Standard 4 CQC Outcome 6	2.An admission and discharge message is sent from OASIS to JAC when the patient is either admitted or discharged	2.The OASIS to JAC interface is monitored by Siemens.		2. It is not easy to monitor the JAC system for open episodes where a patient has been discharged in OASIS.	2. If the patient for any reason has an open episode in JAC the message will not be processed resulting in no discharge being created.	1 Meet with Indigo4 to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed.
						2. Because the system is not actively monitored the Trust is unaware when a discharge message is not sent and a GP does not receive the electronic discharge summary.	2.The JAC to Keystone interface is not actively monitored. The Keystone system is used to send discharge summaries to GPs.	2 Create a new set of processes to actively monitor JAC and Keystone error messages

			3.The Trust is able to generate the current bed state from OASIS and is then able to manually match this to the ward list in JAC in order to be able to close open episodes which would prevent an OASIS admission message being processed			3. This is not actively monitored, therefore discharge summaries that have failed the automated messaging are not sent to the GP and Soarian. Often the GP telephones the Trust to request a discharge letter, this is often not reported.	3. This requires resources from the Trust to actively match patients across both systems.	3 Develop Joint Audit between the CCG and The Dudley Group NHSFT
Risk Ref	**Risk Description**	**Monitor / CQC / NHSLA ref**	**Current Controls**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**	**Gaps in Control**	**Mitigating Actions**
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	4. In order for discharge summaries to appear in Soarian a folder in the Keystone system is searched and documents copied to Soarian.	4.Documents in the Keystone folder appear in Soarian	.	4.Documents belonging to incompatible GPs are not created in the Keystone folder and are not sent to GPs or Soarian However delays in updating the national spine continue to cause some issues updating the files where GPs have changed.	4. There are a number of incompatible GP practices in Keystone, therefore these do not generate a discharge summary document and as such will not appear in Soarian	4 Reference files across the Trust to be updated.

			5. Admission and discharge on OASIS does not always correspond to admission and discharge on JAC. This happens very frequently in some areas with high throughput, such as EAU or day case units	5. Staff should reclose the admission so that any future admissions are generated correctly.	5.Display warning message on Soarian front page 5. Display warning message on doctors App	5. Staff do not close reopened admission spells on JAC until the patient is readmitted. By closing the original spell a new summary will be created and sent electronically which is now out of date	5. Staff are able to override the closed admission in JAC by manually opening a spell previously closed by OASIS	5 Create a new set of processes that only permit a select group of users to reopen correctly closed spells
			6. Multiple individuals complete the TTO letter, with no clear final sign-off process.	6. A new sign-off procedure is needed for TTOs. Letters should be signed and clearly identified by the discharging doctor	6. Fully addressed through Sign and Stamp campaign. Pharmacy will no longer accept letters not correctly and clearly signed.			
			7.Not all drugs can be included on JAC from the pick list				7. The drug list on JAC has not been updated for 7 years, meaning not all drugs can be picked accurately.	7. Display urgent message on the Hub. Trust data base and drug list on the JAC to be updated with the local formulary
Risk Ref	**Risk Description**	**Monitor / CQC / NHSLA ref**	**Current Controls**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**	**Gaps in Control**	**Mitigating Actions**
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	8. TTO's are sometimes completed and sent to pharmacy when the patient is medically fit but before the patient is ready for discharge and then the TTO drugs are kept on the ward, sometimes for many days.	8. There needed to be a expiry date on TTOs – approx 48 hours.	8. Sign and Stamp Campaign has addressed this. A three way check is now in place	8. Nursing staff currently only check the TTOs against the TTO letter, not the patient's drug chart. This misses an opportunity to cross-check for accuracy	8. Patient's medication and diagnosis may change during that time, but this will not be included on the TTO.	
			9.There are many prescribing errors on TTOs which have to be corrected in pharmacy		9. Sign and Stamp Campaign has addressed this. A three way check is now in place		9.When pharmacy updates a TTO, there is no process for a further sign-off by the prescribing doctor	8 / 9 Review TTO process to ensure it is clinically safe

			10. The GP list of emails on Keystone is not up to date				10.Letters are not sent electronically to GP. A copy of the letter is not stored for future reference	10 Gen Practitioner email address to be updated
			11.Dudley CCG monitors receipt of discharge summaries twice yearly, to monitor contract standard target	11.There must be a robust audit process around discharge letters	11.Joint audit with CCG under development	Dudley CCG has raised a contract query and want to investigate further Sandwell CCG has reported problems with the Trust discharge summaries – to be investigated		11 Develop a framework that ensures incompatible letters are saved

Board Strategic Theme: Patient experience	Strategic Goals		Key Priorities			Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG02: To provide the best possible patient experience		**a) Mobilising the workforce with a passion for getting things right for patients every time**			**Section C: Clinical and Quality Strategy.** **Appendix 3E**	**Outcome 12, 13, 14**	**CQSPE**
			b) Creating an environment that provides the facilities expected in 21st C healthcare and which aids treatment and or/recovery			**Appendices 3 C & 3F**	**Outcome 8 Outcome 10**	**CQSPE**
			c) Providing good clinical outcomes and effective processes so that patients feel involved and informed			**Section C: Clinical and Quality Strategy.**	**Outcome 1,4**	**CQSPE**
Risk Ref	**Risk Description**	**Monitor / CQC / NHSLA ref**	**Current Controls**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**	**Gaps in Control**	**Mitigating Actions**
There are currently no Corporate Risks scoring 20 – 25 in this category								

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

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

Board Strategic Theme: Clinical Partnerships	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG04: To develop and strengthen strategic clinical partnerships to maintain and protect our key services	a) Demonstrate a distributed leadership model with empowered clinical leaders	Section G: Leadership & organisational Development	Outcome 12, 13, 14	CQSPE
		b) Promoting risk sharing with CCGs	Appendices 3a & 3d	Outcome 6	F&P
		c) Developing clinical links with local GPs and healthcare practitioners	Appendix 3d	Outcome 6	CQSPE
		d) Develop new clinical networks that provide resilience through a more distributed service model	Appendices 3a & 3d	Outcome 6	F&P

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

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

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

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR059 **Director Lead:** **Director of Operations** **Current Risk Score 16** **Target Mitigated Risk Score 10**	The capital development costs of the UCC exceed that available to the Trust. The financial consequence of the planned reduction in ED activity causes financial pressure.		1. Urgent Care Project Group (Involves senior staff from DCCG as equal partners in planning the development and its finances).	1. Urgent Care Project Group Minutes discuss key financial issues. 1. DCCG Board Minutes support project. 1. 2-year operational plans (DCCG and DGFT) support project. 1. Project Board re-focus jointly project managed by external organisation. 1. Finance and Performance Committee Minutes.	Update from Director of Strategy and Performance on UCC at the F&P Committee on 27th Nov 2014 plus further updates to F&P Jan and Feb 2015	No agreed budget and cost	1. No final agreement in place.	1/2. Contract negotiation with DCCG including consideration of risk share arrangement and/or local tariff on both ED attendance and AEC/SAU/EAU assessment activity, better reflecting re-designed service.

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

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont…. COR061					Summary of Financial Position to F&P Committee Feb predicted out turn back to established 2014/15 planned level of deficit Letter from Monitor regarding acceptance of outline view on 14/15 out turn and thus starting point for 15/16 five year plan			
COR065 **Director Lead: Director of Finance** **Current Risk Score 20** **Target Mitigated Risk Score 12**	The current Trust plan of a £6.7m deficit is predicated on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to deliver this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years.	CQC Outcome 26 Monitor	1. Development of rigid PMO structure to properly assess each saving opportunity, requiring completion of PID with key milestones and a QIA. 1.Weekly/Bi-Weekly PAR meetings held with Performance Director/Operations Director and Chief Executive to offer significant challenge to project leads. Further escalation where necessary.	Bi-weekly meetings with managers to run through key milestones. Completion of CIP tracker showing PID and QIA. CIP update report to Directors, F&P, Board. Escalation meetings now include Director of Ops/Chief Executive; Dashboard available on Hub;	Improved QIA process Monthly progress reports to Board and F&P PMO processes have been implemented across all projects in line with policy, ongoing monitoring of compliance is underway The forecast year deficit has been reduced as a consequence of another “good” month to a forecast of £8.0m (an improvement in a month of £0.6m).	1. Some central schemes not fully owned by Directorates		Focus on saving cost schemes reinforced through PAR meeting and escalation processes

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont.… COR065			2. Monthly report to F&P Committee 2.Development of a Turnaround programme designed to ensure that saving/efficiency opportunities are maximised without detriment to quality/patient care. Wider debate with Monitor/CCG Area Team at round table sessions. New vacancy control process developed including weekly executive led Approval Panels 3.Increased budget manager accountability to ensure rectification plans are prepared for overspending budgets	Reports to F&P 2.Turnaround plan/reports to Directors, F&P, TME and Board. Reports continue to be presented on a monthly basis; however, Month 7 position shows an adverse variance of £1.981m and projected year-end forecast of £8.705m Workforce Work stream commenced with robust vacancy controls and scoping of workforce reductions over coming years 3. Development of controls framework. Relaunch of Budget Manager responsibility policy. Discussions held with budget managers. Rectification plans for overspends in excess of £50k expected	Weekly Turnround exception reports to Directors Monthly divisional performance meetings focus on quality and financial performance	2. Poor detail presented to QIA panels - requiring deferral of support by MD/DN. 3. New management structure has resulted in doubts about accountability for overspends.	.	Board require sign-off of 2015/16 Plan by April.

			4. Devolution of income to directorates to create greater ownership and accountability. 5. Drive to reduce run rate including medical staffing exercise and formal announcement of reduction of 400 posts over 2 years. Stricter control on vacancies in lieu of this	4. Discussion with CCG at CLT around re-patriation options. Income currently exceeding plan. 4.Monitoring of income levels 5. Chief Executive address to staff on importance of financial balance to clinical sustainability. 5. Additional winter pressure income received to provide finances to keep beds open.	Increased revenue in elective activity 75% of consultant workforce attendance at C Exec / MD briefing		5. Inability to achieve required savings due to other pressures, i.e. increased emergency activity resulting in inability to close beds.	5. Workforce Efficiencies (medical staff), agency reduction and programme to look at post 5. Increased drive on reduction efficiency for outpatient involving specific specialties of greatest impact.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR076 **Director Lead: Director of Nursing** **Current Risk Score 20** **Target Mitigated Risk Score 15**	The Registered Nursing (RN) staffing levels do not meet Safe Staffing for Nursing in Adult Patient Wards in Acute Hospitals NICE/Guidance		1. Identified nurse rostering system across all wards (Allocate). 2. Process embedded to monitor staffing levels daily, includes: - Daily review by Lead Nurses - Staff ratios displayed on Huddle Boards and discussed at Huddle Board Meetings 3. Process embedded for managing prospective staff levels short and long term. 4. Trust has an integral Staff Bank to provide staffing cover. 4. Agency framework used if Bank cannot supply.	2. Daily e-mails of Lead Nurses review of staffing levels - requesting Bank. 2. Monthly report to the Board of Directors. 2. Weekly Agency Stats report. 2. Report to Finance and Performance. 3. Monthly report to the Board of Directors. 3. Weekly Agency Stats report. 3. Report to Finance and Performance. 4. Monthly report to the Board of Directors. 4. Report to Finance and Performance.	Monthly Board reports F&P Report Presentation from Director of Nursing to F& P (Nov 2014) Presentation to Board on safer staffing levels Feb and March 2015			

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

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 2nd April 2015

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

CORPORATE OBJECTIVE:

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

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

SUMMARY OF KEY ISSUES:

In January the Board of Directors agreed to roll over the present Quality Account Priority topics to next year (2015-16). These are:

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

This was after a discussion at their December 2014 meeting by the Governors who had a similar view. The paper at the January Board meeting explained that the specific targets for each of these topics would have to be agreed later in the financial year, once it was reasonably clear about the outcomes of the 2014-15 targets.

The attached paper now makes suggestions with a rationale for the specific targets for next year. These have already been discussed by the Executive Directors.

The Board of Directors are asked to either agree with the suggestions or agree alternatives.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
√		√	

RECOMMENDATIONS FOR THE BOARD:

To agree the specific Quality Priority targets for next year (2015-16).

THE DUDLEY GROUP NHS FOUNDATION TRUST

QUALITY PRIORITY TARGETS THIS YEAR AND SUGGESTIONS FOR 2015/16

QUALITY PRIORITY 1: PATIENT EXPERIENCE.

THIS YEAR

Hospital: a) Maintain an average score of 8.5 or above throughout the year for the patients who report receiving enough assistance to eat their meals. 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. **Community:** 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: 8.8 out of 10). 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: 8.3 out of 10)

SUGGESTION 2015/16

Hospital: 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 publication during 2015-16).*

Community: 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: The present two hospital targets are likely to be met. We presently do not have the one-off community survey results but to ensure consistency change all the targets to the FFT so that national and local comparisons can be made.

QUALITY PRIORITY 2: PRESSURE ULCERS

THIS YEAR

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

SUGGESTION 2015/16

Hospital: a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2015/16 does not increase from the number in 2014/15. **Community:** 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 pressure ulcers acquired on the district nurse caseload in 2015/16 does not increase from the number in 2014/15

Rationale: To retain the emphasis on reducing pressure ulcers.

QUALITY PRIORITY 3: INFECTION CONTROL

THIS YEAR

Reduce our MRSA and Clostridium difficile rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C. difficile is no more than 48 post 48hr cases in 2014/15.

SUGGESTION 2015/16

Reduce our MRSA and Clostridium difficile rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C. difficile is no more than 29 post 48hr cases in 2015/16.

Rationale: To retain the emphasis on reducing healthcare acquired pressure ulcers. These are the new national targets for 2015/16

QUALITY PRIORITIES 4 AND 5: NUTRITION/HYDRATION

THIS YEAR

Nutrition: Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90% of patients will have the weekly risk assessment completed and this will rise to at least 93% by the end of the year (March 2015).
Hydration: Ensure that on average throughout the year 93% of patients' fluid balance charts are fully completed and accumulated at lunchtime.

SUGGESTION 2015/16

Nutrition/Hydration: Ensure that the yearly score for every ward in the hospital on the whole of the monthly Nutrition Audit (which consists of 24 items) is 93% or above.

Rationale: To retain the emphasis on nutrition/hydration. The two specific targets for this year are likely to be met. This target covers all of the 24 items of the audit (not just two specific ones) so is more comprehensive. It also looks at every ward separately not an overall Trust score. This ensures that every ward will have its results published rather than being subsumed into an aggregate Trust score so that the situation in every ward is clear.

QUALITY PRIORITY 6: MORTALITY

THIS YEAR

Ensure that 85% of in hospital deaths undergo specialist multidisciplinary review within 12 weeks by Mar15.

SUGGESTION 2015/16

Ensure that 90% of in hospital deaths that are able to be reviewed undergo specialist multidisciplinary review within 12 weeks by Mar16.

Rationale: The present target is likely to be met. To retain the emphasis on the timely review of deaths. To strengthen the target (from 85 to 90%) but only to include those cases that can be reviewed at the Trust e.g. not those cases awaiting or under review by the coroner.

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 2 April 2015

TITLE	**Performance Report April 2014 – February 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: • **Deficit of £1.3m in February 2015 (£0.4m worse than plan)** • **Deficit of £6.4m for year to date, (£0.9m better than plan)** • **Deficit budget for 2014-15 of £6.7m which is now expected to be met** • **Provision for redundancy of £2m now included for the first time** • **Some risks to the year-end position remain which are principally CCG income and some potential outstanding IT payments.** • **A&E 4 Hours waiting time target met for Q4 up to 15th March 2015 (95.9%)** • **Some RTT waiting time pressures, but major RTT and Cancer targets being met**			

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

			The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS) at Q2, but 2 for Finance for the forthcoming 12 months. The Trust remains on monthly monitoring by Monitor. **Monitor has notified the Trust that it is 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 ratify the Chairman's action noted in item 6 and the note the contents of the report.

The Dudley Group NHS
NHS Foundation Trust

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

Report on Finance and Performance for April to February 2015

1. Background

The Finance & Performance Committee of the Board met on 26th March 2015. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports.

Highlights of the discussion at the meeting are as follows:

2. Financial Performance for the 11 months period April 2014 to February 2015 (Appendix 1)

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

February 2015 continued the recent trend of the Trust's in-month and forecast year-end position improving although because the month is a short one in days terms, the actual in-month performance was a deficit

In February 2015 the Trust posted an in-month deficit of £1.27m, which was £0.4m worse than plan.

For the 11 months period to February 2015 a cumulative deficit of £6.5m was recorded. Key variances include income at +£6.2m (+2.1%); Non Pay -£5.0m (-4.8%); CIP not achieved -£2.6m.

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

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

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

The Trust is now forecasting a deficit of £6.7m for 2014-15 on its operating position and a deficit of £8.48 in its bottom line position when the additional redundancy costs are accounted for

At 28th February 2015 the Trust had cash reserves of £22.2m (£21.2m in January) and 8.8 days liquidity (9.85 previously).

Capital spending for the period was £8.1m (£1.2m Medical Equipment, £4.5m IT, £1.47m PFI Lifecycle), some £1.2m below plan.

3. Performance Targets and Standards (Appendix 2)

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

Highlights include:

a) A&E 4 Hour Waits

The February 2015 performance was 96.6% compared to the constitution target of 95%. The Q4 performance to 15th March 2015 was 95.6% - continuing the trend of good performance of recent months. The Trust is now confident of meeting the 95% constitution standard

b) Never Events

The Trust had no 'never events' in February 2015 or since Q2.

c) Referral to Treatment Waiting Times

The RTT admitted waiting time standard of 90% of patients was just met again in February 2015 with 93.4% of patients being seen in time. There is confidence that this will continue to be achieved for the rest of the year. RTT non-admitted and incomplete pathways KPIs are both well within their thresholds, although the performance on the incomplete pathways reduced in month.

d) Diagnostic Waits

Diagnostic waits continue to underperform compared to targets with 98.4% of patients being seen in 6 weeks compared to a target of 99%. This is a very small improvement on the previous month. The remedial action plan continues to be implemented by the Division but it is not expected that the standard will be met until May 2015.

4. Divisional performance Review

The Committee considered the performance presentation from the Division of Surgery relating to Obstetric services, particularly focussing on the financial aspects. A number of areas were discussed including the progress on improved coding and income from birth related episodes

5. Report from the IT Steering Group

Jane Dale and Mark Stanton reported back verbally from the IT Steering Group, although no further meetings had been held since the previous report to Finance & Performance Committee

A further discussion was undertaken about the scoping exercise and it was agreed that resource implications for clinical and other staff would be presented to the next meeting, along with a recommendation from the IT Steering Group on the approach to be taken

It was noted that the internal audit report into Project Fusion was being finalised and would be presented to the next meeting of the IT Steering Group

6. Budget Package 2015-16

Richard Price outlined the three components of the budget plan for 2015-16:

- The baseline budgets which have largely been based on forecast out-turn (for the first time)
- Contract income – which has largely been agreed with major commissioners
- Cost Improvement Programme – which has been agreed internally

Finance and Performance committee debated aspects of all elements of the budget and agreed a package of measures resulting in deficit budget of £4.2m in 2015-16. Under Chairman's Action the Trust Board delegated approval of the 2015-16 budgets to the Committee and the Board is asked to ratify the Chairman's action. Under this delegated approval, the Finance and Performance Committee formally approved a revenue deficit budget of £4.2m and a Capital Programme of £6.9m for 2015-16.

P Taylor
Director of Finance & Information

THE DUDLEY GROUP NHS FOUNDATION TRUST

APPENDIX 1

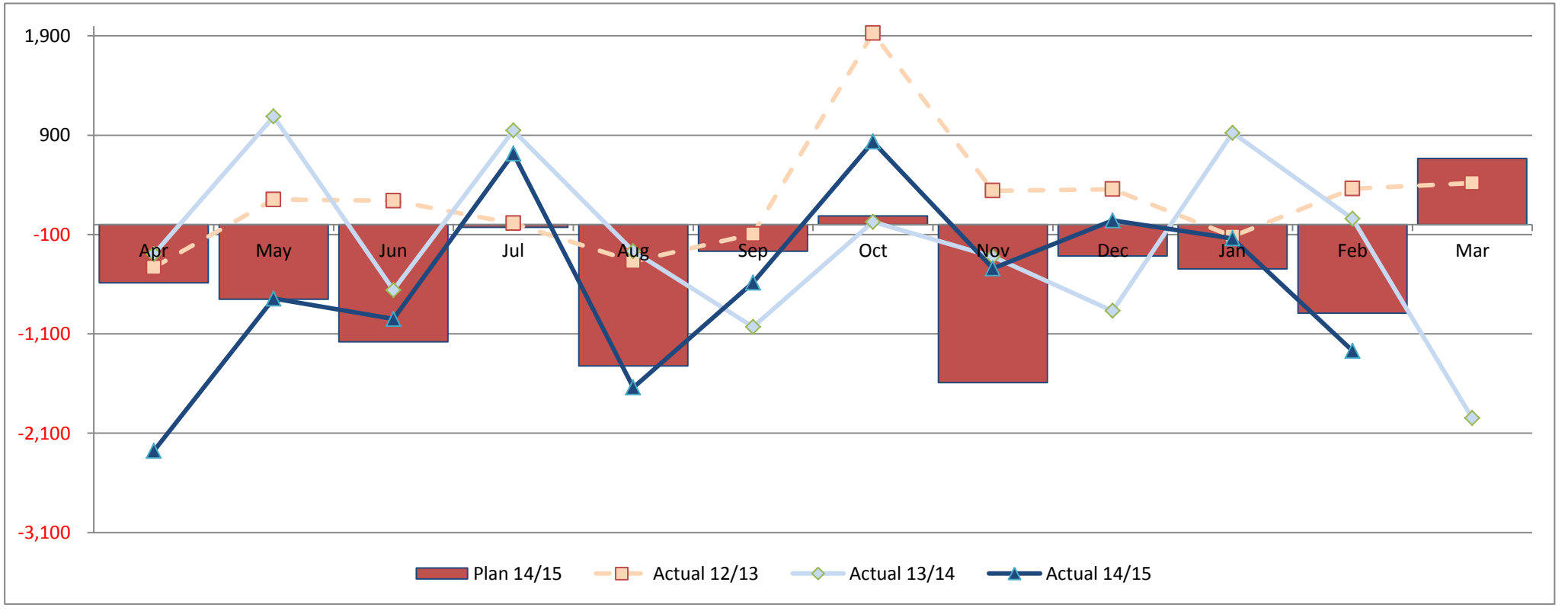
FINANCIAL SUMMARY **FEBRUARY 2015**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£25,738	£25,757	£19
PAY	-£15,948	-£15,752	£196
CIP	£254	£0	-£254
NON PAY	-£9,052	-£9,394	-£342
EBITDA	**£992**	**£611**	**-£381**
OTHER	-£1,883	-£1,881	£2
NET	**-£892**	**-£1,270**	**-£379**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£290,357	£296,589	£6,232
PAY	-£176,304	-£174,477	£1,827
CIP	£2,598	£0	-£2,598
NON PAY	-£103,108	-£108,077	-£4,969
EBITDA	**£13,542**	**£14,035**	**£493**
OTHER	-£20,936	-£20,489	£447
NET	**-£7,394**	**-£6,454**	**£939**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£317,524	£323,619	£6,094
PAY	-£192,765	-£190,851	£1,914
CIP	£3,119	£0	-£3,119
NON PAY	-£111,741	-£116,864	-£5,123
EBITDA	**£16,137**	**£15,903**	**-£234**
OTHER	-£22,865	-£24,385	-£1,519
NET	**-£6,728**	**-£8,481**	**-£1,753**

NET SURPLUS/(DEFICIT) 14/15 PLAN & ACTUAL **FEBRUARY 2015**



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Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold & Weighting		Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements							N/A
INFECTION CONTROL (SAFETY)							
HCAI - Clostridium Difficile - meeting the C Diff objective	48	1.0	7	8	11	7	**33**
HCAI - Clostridium Difficile - Avoidable Cases			5	6	9	Not Yet Available	**20**
CANCER WAIT TARGETS (QUALITY)							
Max waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	1.0	97.0	96.1	96.2	97.2	**96.5**
Max waiting time of 2 weeks from urgent GP referral to date first seen for symptomatic breast patients.	93%		97.3	94.7	97.5	86.3	**95.6**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	1.0	99.7	99.8	99.8	99.4	**99.7**
Maximum waiting time of 31 days for second of subsequent treatments – Anti Cancer Drug Treatments	98%	1.0	100	100	100	100	**100**
Maximum waiting time of 31 days for second of subsequent treatments – Surgery	94%		98.2	100	100	100	**99.6**
Maximum waiting time of 31 days for second of subsequent treatments – Radiotherapy	94%		N/A	N/A	N/A	N/A	N/A
Maximum two month (62 days) wait from referral to treatment for all cancers – Urgent GP Referral to Treatment	85%	1.0	88.7	87.4	88.1	85.5	**87.8**
Maximum two month (62 days) wait from referral to treatment for all cancers – From National Screening Service Referral	90%		100	100	95.6	88.9	**98.2**
A&E (QUALITY)							
% Patients Waiting Less than 4 hours in A&E	95%	1.0	92.1	96.1	95.0	95.5	**94.5**
REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)							
RTT – Admitted % Treated within 18 weeks	90%	1.0	90.1	90.6	92.1	92.9	N/A
RTT – Non-Admitted % Treated within 18 weeks	95%	1.0	99.2	99.1	98.7	97.6	N/A
RTT – Incomplete pathways % waiting within 18 weeks	92%	1.0	94.7	95.9	95.6	95.7	N/A

Community Services (Effectiveness)							
Referral to treatment information	50%	1.0	98.0	99.0	99.5	99.1	N/A
Referral information	50%		64.9	65.4	66.7	86.9	N/A
Treatment activity information	50%		99.5	100	100	100	N/A

Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

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