The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 3rd July 2014 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apols. – D. McMahon**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 5th June 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 5th June 2014	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	E Rees	To Note & Discuss	10.00
	7.2 Workforce and Staff Engagement Committee Exception Report	Enclosure 5	A Becke	To Note & Discuss	10.10
	7.3 Moving Patients Out of Hours	Enclosure 6	R Cattell	To Note & Discuss	10.20
	7.4 Safeguarding Quarterly Report	Enclosure 7	Y O'Connor	To Note & Discuss	10.30
	7.6 Corporate Risk Register	Enclosure 8	J Cotterill	To Note	10.40
	7.7 Board Assurance Framework	Enclosure 9	J Cotterill	To Note	10.50
	7.8 Francis Report	Enclosure 10	J Cotterill	To Note	11.00
	7.9 Nurse Staffing Report	Enclosure 11	Y O'Connor	To Note & Discuss	11.10
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 12	D Badger	To Note & Discuss	11.20
9.	**Date of Next Board of Directors Meeting** 9.30am 4th September, 2014, Clinical Education Centre		J Edwards		11.30

10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		11.30

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

MINUTES OF THE PUBLIC BOARD OF DIRECTORS
5 JUNE 2014, EDUCATION CENTRE, RUSSELLS HALL HOSPITAL

PRESENT: John Edwards, Chairman (in the Chair)
David Badger, Non Executive Director
Jonathan Fellows, Non Executive Director
Richard Miner, Non Executive Director
David Bland, Non Executive Director
Paul Assinder, Director of Finance and Information
Paula Clark, Chief Executive
Denise McMahon, Nursing Director

IN ATTENDANCE: Annette Reeves, Associate Director of Human Resources
Richard Cattell, Director of Support Operations
Liz Abbiss, Head of Communications and Patient Experience
Julie Cotterill, Associate Director of Governance/Board Secretary
Alison Fisher, Executive Assistant
Amanda Howes, Personal Assistant

14/045 APOLOGIES AND WELCOME

Apologies were received from Dr P Harrison and Mrs A Becke.

14/046 DECLARATION OF INTERESTS

There were no declarations of interests.

14/047 ANNOUNCEMENTS

Mr Edwards, Chairman (C) announced that item 7.3 Nurse Staffing (Enclosure 6) had been moved to the Private Board of Directors agenda as individual members of staff would be discussed.

14/048 MINUTES OF MEETING 1 MAY 2014 (ENCLOSURE 1)

The minutes were agreed as an accurate record of the meeting.

14/049 ACTION SHEET 1 MAY 2014 (ENCLOSURE 2)

All items on the action sheet had either been actioned, were included on the agenda or were for a future meeting of the Board of Directors.

14/050 PATIENT STORY

Mrs McMahon, Nursing Director (ND) gave details of a patient's story that was raised as part of a real time survey carried out on 29 May 2014.

It detailed a patient's concern around the lack of communication during and following a planned operation and the action taken to address the concerns.

The Board noted the timely response given to the patient and the outcome of the story. Mr Cattell, Director of Support Operations (DSO) stated that we need to ensure that when a patient has been sedated we communicate with them later when they are fully awake.

Mr Badger, Non Executive Director (NED) said this story shows a failure in a key patient experience, but it has been raised and we have put actions in place to ensure better communication to patients, especially those who have been sedated. Ms Clark, Chief Executive (CE) commented that we need to sustain this improvement in communication to patients and using the new Huddle Boards will be one way we achieve this.

Mr Assinder, Director of Finance and Information (DFI) suggested that we include a reminder on the screen saver and Mr Badger (NED) suggested using the patient safety walkrounds to pick up if patients are observing the huddle boards. Both of these were agreed and will be taken forward.

Mrs Abbiss to take forward a screen saver reminder to staff about communicating to patients at all times, but especially if they have been sedated

(HCPE)

Mrs Cotterill to include the question of patients observing huddle boards as part of the patient safety walkrounds

(ADGBS)

14/051 CHIEF EXECUTIVE'S OVERVIEW REPORT (ENCLOSURE 3)

Ms Clark (CE) presented her report to Board members, which covered the following issues:

95% Hospital/Emergency Department 4 hour Wait Target – May performance against the target was noted as 91.37%, which was the same as the April performance. Ms Clark (CE) highlighted key factors affecting our performance:

- May had been a very busy month with the highest number of attendances in almost 2 years (8631)
- There was a high number of ambulances in May (2669), which is the third highest month since the start of 2012
- High number of patients 80+ attending – 750 May 2013, 963 May 2014
- Number of admissions remains very high with the average pre December 2013 1900 and post December 2200 which is an increase of 15%. Taking out the 0 – 1 day admissions, the increase in admissions is still 9% and it was noted that Dudley CCG have concurred with these figures
- The Trust saw the highest number of majors during May (6098).

Ms Clark (CE) reported that pressure within the West Midlands had continued into June, with the majority of Trusts working at Level 3 and 4. Dudley CCG are raising with the West Midlands Ambulance the algorithm they are using, due to the number of patients coming through from the 111 service.

Ms Clark (CE) is hoping that pressures eases up over the summer months and we achieve the ED target in Q2, a quarter the Trust has not failed in 5 years.

Mr Badger (NED) asked what debate are we having with Dudley CCG about the pressures in ED and also commented that as well as patients being 80+, they are also very unwell patients and how are the CCG dealing with this. Mr Cattell, (DSO) reported that Dudley CCG are setting up a Community Rapid Response Team (RRT), which will comprise of expert nurses that will review patients in the community to try and avoid admissions. He commented that the Health Economy plans for the next two years have been modelled on the RRT working. The RRT will work between us, GP, Ambulance Service and the 111 Service.

Mr Edwards (C) commented that there is a risk that these nurses could increase admissions as they will need to manage the clinical risk of caring for patients in the Community. Mrs McMahon (ND) agreed and reported that we are seeking national guidance on working with this model of care.

Mr Cattell (DSO) reported that there are three initiatives being worked on to help reduce ED activity:

- Urgent Care Centre
- Community Rapid Response Team
- Locality Teams being merged from five teams into one

Mr Badger (NED) stated that he have very little confidence that the Better Care Fund will resolve the current problems and he feels we need a better response from Dudley CCG on what actions they are taking to resolve these issues. Ms Clark (CE) said that Mr Cattell's new role is to build bridges between the Trust, CCG, Local Authority and Ambulance Service and make sure that clinical discussions between our doctors and GPs on patient pathways, community pressures etc are effective.

Mr Edwards (C) commented that ED activity has been rising since 2005 and initiatives such as the 111 Service and the Better Care Fund will not stop patients attending ED and we need to look at how we change the culture of patients attending.

Ms Clark (CE) said that the Urgent Care Centre will help as this will stream patients as they attend and also Mr Cattell will now sit on the CCG Executive Board and this will help align the two Boards on issues such as ED. She also commented that social care budgets are an issue, as they have been squeezed.

Mr Cattell (DSO) reported he had attended a meeting at the CCG yesterday and he feels there is work we can do to align both Boards which is very positive. Mr Edwards (C) said we can use Mr Cattell's new role and his Chair to Chair meetings with Dr Heggerty to move this agenda forward. Mr Edwards (C) suggested we arrange a Board to Board meeting with Dudley CCG for October 2014.

Mr Assinder (DFI) commented that maybe this is the time to look at the services we provide and should we be growing the footprint of the hospital to match the needs of our patients. Mr Edwards (C) agreed and said maybe we needed to step back and look at how we can adapt our services to meet the needs of our patients.

Friends and Family Test – there will be a push during June, as response rates dropped slightly during May.

CQC Inspection Update - Ms Clark (CE) reported that the risk Summit had been reorganised for 23 June and expected the report will be released on that date.

Parliamentary and Health Service Ombudsman – the Board noted that anonymised extracts from completed investigations is to be published from July 2014.

14/052 PATIENT SAFETY AND QUALITY

14/052.1 INFECTION PREVENTATION AND CONTROL EXCEPTION REPORT (ENCLOSURE 4)

Mrs M McMahon (ND) presented her report and highlighted the following key issues:

Clostridium Difficile – The Trust had 4 cases in April and 1 in May, so we are well within trajectory. A meeting took place with Dudley CCG on 3 June and the algorithm to review all post 48 hour cases was agreed. A review will now take place using the algorithm on the cases the Trust has had so far.

Mrs McMahon (ND) reported that cases of Clostridium Difficile within the Community are rising and we are reviewing this and discussing with Dudley CCG.

MRSA – There have been no cases so far this year.

Norovirus – There are no wards affected at present.

CPE – A draft algorithm has been put together which should be agreed next week.

The Board was pleased to note that performance for Clostridium Difficile is within trajectory and that the algorithm has been agreed to enable a review of the cases that have occurred so far this year.

14/052.2 CLINICAL QUALITY, SAFETY, PATIENT EXPERIENCE COMMITTEE EXCEPTION REPORT (ENCLOSURE 5)

Mr Bland, Non Executive Director (NED) presented the summaries from the CQSPE meetings held in April and May.

Highlights from the April meeting were:

National Survey of Adult Inpatient Results 2013 – The report has taken a long time to come through, but in the majority of areas we have improved. The food question received a negative response, but we are hopeful that this should start to improve. The data is now old as the survey was carried out in July 2013, but Mrs L Abbiss, Head of Communications and Patient Experience (HCPE) reported that Mrs Mandy Green has been mapping the real time survey with the same questions and it shows that for next year we should see improvements.

Highlights from the May meeting were:

Cancer Patient Experience Survey Action Plan update – the Cancer Team had been back and presented an update which had been positive. The CQSPE Committee had been pleased to note that improvements were being made in the right direction.

Major Internal Incident Plan/Business Continuity Plan - The CQSPE Committee had been reassured following presented of both plans.

Serious and Adverse Incident Monitoring Report – The CQSPE Committee had noted that the cases of patient falls were continuing to decrease which was positive. Mrs McMahon (ND) commented that Matrons had been working very hard on this.

The Committee had also been pleased to note that there were no confidentiality breaches in the month.

The Board of Directors received and noted the report.

14/052.3 AUDIT COMMITTEE EXCEPTION REPORT (ENCLOSURE 7)

Mr Fellows, Non Executive Director (NED) highlighted key areas in his report:

Head of Internal Audit Opinion – he was pleased to report the Trust had received a positive HIA opinion from Baker Tilly. This was particularly pleasing given the approach the Trust had taken to identify areas of concern and include them in the audit plan. This approach runs the risk of receiving Red Opinion audit reports as these are challenging areas and both Baker Tilly and Deloitte (External Auditors) commended the Trust on taking this approach.

Annual Reporting Cycle – the Board of Directors at its meeting on the 22 May 2014 had approved all relevant documents as part of the year end process.

Internal and External Tender Process – both services are up for renewal and the tender process was outlined. The Board of Directors is responsible for the appointment of the Internal Auditors and the Council of Governors is responsible for the appointment of the External Auditors. Mr Fellows (NED) will discuss with the Lead Governor which Governors will sit on the External Audit evaluation panel. The Board of Directors approved the approach outlined.

The Board of Directors received and noted the report.

Mr Fellows to discuss with the Lead Governors which Governors will sit on the External Audit tender evaluation panel

(JF NED)

14/052.4 RESEARCH AND DEVELOPMENT OPERATIONAL CAPABILITY STATEMENT (ENCLOSURE 8)

Due to capacity issues within the Trust Dr Neilson was unable to attend the meeting, so Ms Clark (CE) presented the report.

The Board of Directors received the report and approved the Research and Development Operational Capability Statement. This updated statement will now be uploaded onto the national Research Support Services website.

14/052.5 QUARTERLY COMPLAINTS REPORT (ENCLOSURE 9)

Mrs Cotterill, Associate Director of Governance/Board Secretary (ADGBS) presented the report and highlighted key areas:

- The Trust received 330 complaints in 2013/14, which was down from last year
- There were more face to face meetings held this year
- Complaints have been risk assessed into low, medium and high as they had arisen
- Complaint categories have been revised from Q3 onwards
- The number of complaints received against activity was 0.04% for 2013/14 and the number of compliments far outweighs the number of complaints received
- Two Listening into Action events for complainants have been held during the year and feedback from the events is being taken forward
- An internal Complaints Review Group has been set up to review complaints raised and ensure that lessons are learnt to stop them reoccurring.

Mr Edwards (C) asked if we will now always report on the complaints in the revised categories listed in the report. Mrs Cotterill (ADGBS) confirmed that we would continue with these categories at the moment as these are the categories that most complaints fall into. They are also the categories captured from national guidance.

Mr Assinder (DFI) commented that both Keogh and CQC commended us for our complaints handling and how can we ensure that we link this to a financial benefit.

Mrs Cotterill (ADGBS) said we can defend more claims now as we have made big improvements and we are taking this forward.

Mr Miner, Non Executive Director (NED) said that attitude and lack of empathy was an area that the review team raised and asked how we are taking this forward. Mrs Cotterill (ADGBS) said that she had summarised all action plans and forwarded these to the Directorates as they need to look at how they are taking these forward. Ms Clark (CE) commented that once all the restructure is sorted this will form part of customer care. She also reported Customer Care Ambassadors are being reintroduced which will be positive. Mrs Abbiss it taking this forward to see how we embed this within the organisation.

Mrs Cotterill (ADGBS) said that where there are areas of good practice, we do share these.

Mr Badger (NED) said it is important to commend the outcome of the report and felt the Board can take comfort that the number of complaints received is reducing, especially when we have made it easier to make a complaint. He felt that the LIA events are a very positive step forward.

Mr Bland (NED) commented that the % of complaints responded to within 30 days was low (46%). Mrs Cotterill (ADGBS) feels that it is early days to monitor this, but confirmed to the Board that we do maintain contact with patients even if they don't receive the formal report within 30 days. The 30 days target is an internal target, not a national one and the formal response time depends on how complex the complaint is.

The Board received the report and noted the positive trend in the right direction of complaints reducing. It also noted that we maintain contact with complaints whilst they are awaiting their formal response. It was agreed that we need to look at how we triangulate complaints, feedback and huddle boards and how the Board uses this data.

Mrs Cotterill to look at how the Board can triangulate complaints, feedback and huddle board and how the Board use this data

(ADGBS)

14/053 FINANCE AND PERFORMANCE REPORT (ENCLOSURE 10)

Mr Fellows (NED) presented the summary report from the Finance and Performance meeting held on 29 May 2014 and highlighted three areas were the Committee had concerns:

18 Weeks RTT Performance – there is no headroom in the current performance. Each specialty has produced an action plan to prevent them falling behind threshold.

ED 4 Hour Target – pressure is continuing. The latest recovery plan had been shared with the Committee which included lots of actions. The Committee had a number of concerns that the action plan would not address all of the ED issues, especially the cultural/behavioural issues.

Financial position – the Trust had a poor start to the year. Income had not been factored in yet as we are still discussing with the CCG, however, even if income had been in line with our plan, cost overruns would still have meant we ended the month above the planned deficit. The Committee had noted that the Turnaround Plan is very challenging.

Mr Badger (NED) commented that he was disappointed in a further drop in appraisal rates as the Trust is slipping back on this. The Workforce Committee will be picking this up to address the current downward trend in performance.

The Board received and noted the report.

14/054 ANY OTHER BUSINESS

There being no other business the meeting closed at 10.45am

14/055 DATE OF NEXT MEETING

The next meeting will be held at 9.30am on the 3 July 2014, in the Education Centre.

Signed as correct.....Chairman

Date.....

JE/AF/10.6.14

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 5 June 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/039	Patient Story	Clinical Quality, Safety, Patient Experience Committee to discuss adopting a process for gowns that protects patients privacy and dignity and report back to Board.	DM	3/7/14	To September Board
14/041.1	Infection Control	MRSA RCA outcome report to be presented to the Clinical Quality, Safety, Patient Experience Committee and then back to Board.	DM	3/7/14	To September Board
14/049.4	Patient Story	Council of Governors to be invited to taste test the new menu.	RB	5/6/14	Food Report on Private Agenda
14/050	Patient Story	Liz Abbiss to look into the possibility of offering a hairdressing service through volunteers who may have hairdressing skills.	LA	3/7/14	In Chief Executives Report
14/052.4	Report on Moving Patients Out of Hours	Paper on moving patients out of hours to be brought back to the July Board confirming a date for sampling and information on discharging patients out of hours.	RC	3/7/14	On Agenda
14/061	Patient Story	Liz Abbiss to take forward a screen saver reminder to staff about communicating to patients at all times, but especially if they have been sedated. Director of Governance to include the question of patients using huddle boards as part of the patient safety walkrounds.	LA JC	3/7/14 3/7/14	Done A reference to confirm patients awareness of the huddle boards has now been added to the Governors Patient Safety Walkround questionnaire.

14/063.3	Audit Committee Exception Report	Mr Fellows to discuss with the Lead Governors which Governors will sit on the External Audit Tender Evaluation Panel.	JF	3/7/14	Done
14/052.5	Quarterly Complaints Report	Director of Governance to look at how the Board can triangulate complaints, feedback and huddle boards and how the Board uses this data.	JC	4/9/14	

Enclosure 3

The Dudley

NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 3rd July 2014

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
- CQC inspection update
- Sign Up to Safety campaign
- Director appointment – Anne Baines
- Hairdressing/Barbering for Patients

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 – July 2014

Friends and Family Test:

RAG ratings have been updated for Friends and Family Test scores to benchmark top 20 per cent and top 30 per cent of trusts (based on March 2014 (year end) data).

Inpatients and A&E Friends and Family Test

Preliminary data for June shows a continued drop in response rates from the high rates seen in the second half of 2013/14. Areas have been reminded of the requirements and meetings held with new lead nurses following changes in staff A new token system has been introduced into EAU with a further one order for A&E minors to help improve collection rates here. CQUIN requirement for quarter one is to achieve an inpatient response rate of 25 per cent and A&E response rate of 15 per cent – We are almost there and staff are having a final push. Inpatient scores have remained green for the first quarter. A&E scores are red but generally above the national average which is usually mid-fifties.

	Apr-14	May-14	Preliminary June 2014	Preliminary Q1
	01.04.14	01.05.14	01.06.14	01.04.14
Date range	30.04.14	31.05.14	22.06.14	22.06.14
Number of eligible inpatients	1886	**2023**	1392	5381
Number of respondents	644	**519**	354	1521
Ward FFT score	82	**86**	87	84
Ward footfall	34%	**26%**	25%	28%
Number of eligible A&E patients	4258	***4605***	3426	12480
Number of respondents	686	***614***	487	1809
A&E FFT Score	64	**53**	57	58
A&E footfall	16%	**13%**	14%	14%
TRUST FFT Score	73	68	70	70
TRUST footfall	22%	17%	17%	19%

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

Maternity Friends and Family Test

Preliminary June data shows continued fluctuation in scores and response rates. Low response for antenatal and postnatal community is a national problem, but one which the Trust did not see previously. Managers have discussed this with leads and have been provided with a breakdown of individual areas.

		Apr-14	May-14	Preliminary June 2014
Maternity - Antenatal	Score	64	80	74
	Response rate	14%	18%	9% (19)
Maternity - Birth	Score	62	85	83
	Response rate	44%	33%	25% (66)
Maternity - Postnatal ward	Score	57	85	76
	Response rate	43%	31%	24% (63)
Maternity - Postnatal community	Score	86	90	89
	Response rate	16%	9%	11% (19)
Combined	Score	63	85	80
	Response rate	32%	24%	19%

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

Antenatal	80+	76-79	<76
Birth	89+	86-88	<86
Postnatal ward	81+	75-81	<75
Postnatal community	90+	84-89	<84

FFT Scores key	Top 20% of Trusts (based on March 14 scores)
	Top 30% of Trusts (based on March 14 scores)
	Below top 30% of Trusts (based on March 14 scores)

NB: June data is preliminary only (as at 22.06.14) and will change as additional entries and validation are still to take place.

CQC Inspection Update:
The release of the report has been delayed and the report will be released in late June/early July.

Sign Up to Safety:
The Trust is joining the Sign Up to Safety campaign. It is about listening to patients, carers and staff, learning from what they say when things go wrong and take action to improve patients' safety.

Sign up to Safety is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation and achieving it requires us all to unite behind this common purpose. We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times.

Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.

Sign up to Safety's 3 year objective is to reduce avoidable harm by 50% and save 6,000 lives.

The five Sign up to Safety pledges

We commit to setting out the actions we will undertake in response to the following five pledges:

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public the goals and plans we have developed locally.
2. **Continually learn**. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.
3. **Honesty**. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. **Collaborate**. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
5. **Support**. Help people understand why things go wrong and how to put them right. Give our staff the time and support to improve and celebrate the progress.

The Dudley Group NHS
NHS Foundation Trust

Director Appointment:

I am delighted to announce that Anne Baines has accepted the post of Associate Director of Strategy and Performance. She will join the Trust in late September from Walsall Healthcare NHS Trust.

Hairdressing/Barbering for Patients:

This issue was raised by a Patient Story at the Board, hence its return for information. The views of nursing staff on wards were obtained and all were in agreement of the need for this service saying that many older ladies have their hair done weekly and miss this while in hospital.

Present position
Some patients express a wish for more frequent hair washing while in hospital; patients able to undertake their own hygiene care would normally take responsibility for their own hair washing, with nurses undertaking this on request for patients who require assistance.

Dudley College students (usually first years) visit once a week for two and a half hours to provide hair styling (not washing/blow drying) and beauty treatments free of charge. Some wards have day rooms to use for treatments but most do not.

There are three options for consideration by the Patient Experience Group:

1. **Mobile hairdressers**. Other hospitals in the country utilise mobile hairdressers who offer a limited range (trim/cut and blow dry/style). Discussions with Dudley College and mobile hairdressers indicate a small fee (approximately £8-10 per cut or style). Infection control, health and safety and suitable ward space would need to be considered.
2. **Scope out dedicated room in the hospital**. Dudley College has offered fixtures to equip a salon if required (from their Mons Hill campus as they now operate from Evolve in the town centre). The Trust would need a room that could be fitted out (water, lights, sockets etc). A mobile service for the hospital patients who are unable to travel to the in-house salon would also need to be provided.
3. **Status quo.** Students will continue to visit wards from September.

A decision on the chosen option will be brought back to the Board via CQSPE so that the Patient Story is followed to its conclusion.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on July 2014 - 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.

Subject: Infection Prevention & Control Report

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 we have 1 post 48 hour cases recorded in June 2014 against a trajectory for the month of 3 cases. An algorithm to review all post 48 hour cases was presented to the CQRM on 3rd June 2014 and agreed.

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

CPE – A draft action plan is in place. The key actions are to commence with developing a screening programme for high risk clinical areas (oncology and renal), to commence a training programme of awareness and clinical skills for staff in relation to screening for CPE infections and to update the antimicrobial prescribing guidelines to include specific advice for patients with CPE.

Norovirus – There are no wards currently affected.

Glossary of new terms:

1. CPE- Carbapenamase producing enterobacteriaceae- the carbapenems are a powerful group of broad spectrum beta-lactam (penicillin related) antibiotics which, in many cases, are our last effective defence against multi – resistant bacterial infections. Carbapenamase are enzymes produced by some bacteria and this term is used to describe any beta – lactamase that breaks down carbapenems. Of clinical concern, many carbapenamases confer resistance to all members of the beta-lactam class. There have been outbreaks in the UK with these organisms particularly in the North West, becoming endemic in pockets. Therefore early detection and prevention of nosocomial spread of these organisms is essential to prevent the rapid spread of these organisms seen in other countries in Europe.[1]

References:

1. Public Health England. Acute trust toolkit for the early detection, management and control of carbapenamase – producing Enterobacteriaceae. December 2013.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th June 2014

TITLE:	**Workforce and Staff engagement Committee**		
AUTHOR:	**Annette Reeves Associate Director of HR**	**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:

Local Education and Training Group (LETG)
The committee reviewed and approved the Terms of Reference for this group.
Minutes from the last meeting of the LETG highlighted that there are changes to the way that medical education is funded from Health Education England which will result in and increase in the tariff the trust receives. The exact figure will be determined following a series of data collection which the Trust is required to do and submit to Health Education West Midlands. The Trust has already completed a high level collection and is due to complete a more detailed collection in June 2014.
Members of the LETG have developed and Training Needs Analysis for Clinical Skills, using the system developed for Mandatory Training. This is ensuring we are make the most effective use of the training available and has reduced the number of staff not attending courses.

Workforce Audits
Good progress is being made on the 3 red audits

- Pre employment checks for Bank workers
- European Work Time Directive
- Compliance with appraisal/personal development review policy

The Trust is on track to complete all actions within the required time scales

Joint Negotiating Committee (JNC)
Changes to the car parking policy will be put in place during the summer of 2014 by the Estates team and this was discussed by the JNC
Negotiates are underway to change the Agenda for change notice periods to increase the time required by bands 5 and 6.

Joint Local Negotiating Committee (JLNC)
Lack of available car parking spaces was discussed and the views from this group have been included in the future changes.
It has been agreed that the Clinical excellence Awards for 2014 will go ahead and are currently being implemented.

Diversity Management Group
The committee reviewed and approved the Terms of Reference for this group.
There is no longer a legal requirement for public body organisations to complete equality impact assessments (EIA). Therefore the committee has agreed to stop the completed of EIA's and replace this with a system where 4 areas per year report to the diversity Management group on equality issues in their area. The first area to report will be estates for disabled access.

Finance and Performance Handover
A full handover to this committee has taken place in order that the work on

- Appraisal
- Sickness

Can be continued. The committee has agreed that the Areas in the Trust which are under performing across a number of HR KPI's will be asked to report to the committee with a recovery plan. the first area to be invited to do this will be Women's and Childrens

Workforce KPI's
Absence has closed the year at 3.65% which is a reduction on last years of 4.12%. the trend is still low at 3.63% for April, however this is still above the 3.5% target
Turnover remains consistent at 8.02%. however the committee is undertaking work to look at the 11% target and if this is still fit for purpose.
Mandatory training has increased for the 6th consecutive month and stands at 78% for the Trust.
Appraisals compliance has reduced again this month at 77.26%
Pre employment check are green
Professional registration is green
Vacancies being handles by the recruitment team are 278.1FTE, which included the overseas nurses and the Clinical Support Workers Novice programme.
Employee relations cases are currently 56 with 4 employment tribunals ongoing.

Those directorates which are red across a number of workforce KPI's will be invited to report on their recovery plans to this committee. Women's and Childrens have been invited to the June meeting.

National Staff Survey 2013
The results from this survey have previously been reported. However it was appropriate to report to this new committee to ensure that follow up action is taken.
The committee will be requiring a summary of all directorate action plans to be presented to the committee and a presentation from the directorates who have has the lowest scores.

Health and Safety Group
The group is reviewing 2 Trust process

- the reporting of RIDDORs
- The Trust compliance with sharp instruments in health care regulations 2013.

Policies
The committee ratified 1 policy, Security within the maternity unit and Women's and Childrens outpatients' department guideline.

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

To receive the report

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

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors
on Thursday 3rd July 2014

TITLE:	Review of practices relating to overnight patient moves		
AUTHOR:	Richard Cattell Director of Support Operations	**PRESENTER**	**Richard Cattell** **Director of Support Operations**
CORPORATE OBJECTIVE: SG02: To provide the best possible patient experience			

SUMMARY OF KEY ISSUES:
DG FT Board, following a letter from the Chief Medical Officer, was assured that the Trusts Patients Moves policy met the good practice requirements laid out in the letter.

The Board also asked the operations directorate to audit the practice of moving patients overnight to ensure that our local policy is adhered to.

A retrospective audit will be undertaken in the month of August (using data for the month of July as a sample) and ADT data from Oasis will be used to identify patients transferred internally from ward-to-ward between the hours of 23:00 and 06:00. Depending on the volume of patients transferred within this window, either all patients or a sample of patients will be selected for a retrospective review of the case notes.

The review of the notes will include compliance with

i) completion of the inter-ward transfer form (in accordance with section 6.6 of the Transfer and Handover of Patient Care Policy) in order to identify the origin and destination,
ii) the reasons for the transfer (and compliance with local policy and national guidance) and
iii) whether or not the patient was informed (in accordance with section 6.2 of the Transfer and Handover of Patient Care Policy).
iv) In the case of discharge, good practice is maintain (section 5-10 of the policy)

The audit team and Clinical Audit Department support are being determined. An assessment of the total number of all moves will be made, and used regularly to assess practice change.

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

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE	**CQC**	**Y/N**	**Details:**
	NHSLA	**Y/N**	**Details:**

and/or LEGAL REQUIREMENTS			
	Monitor	**Y/N**	**Details:**
	Equality Assured	**Y/N**	**Details:**
	Other	**Y**	**Details: NHS England LAT Medical Director will review each organisations response to this request and ensure that practice has been reviewed.**

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

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE FINANCE AND PERFORMANCE COMMITTEE:

To receive this briefing
Consider the audit outcome report when available

Board Strategic Themes: Quality , Safety & Service Transformation, Reputation	**SG01: To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation**
Board Strategic Theme: Patient experience	**SG02: To provide the best possible patient experience**
Board Strategic Theme: Diversification	**SG03: To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio**
Board Strategic Theme: Clinical Partnerships	**SG04: To develop and strengthen strategic clinical partnerships to maintain and protect our key services**
Board Strategic Theme: Staff Commitment	**SG05: To create a high commitment culture from our staff with positive morale and a "can do" attitude**
Enabling objectives	**SG06: To deliver an infrastructure that supports delivery**

The Dudley Group NHS Foundation Trust

Enclosure 7

Paper for submission to the Trust Board on 3rd July 2014

TITLE:	**Safeguarding Report to Trust Board – June 2014**		
AUTHOR:	**Pam Smith Deputy Director of Nursing**	**PRESENTER**	**Denise McMahon Director of Nursing**
CORPORATE OBJECTIVE: SGO1, SGO2 and SGO6			

SUMMARY OF KEY ISSUES:

1. CONCERNS RAISED BY INDEPENDENT CHAIR OF SAFEGUARDING BOARDS

Two further Pan Board Reassurance group meetings have been held to review the Trust's practices for the restraint of patients. The Police have visited the Trust to investigate eleven cases where patients had been restrained and found no practices of unlawful restraint. The Chief Executive presented a report regarding the Trust's investigation into the media allegations of unlawful restraint practices within the Trust. The Independent Chair of the Children's and Adults Safeguarding Board confirmed that the Pan Board Reassurance group had found that the media allegations of unlawful restraint of adults and children were groundless. The Independent Chair reported that he would be contacting the individual's who had raised concerns to the Safeguarding Board to advise them of the Board's findings.

The Independent Chair advised that two cases where adults had been restrained in December 2013 and March 2014 would need to be investigated by the Police. The outcome of the investigation would be reported to the Safeguarding Adults Board.

The Adult Abuse Safeguarding Officer attended the Trust on the 10th June 2014 to review the two cases. A report on the outcome of the cases is awaited.

2. CQC/OFSTED ASSESSMENT

This unannounced inspection is still awaited; the inspection is expected imminently. The local Authority has requested that all agencies are prepared for this.

3. SECTION 11 AUDIT ACTION PLAN

The Section 11 audit is being monitored at the Internal Safeguarding Board monthly. This has been remitted back to the Safeguarding Children's Board.

4. DO NOT ATTEMPT RESUSCITATION TRAINING

The Do Not Attempt Resuscitation policy has been updated and circulated to staff. Training sessions have been arranged for medical staff and senior nursing staff for the end of June 2014.

5. LEARNING DISABILITY STRATEGY

The Learning Disability Strategy was launched on 28th March 2014 and received positive feedback from Trust staff and partner agencies. The Acute Liaison Nurse for Learning Disability is liaising with wards/departments to develop bespoke Communication boxes. Once the Communication boxes have been circulated work will be undertaken to embed the strategy; including improved signage with pictures and further work with Misfits drama group to maintain staff awareness.

6. TRAINING

6.1 Safeguarding Children compliance

Safeguarding Children Foundation training compliance is now at 87%. Intermediate training compliance is now at 63.2%.

The Named Nurse for Safeguarding Children is working with the Designated Doctor and the Designated Nurse, Dudley Clinical Commissioning Group to review Safeguarding Children training following new guidance issued by the Royal College of Paediatricians and Child Health.

6.2 Safeguarding Adults compliance

Safeguarding Adults training compliance is now at 85.6%.

6.3 Mental Health compliance

Mental Health training compliance is now at 73%.

6.4 Learning Disabilities CQUIN

The numbers of staff to be trained in Learning Disability to meet the CQUI target for 2014/15 has been identified. 25 staff in Outpatients have received training to date.

6.5 Safeguarding Maternity Compliance

Foundation training compliance is now at 90%. Maternity Intermediate training compliance is now at 85%. Adults Safeguarding training is now at 90%.

IMPLICATIONS OF PAPER:

Risk Management	**Risk Register: N**		
	Risk Register: CSO11 Score 6		Lack of Safeguarding Children Intermediate Training
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Compliance with Care Quality Standards Outcome 7
	NHSLA	**Y**	**Details:** CNST Maternity standards
	Monitor	**Y**	**Details:** Ability to maintain at least level 1 NHSLA
	Equality Assured	**Y**	**Details:** Better Health outcomes Improved Patient access and Experience
	Other	**N**	**Details:** Safeguarding

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE: To note the key issues arising from the Safeguarding Report to Trust Board and identify any actions for follow up.

JUNE 2014

1. CONCERNS RAISED BY INDEPENDENT CHAIR OF SAFEGUARDING BOARDS

Two further Pan Board Reassurance group meetings have been held to review the Trust's practices for the restraint of patients. The Police have visited the Trust to investigate eleven cases where patients had been restrained and found no practices of unlawful restraint. The Chief Executive presented a report regarding the Trust's investigation into the media allegations of unlawful restraint practices within the Trust. The Independent Chair of the Children's and Adults Safeguarding Board confirmed that the Pan Board Reassurance group had found that the media allegations of unlawful restraint of adults and children were groundless. The Independent Chair reported that he would be contacting the individual's who had raised concerns to the Safeguarding Board to advise them of the Board's findings.

The Independent Chair advised that two cases where adults had been restrained in December 2013 and March 2014 would need to be investigated by the Police. The outcome of the investigation would be reported to the Safeguarding Adults Board.

The Adult Abuse Safeguarding Officer attended the Trust on the 10th June 2014 to review the two cases. A report on the outcome of the cases is awaited.

2. CQC/OFSTED ASSESSMENT

This unannounced inspection is still awaited; however, an inspection is expected imminently. The local Authority has requested that all agencies are prepared for the unannounced visit.

3. SECTION 11 AUDIT

The Section 11 audit is being monitored at the Internal Safeguarding Board monthly. This has been remitted back to the Safeguarding Children's Board.

4. SAFEGUARDING CHILDREN'S BOARD

The Independent Chair of the Safeguarding Children's Board is reviewing the structure of the Children's Board. It is expected that the number of representatives at the board meeting will be reduced across all agencies; representatives will be offered the opportunity to attend the board sub group meetings.

5. DO NOT ATTEMPT RESUSCITATION TRAINING

The Do Not Attempt Resuscitation policy has been updated and circulated to staff. Training sessions from the Trust Solicitors have been arranged for medical staff and senior nursing staff has been arranged for the end of June 2014.

6. FEMALE GENITAL MUTILATION

There has been an increase in the number of cases of Female Genital Mutilation across the Borough with two communities where this is prevalent residing in Halesowen. Multi agency clinical pathways are in place and all management plans are coordinated via the Lead Obstetrician. The Maternity Safeguarding policy has been updated to include this. The Trust is reporting the number of cases in accordance with Government guidance.

7. DOMESTIC VIOLENCE AND ABUSE GUIDANCE

A working group is being set up to review the NICE guidance – Domestic Violence and Abuse – how services can respond effectively. This is being monitored by the Internal Safeguarding Board.

8. LEARNING DISABILITY

8.1 Learning Disability Strategy

The Learning Disability Strategy was launched on 28th March 2014 by Misfits; a drama group with Learning Disabilities from Bristol. The launch had received positive feedback from Trust staff and partner agencies. The Acute Liaison

Nurse for Learning Disability is liaising with wards/departments to develop bespoke communication boxes. Once the Communication boxes have been circulated to all areas further work will be undertaken to embed the strategy; including improved signage with pictures and further work with Misfits drama group to maintain staff awareness.

The Learning Disability Strategy action plan is being presented to the Clinical, Quality, Safety and Patient Experience Committee in July 2014.

9. TRAINING

9.1 Safeguarding Children compliance

Safeguarding Children Foundation training compliance is now at 87%. Intermediate training compliance is now at 63.2%.

The Named Nurse for Safeguarding Children is working with the Designated Doctor and the Designated Nurse, Dudley Clinical Commissioning Group to review the Safeguarding Children Training following new guidance issued by the Royal College of Paediatricians and Child Health.

9.2 Safeguarding Adults compliance

Safeguarding Adults training compliance is now at 85.6%.

9.3 Mental Health compliance

Mental Health training compliance is now at 73%. The Mental Health CQUIN requires 100% compliance by quarter 4 – 2014/15.

9.4 Learning Disability CQUIN

The numbers of staff to be trained in Learning Disability to meet the Learning Disability CQUIN target for 2014/15 has been identified. To date 25 staff in Outpatients have received training on Learning Disability.

9.5 Safeguarding Maternity Compliance

Foundation training compliance is now at 90%. Maternity Intermediate training compliance is now at 85%. Adults Safeguarding training is now at 90%.

Pam Smith
Deputy Director of Nursing
25th June 2014

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors 3rd July 2014

TITLE:	Corporate Risk Register		
AUTHOR:	Sharon Phillips Risk and Standards Manager	**PRESENTER:**	Julie Cotterill Associate Director of Governance/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 the Directors are currently managing 12 corporate risks, of which 6 risks score 20 or above (refer to page 4). Assurance is actively monitored and mitigating actions have been identified.

There have been 5 new risks since the previous report and 14 risks removed from the Corporate Register as they have been mitigated to their lowest or superseded (refer to page 3).

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 BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE COMMITTEE:

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

To discuss if all risks are required to stay on the Corporate Risk Register

CORPORATE RISK REGISTER

In addition to the operational risk registers the Directors are currently managing 12 corporate risks, of which 6 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified. The risk scores are as follows:

Risk Score	Number of Risks
25	2
20	4
16	2
15	1
12	2
9	1

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

RISK REGISTER MOVEMENT

There have been 5 new risks added to the corporate risk register between 1st March to the 31st May 2014 (these are indicated in the table commencing page 3). *(COR060 Deteriorating Liquidity Position and deteriorating cash balance was added and superseded by COR060 within this period.)*

There have been 15 risks removed from the corporate risk register as they have been mitigated to their lowest or superseded, a summary of these are below:

Director lead	Risk Summary	Date Closure
Mr Richard Beeken	Construction of a two year operation plan element to the IBP .	20/05/14
Mr Paul Assinder	Failure to achieve CIP target 2013/14	06/05/14
Mr Paul Assinder	Failure to deliver financial target 2013/14	06/05/14
Mr Paul Assinder	Working towards a much more onerous contract 2013/14	06/05/14
Mr Paul Assinder	Failure to achieve Monitor target	05/13/14
Mr Richard Beeken	Failure to engage clinical staff in major transformation	25//03/14
Mr Richard Cattell	Diabetic Management	19/06/14
Mr Richard Cattell	Rising urgent care demand on Ed as a result of poorly planned management across the health economy	19/06/14
Mr Richard Cattell	Neonatal Capacity	19/06/14
Mr Richard Cattell	Potential compromise of clinical care due to the non availability of clinical information	19/06/14
Ms Denise McMahon	Increase in the number and grade of avoidable pressure ulcers	19/06/14
Ms Denise McMahon	Nurse Staffing Levels are suboptimal in certain areas	19/06/14
Mr Richard Cattell	Loss of all early discharges by the DRAS team reducing the ability of the trust to admit emergency patients	19/06/14
Ms Denise McMahon	Learning Disability Liaison role	19/06/14
Mr Paul Assinder	Deteriorating Liquidity Position and deteriorating cash balance	19/06/14

PENDING NEW RISKS

There are presently 4 known pending risks to be added to the risk register, these are risks that have been identified at a Committee/group or have arisen from an incident, complaint, claim, internal external review etc for the Corporate Risk Register . The following is a summary of these:

Director lead	Risk Summary	Requested
Mr Steve Davis	Critical path for recovery of The Dudley Group turnround programme .	May 2014
Director of Finance and Information	Acute contract for financial penalties 2014/15	May 2014
Director of Finance and Information	CIP delivery	April 2014
Director of Finance and Information	CQUIN delivery	April 2014

CORPORATE RISK REGISTER AS OF 28th March 2014

Risk Ref / Initial Risk Score	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
COR007 (OP080) **Director Lead: Director of Operations** **Initial Risk Score 25**	Unable to admit emergency patients due to externally caused delayed discharge /transfer	31/03/2011 **Last Review Date:** **June 2014**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	Daily monitoring of the delayed discharges via the delayed list, ensuring its accuracy and that challenges by the ward to the patients care is being managed and escalated appropriately. Ward-based Discharge Team support and plan discharge. Use of estimated discharge at ward level. Escalation to Medical Service Head as appropriate. Lead Nurse meetings with patients and relative to identify needs for discharge. Early notification to LA via Section 2 to prepare for patients likely needs. Agreed health economy escalation plan. Provision of training on compliance with escalation plan. Issue of letter to prepare patients and family for discharge arrangements. Utilisation of independent company Care Home Select (CHS) to support patients/relatives in identifying suitable 24-hour care placement. Matron/Lead Nurse ensure that understanding of discharge processes is provided by all nurses/carers. Daily multi-agency teleconference at Level 2 or above. MOA - Local Authority and PCT signed off.	5	5	25	Escalation meeting daily at 9.15am. Information available on the HUB. Section notifications. Escalation Plan. Training Records. Letters to Patients. MOA (Memorandum of Agreement) Integrated Care Group Minutes and actions. Acute Medical Unit Provision of non-acute care. Capacity Team; escalate to Director of Operations as appropriate. Delayed Discharge database managed, available and communicated Use of standard 'expectations' letter. Lead Nurse contact. Early understanding of financial constraints from Local Authority and planned use of new re-ablement monies to increase current capacity and response from Local Authority. Working with CCG and LA to manage delayed discharge database, improve admission prevention SW input.	Poor service cover from multi-agency Discharge Teams because of vacancy, sickness, leave etc resulting in further delays. Disagreement regarding the responsibilities in the DISCO database. No ubiquitous medical and support service cover across hospital. Patient or relative exercising "choice" exacerbates problem. DMBC overseeing a higher than agreed number of patients. Inconsistent bed management processes.	Number of patients as per MOA is too high to prevent capacity issues.	Negotiate a reduction of agreed number of DTOC's patients as per MOA (MOA remains unagreed. Escalated to CCG/MBC/NHS leadership triumvirate for agreement for 2014/15). Evaluation of the benefit of external elements of the winter plan.	30/06/2014	4	4	16

				Directorate solutions to manage delayed discharge. Training of Bed Managers and Discharge Facilitators across Directorates. Escalation of issue to Director level. Manager of the day identified for each Directorate.											
Risk Ref / Initial Risk Score	**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**
COR053 (OP052) **Director Lead: Director of Operations** **Initial Risk Score 20** **Increased to 25 19/06/14**	Failure to maintain 18-week Pathway	31/03/2011 **Last Review Date:** **April 2014**	3. To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio.	1. Extensive training programme for medical secretaries undertaken to improve knowledge of Oasis and the 18-week Access Policy. 2. Assistant GMs on behalf of GMs oversee the process of validating waiting list reports. 3. Breach reports are validated weekly by RTT Support Team. 4. Extra clinics arranged by RTT Support Clerk. 5. Extra theatre lists arranged by Asst Gen Mgrs. 6. Diagnostics manage their waiting list to achieve two week diagnostic wait. 7. PTL reports of target outturns are validated prior to circulation team by RTT Support Team. 8. Directorate have developed demand and capacity models. 9. 20 extra beds available in C6 transferred from medicine.	5	5	25	18 week reports. Directorate dashboard. Reduction of medical outliers.	1. Secretaries do not follow policy. 8,9. Trauma emergencies outstrip beds available on B2 and overspill onto elective ward. 8,9. A high volume of emergency surgical patients impacts on bed availability for elective patients.	Lack of ring-fenced elective capacity. Consultant staff shortages in some specialties. Increased demand for specialties.	To retain and monitor 18-week headroom in individual pathways so any unplanned cancellations does not cause a breach. Undertake waiting list sessions as appropriate to ensure RTT headroom is maintained. Ring-fence all of T&O and S&A beds, preventing medicine outlying at any stage.	31/05/2015	5	3	15

Risk Ref / Initial Risk Score	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
COR055 **Director Lead: Director of Operations** **Initial Risk Score 20**	Cancellation of elective surgical patients due to excessive emergency admissions from medicine, trauma or surgery.	10/02/2014 **Last Review Date:** **June 2014**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	- Matron review of elective admissions to prioritise elective admissions, if cancellations are imminent. - Surgical capacity lead involved in trust wide daily capacity planning for emergency and elective demand - Visualisation ward boards to manage patient flow. - Surgical Capacity Team 24/7. - Discharge Co-ordinators DISCO dedicated to surgery. - Escalation Policy. - Surgical patients admitted on the day of surgery, unless there is a clinical imperative to do otherwise - Training programme for medical secretaries to improve use of OASIS and knowledge of 18 week RTT pathways. - Enhanced recovery embedded in urology, general surgery. - Nurses empowered to conditionally discharge patients - Hospital to home service to reduce re-admissions to urology - Increased use of day case - Medicine have purchased additional beds in the community - C6 transferred to surgery with 20 additional beds & B4- 10 beds converted to inpatient care - Lean action days held in	4	5	20	- Board Reports -18 week RTT report by specialty outcome, activity and expenditure reports for surgery - Transformation Board – Length of Stay review report - Operational reports - Capacity meeting reports indicating emergency and elective demand on hospital (4 times daily) - Outlier report (daily) - Delayed discharge database (daily) - Directorate in upper quartile for KPI efficiencies eg LOS. - Pre-op Length of Stay report (Surgery Directorate performance meeting) Day case utilisation report (Surgery Directorate performance meeting)	- Escalation Policy not followed - Outlier policy not followed - Emergency (medical and surgical) admissions growing. - Demand above plan for the vascular surgery unit. - Repatriation challenges with vascular patients from other health economies. - Difficulty in acquiring sufficient intermediate or step down beds for medical patients means that they remain in acute beds after they are MFFD. - Matrons control of capacity not available out of hours - Failure to repatriate Walsall and Wolverhampton vascular patients - Use of DCU for capacity - Limited availability of Ultrasound scanning in SAU. - Lack of clear pathways and senior decision makers to ensure none pt pathways are offered low risk emergency surgical patients.	- Medicine patients continue to outlie. - Elective surgery is cancelled periodically due to capacity issues - 18 week RTT performance has dropped	Implementation of full ECIST Action Plan (from Nov 13 and Feb 14). Revised 4-hour wait recovery plan based on ECIST visits in Nov 13 and Feb 14). Plan elective surgery during weeks, months and quarters with historically lower emergency demand Complete SAU improvement project CCG commissioned Urgent Care Centre reduces non-elective demand	31/01/2015	4	4	16

				November 2013 to review functionality of SAU in order to optimise alternative pathways and avoid admissions wherever clinically safe and appropriate to do so - Ring fenced beds for vascular surgery - Reporting of incidents through DATIX - Exceptional use of WLI operating lists at times of improved capacity to recover 18wk performance											
Risk Ref / Initial Risk Score	**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 and Information** **Initial Risk Score 20**	The Trust must sign a "viability statement" in relation to its long term clinical and financial sustainability, as part of the 5 year strategic plan submission. 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 able to sign that viability statement and submit a robust and complete 5 year plan.	16/05/2014 **NEW RISK**	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.	4	5	20	1. Board Workshop and Private Board papers on 5 year plan.	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. Conduct internal, exec-led mitigation planning sessions during June, to agree further, organisation-wide mitigations. These may include estate reconfigurations/alternative uses, community service rationalisation, further commercial assumptions, service marketing and elective expansion beyond current plan. 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.	30/09/2014	4	3	12

Risk Ref / Initial Risk Score	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
COR057 **Director Lead: Director of Operations** **Initial Risk Score 16** **Increased to 20 19/06/14**	There is a risk that the national Better Care Fund planning assumptions applied locally, do not lead to a community team operational response of sufficient resilience or system-wide admissions avoidance to meet expected 15% activity reduction in non-elective admissions	15/05/2014 **NEW RISK**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Creation of 5 locality based district nursing teams from current number of 14. 2. Alignment of locality teams to CCG locality boundaries. GP clinical lead appointed for each locality. 3. Rapid Response Nursing Team establishment.	5	4	20	1. CSIC Directorate Meeting Minutes. 2-year plan submission. 2. CCG Board Papers. Integration Working Group (multi-agency) Minutes. 3. CSIC Directorate Meeting Minutes. 2-year plan submission.	1. No full integration (non-institutional) plans yet in place with social care teams or mental health. 2. No clear SOPs available on how the coordination of care for individual patients will change to reflect the new structure. 3. Recruitment to full establishment may be difficult. 3. Unclear how this team will formally relate to GP practices and 5 locality teams.		1. Medical LOS reduction and Surgical admission avoidance plans being enacted through ECIST action plan, AMU expansion plan, ED recovery plan, LOS steering group and SAU project plan. Operational plan target 38 beds through these measures. 1/2. Ambulatory Emergency Care Unit and operating principles being deployed at front door to avoid unnecessary admissions. Similar principles being deployed in SAU redesign pilot. 3. To undertake a review of the requirements and any identified actions to take forward.	30/11/2014	5	3	15

Risk Ref / Initial Risk Score	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
COR003 (OP090) **Director Lead: Director of Operations** **Initial Risk Score 20**	Urgent care demand exceeds capacity	01/07/2011 **Last Review Date:** **April 2014**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Re-designation of surgical beds to medicine has taken place. 2. CD/MSH review of elective admissions to prioritise urgent admissions, if cancellations are imminent. 4. New capacity management system partially deployed. 5. Discharge Co-ordinators to manage delayed discharges. 6. Escalation Policy and contingency capacity policy reviewed and deployed. 7. Daily capacity meetings. Using capacity hub, standardised meeting template. 8. Work with primary care and commissioners to curtail urgent care demands, provision of virtual ward. Rapid response teams and other admission avoidance schemes. 9. Admit on the day of surgery to reduce pre-op LOS. 10. IST recommendations roll-out.	5	4	20	1. Surgical LOS 2. Capacity reports/cancellation lists 3. Board reports include elements of bed capacity etc.capacity reports communicated after each capacity meeting 3. Level of cancellations.via reporting to CCG and LAT 4. Operation of capacity hub, output of capacity meetings 5. Delayed discharge database managed, available and communicated 6. Escalation policy up to date, available and agreed 7. See 4 CCG Board Papers. Integration Working Group (multi-agency) Minutes. 8. Minutes of urgent care working group 9. Surgery LOS 10. Revised ECIST action plan delivery overseen by LOS transformation steering group	1. Medical outliers in surgical beds 2. MSH/medical staff not consistently engaged in Capacity Management. 3. Bed/ Capacity Management approach/systems not aligned to predictive demand management within specialities/wards locally. 3,6. Understanding of policies by all staff. 7. Poor attendance at Capacity Meetings. 1,2,3,9. Surges in Emergency surgical activity demand. 1-10. Failure of all parties to contribute. 1-10. Failure of parties to agree. 8. DTOC remains above MOA. 8. DTOC for Sandwell patients too high.	Database only covers Dudley patients.	1. Deliver the SDIP in conjunction with the CCG to ensure 15% reduction in emergency admissions. 2. Empower non-medical staff to improve MDT-led discharge(ongoing). Delivery of ECIST action plan.	30/06/2014	4	3	12

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR059 **Director Lead: Director of Strategy and Transformation** **Initial Risk Score 16**	The Trust is working in partnership with Dudley CCG to respond to our responsibilities in the Dudley Health Economy urgent care redesign. In particular, this involves the co-commissioning of an Urgent Care Centre (UCC), integrated with our Emergency Department (ED) on the RHH site	15/05/2014 **NEW RISK**	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 presented to July 2014 Board of Directors meeting for scrutiny.	4	4	16	1. Urgent Care Project Group Minutes. 1. DCCG Board Minutes. 1. 2-year operational plans (DCCG and DGFT). 2. Contract variation audit trail. 3. Business Case. 3. Board of Directors minutes and papers.	2. Approval process by Summit Healthcare not within DGFT control.	3. Board of Directors may not approve business case in July, leading to potential delay in capital development and proposed start date for UCC of 1/4/15.	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 redesigned service. 3. Presentation of business case for capital revenue to Board of Directors July 2014.	30/09/2014	4	2	8

Risk Ref / Initial Risk Score	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
COR058 **Director Lead: Director of Operations** **Initial Risk Score 16**	The Trust has submitted a 2 year operational plan to Monitor. Central to that plan, both financially and operationally, is the expansion of elective surgical activity to improve RTT target performance (move to median wait of 11 weeks) and financial performance (£5 million FYE additional income). Additional beds (20) and theatre sessions (13 per week) are required to deliver that activity. There is a risk that financial and performance targets will not be met if both the bed and theatre staffing and physical capacity cannot be created.	15/05/2014 **NEW RISK**	6. To deliver an infrastructure that supports delivery.	1. Increased elective activity through 3 session day plan and additional weekend working in theatres. 2. Productivity and efficiency assessment of theatres by Turnaround Team to create additional theatre capacity. 3. Length of Stay reduction plan in Medicine to enable redesignation of 20 beds to Surgery/Orthopaedics. plus avoidance of the need to outlie into surgical beds	4	4	16	1. Surgical Division capacity plans Medical Division capacity plans 1. 2 year operational plan submission. 2. Turnaround plan. 3. LOS steering group action plan, ED action plan, ECIST action plan. 3. DTOC database. LOS is at upper quartile or upper decile in comparison with peers	1. Staffing availability to deliver the stepped increase. Medical Division continue to outlie to surgical beds disrupting flow to theatres and overall surgical capacity. 2. Theatre information system is bespoke and has significant limitations. 2. As of 15/5/14, clear conclusions on theatre efficiency have not been made and full effect of theatre activity increase is not in place in plans or operational reality. 3. Inconsistent application of board round expectations on MDT basis. 3. Continued high incidence of DTOC preventing effective patient flow. Medical patients continue to outlie to surgery.	3. Audit results from wards re. board round process changes. Activity data shows continued shortfall in many sub-specialties	1. To complete a business case - Hybrid Theatre development – to enable additional theatre capacity and meet prospective vascular surgery standards. The business case for this is in development but may not be considered necessary or financially viable (all dependent upon outcome of theatre efficiency review - see above). The capital development will take 12 months, so control 1 above is essential to delivering this capacity temporarily. 2/3. Completion for a business case – Discharge to assess beds developed outside acute hospital environment OR rehabilitation beds (Surgery, Orthopaedics and Stroke) developed outside acute hospital environment. (Both are subject to commissioner support and/or internal business case approval).	30/09/2014	4	2	8

Risk Ref / Initial Risk Score	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
COR030 (MAT002 & G010) **Director Lead: Director of Operations** **Initial Risk Score 25**	The loss of experienced midwives from the service and replacement by newly qualified, inexperienced midwives from other hospitals has resulted in an insufficient number of midwives with the required experience for workload/activity /dependency and complexity of women requiring inpatient maternity services, resulting in increased risk of maternal and perinatal mortality/morbidity (RISK LEAD: Yvonne Jones)	01/09/2011 **Last Review Date:** **May 2014**	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Midwives have been and continue to be recruited to fill the agreed staffing establishment in line with the recommendations of BirthRate Plus, but the vast majority have been newly qualified midwives from other hospitals who lack midwifery experience and knowledge of RHH policies and procedures. 2. Midwives on the Staff Bank are utilised to cover shortfalls in numbers of staff on duty due to absence and whilst newly appointed staff are in their induction period/on study leave to undertake mandatory training and to gain experience. 3. The Escalation Policy is used for managing reduced staffing which provides clear direction and action to be followed when the staffing is compromised. 4. Managers ensure compliance with the absence/annual leave/off duty policies. 5. There is an agreement to continue the restriction of OOA bookings at the current level until the review with the CCG in July 2013. 6. There is a monthly review of MW:Birth ratio, staff appointments and vacancies with updates monthly to SHA and quarterly to Directors. 7. Development opportunity has been offered to Senior Midwives to gain experience as Band 7 Shift Coordinator so that there is another Band 7 available per shift to support the junior midwives on duty.	5	3	15	1. All sickness absence managed appropriately as per Trust guidelines and reviewed regularly at Lead Midwives and Managers meetings. 2. Flexible employment opportunities available to Trust staff. 3. Mandatory Training is planned to ensure that the impact of staff study leave is appropriately spaced out to avoid diminishing the workforce unnecessarily. 4. Annual Leave Policy adhered to. 5. Hospital provide accommodation available to staff who would otherwise need to commute long distances. 6. Strong cohesive Supervisor of Midwives team available to support MWs to gain experience and support them in practise. 7. Trust provides centralised recruitment personnel.	1. High sickness absence levels both short and long term and the delay in OH service appointments and reports which prevents timely return to work. 2. High rate of maternity leave in the Band 5-6 midwife establishment. 3. Inability to recruit experienced Midwives form other hospitals. 4. The high level resource requirement of Mandatory Training. 5. The loss of midwives who travel long distances from home who leave when they gain local employment. 6. The loss of experienced MWs to retirement, other jobs etc. 7. Recruitment process is lengthy once appointment offer has been made.	1. Delays in OH Dept reviews due to lack of capacity. 2. Child-bearing age group of midwife population. 3. Not all trainers adhere to the guidance that their training needs to the planned around all the other mandatory training or study days being delivered. 4. New staff coming into post in the Autumn months accrue annual leave but do not take it until after their induction period but then are restricted by the policy that AL is restricted around Christmas period, therefore it must be taken in the final quarter of the financial year. 5. Midwives with families reluctant to stay in hospital accommodation and are unwilling to commit to relocation. 6. Maternity Managers are unable to expedite recruitment process as responsibility lies with Central Recruitment team.	Request HR/OH review service response, to ensure that staff are given timely appointments and reports are available to managers to ensure staff come back to work without delay. Continue to ensure that Lead Midwives/Managers offer annual leave at short notice to staff when rotas identify surplus staffing levels. Continue to ensure that inexperienced staff receives the support required to gain experience and achieve the competence level required to practise safely. Continue to ensure that all staff receive appropriate support in their work, receive feedback, timely appraisals and have opportunity to attend staff meetings and receive the notes from these meetings. Support the quality and rigour of the local University Midwifery Programme develops midwives that are fit for purpose at the end of training.	30/11/2014	5	2	10

				8. Unit Manager and Off Duty Coordinator to ensure best skill mix available within the current resource. 9. The Band 5 Midwife development pathway is in use to support newly qualified and adapted for newly appointed midwives from other hospitals. 10. An electronic diary is used for planning Mandatory Training.							Continue to implement measures to ensure safe staffing levels and regularly review workforce using the 'table top' Birth Rate Plus Tool.				
Risk Ref / Initial Risk Score	**Risk**	**Risk Start Date / Last Review Date**	**Strategic Objective**	**Current Controls**	**Cons**	**Like**	**Score**	**Sources of Assurance**	**Gaps in Control**	**Gaps in Assurance**	**Mitigating Actions**	**Target End Date**	**Cons**	**Like**	**Score**
COR032 (OP097) **Director Lead: Director of Support Services** **Initial Risk Score 12**	Failure to implement Business Continuity Plan during a Major Internal Incident - (RISK LEAD: Robert Graves)	01/12/2011 **Last Review Date:** **May 2014**	6. To deliver an infrastructure that supports delivery.	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.	4	3	12	1. IFM Reports and business continuity. 1. RCA Reports following business continuity incidents. 2. Clinical Quality and Patient Experience Committee Reports.	2. BCP has been updated from a Trust perspective however, response from Summit/Interserve regarding Estates elements including incidents relating to loss of power. 2. Reports from the Deputy Director of Operations (Estates and FM) have been requested with a clear timetable by the Clinical Quality and Patient Experience Committee.		Set up BCP Group including PFI Partners to review potential incidents and agree mitigating actions. This work has commenced to strengthen the Estates and FM Contingency Plans. Provide training and undertake exercise to improve response. Implement recommendations following HV incident July 2013.	30/04/2015	2	2	4

Risk Ref / Initial Risk Score	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
COR051 **Director Lead: Director of Operations** **Initial Risk Score 12**	Potential compromise of clinical care due to the non-availability of clinical information at time of consultation - (RISK LEAD: Louise McMahon)	09/05/2013 **Last Review Date:** **June 2014**	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Clinic are organised in advance, with Health Record preparing case notes up to 4 days in advance and having a process to identify and collect case notes not available at that time due to being tracked to another location. 2. Case note tracking system in place. 3. An internal e-mail alert if case notes required and not at last tracked location. 4. For case notes not provided in time for consultation, process for provision of a temporary file which should be reconciled with case note folder at earliest opportunity. 5. Health Records have a reporting log for case notes not found at last tracked location and they monitor this on a regular basis. 6. Business continuity plans if IT system failures or planned down time so that clinical information is available. 7. Clinicians may have access to specialty shared drive and thus be able to gain access to clinical letters. 8. Process to alert clinician if clinical information may not be available for consultation so they can make the clinical judgement if the consultation should proceed. If the decision is to not proceed with consultation, patient is informed, apology and explanation given and patient offered a rescheduled appoint. 9. Datix reporting of incidents where clinical information is unavailable; incomplete. 10. Reporting of duplicate number for same patient. Use of NHS number as unique identifier.	3	4	12	1. Health Records policies and procedures available through the Hub. 2. Trust and local induction. 3. Screensavers on importance of case notes tracking; case notes structure and filing.	1. Failure of logistics, to guarantee case note delivery in advance of clinic commencement. 2. Failure to know if all clinical information is available in case notes until commencement of consultation. 3. Non-compliance of case note structure resulting in inability to locate information even if filed. 4. Sub-optimal processes to retrieve and provide case notes for those appointment offered at short notice. 5. Clinics allowing 'walk-in' appointment where patient not identified on clinic list and thus notes not prepared. 6. Non-compliance of case notes tracking resulting in inability to locate and prepare case notes in time. 7. No central repository for clinical letters so availability to access clinical letters is permission controlled at speciality/clinician level. 8. Failure to report duplicate Trust ID number for same patient resulting in failure to merge number and clinical information.	1. Lack of organisational accountability and limited to no audit process of compliance with case note structure and filing process; case notes tracking. 2. No central induction, training and accountability of those staff who have responsibility for management, tracking and logistics of case notes and electronic clinical information. 3. Under reporting on Datix of non-availability of clinical information. 4. Lack of feedback on outcomes from Datix reporting and actions taken. 5. Sub-optimal performance monitoring and action with regards to poor and or non-compliance Trust or local policies and procedures.	1. To optimise preparation time for clinic preparation processes through minimising unnecessary work i.e. preparation of clinics/ appointments which are cancelled at short notice (implement via OPD Steering Group, monitor via Operational Meetings). 2. Report case note structure and filing compliance (monitor via Health Records Group). 3. To enforce case notes tracking on Oasis (report and monitor via Operational Meetings). 4. To encourage completion of Datix reporting of non-availability in order for organisation to have a better understanding of the frequency of occurrence and consequences of non-availability (quarterly report to Health Records Group). 5. To investigate and produce a business case for consideration of a central repository for access to clinical letters. 6. To investigate and produce a business case for consideration of an electronic patient record system.	30/06/2014	3	2	6

Risk Ref / Initial Risk Score	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
COR044 **Director Lead: Medical Director** **Initial Risk Score 15**	The need for a Medical 'Workforce Plan' - a fit-for-purpose workforce is needed to meet service needs - (RISK LEAD: Dr A Whallett)	03/01/2013 **Last Review Date:** **May 2014**	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. 5. 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. 5. No process for overseeing education and training of locum and ad hoc post holders. 6. Little flexibility in the system if a doctor leaves a deanery rotation early (e.g. maternity leave, obtains consultant job, illness etc).	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. 5. 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 if proven beneficial. Surgery at FY level 3. Develop a business case for advanced surgical nurse practitioners to take on work traditionally performed by FY1 doctors in surgery. 4. To explore the role of Physicians assistants for other departments where posts may be threatened or where there is demand.	31/08/2014	2	2	4

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3 July 2014

TITLE:	**Board Assurance Framework – as at June 2014**		
AUTHOR:	**Sharon Phillips Risk and Standards Manager**	**PRESENTER**	**Julie Cotterill Associate Director of Governance/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 AGS.

This report identifies the Trust Assurance Framework and specifically:

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

In addition to the operational risk registers (reported to Risk and Assurance Group) the Directors are currently managing 12 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (6 risks in total). The report shows the assurance to date of the effectiveness of the management and control of these risks. Action plans are in place, or being developed to address any gaps in control or assurance identified at this time. New assurance / updates highlighted in yellow

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD:

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

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

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
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: 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
COR053 (OP052) **Director Lead: Director of Operations** **Initial Risk Score 20** **Increased to 25 19/06/14** Mitigating risk score 12	Failure to maintain 18-week Pathway	CQC outcome 6	1. Extensive training programme for medical secretaries to improve knowledge of Oasis and the 18-week Access Policy.				Secretaries do not follow policy.	
			2. Assistant GMs on behalf of GMs oversee the process of validating waiting list reports.	18 week reports. Directorate dashboard. Reduction of medical outliers.		18 week Referral to Treatment Time report to Finance and Performance May 2014 – for 4 months above 90% but deteriorating		
			3. Breach reports are validated weekly by RTT Support Team.		High level RTT Recovery Plan			To retain and monitor 18-week headroom in individual pathways so any unplanned cancellations does not cause a breach. Undertake waiting list sessions as appropriate to ensure RTT headroom is maintained.

Risk Ref	Risk Description	Monitor / CQC / NHSLA	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR053 (OP052) **Director Lead: Director of Operations** **Initial Risk Score 20** **Increased to 25 19/06/14** Mitigating risk score 12	Failure to maintain 18-week Pathway	CQC outcome 6	4. Extra clinics arranged by RTT Support Clerk.		High level RTT Recovery Plan Weekly CCG assurance reports – number of patients waiting 18 weeks are reducing			
			5. Extra theatre lists arranged by Asst Gen Mgrs.					
			6. Diagnostics manage their waiting list to achieve two week diagnostic wait.					
			7. PTL reports of target outturns are validated prior to circulation team by RTT Support Team.		Weekly CCG assurance reports – number of patients waiting 18 weeks are reducing			
	Failure to maintain 18-week Pathway	CQC outcome 6	8. Directorate have developed demand and capacity models.		Weekly CCG assurance reports – number of patients waiting 18 weeks are reducing	Lack of ring-fenced elective capacity. Consultant staff shortages in some specialties. Increased demand for specialties.	Trauma emergencies outstrip beds available on B2 and overspill onto elective ward. A high volume of emergency surgical patients impacts on bed availability for elective patients.	Ring-fence all of T&O and S&A beds, preventing medicine outlying at any stage.
			9. 20 extra beds available in C6 transferred from medicine.				Trauma emergencies outstrip beds available on B2 and overspill onto elective ward. A high volume of emergency surgical patients impacts on bed availability for elective patients.	

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR057 (OP052) **Director Lead: Director of Operations** **Initial Risk Score 16** **Increased to 20 19/06/14** Mitigating risk score 15 **NEW RISK**	There is a risk that the national Better Care Fund planning assumptions applied locally, do not lead to a community team operational response of sufficient resilience or system-wide admissions avoidance to meet expected 15% activity reduction in non-elective admissions	CQC Outcome 4 & 6	1. Creation of 5 locality based district nursing teams from current number of 14.	1. CSIC Directorate Meeting Minutes. 2-year plan submission.	5 X Roadshows and presentation during May 2014 to District Nurses reference Locality working		1. No full integration (non-institutional) plans yet in place with social care teams or mental health. .	1. Medical LOS reduction and Surgical admission avoidance plans being enacted through ECIST action plan, AMU expansion plan, ED recovery plan, LOS steering group and SAU project plan. Operational plan target 38 beds through these measures.
			2. Alignment of locality teams to CCG locality boundaries. GP clinical lead appointed for each locality.	2. CCG Board Papers. Integration Working Group (multi-agency) Minutes.			2. No clear SOPs available on how the coordination of care for individual patients will change to reflect the new structure	2. Ambulatory Emergency Care Unit and operating principles being deployed at front door to avoid unnecessary admissions. Similar principles being deployed in SAU redesign pilot.
			3. Rapid Response Nursing Team establishment.	3. CSIC Directorate Meeting Minutes. 2-year plan submission.		Lack of clarity from CCG of the Service specification	3. Recruitment to full establishment may be difficult. 3. Unclear how this team will formally relate to GP practices and 5 locality teams	3. To undertake a review of the requirements and any identified actions to take forward.

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
COR003 (OPO90) **Director Lead: Director of Operations** **Initial Risk Score: 20** Mitigating Risk Score: 12	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	1.Re-designation of surgical beds to medicine has taken place.	Surgical LOS.			Medical outliers in surgical beds. Surges in Emergency surgical activity demand. Failure of all parties to contribute. Failure of parties to agree.	Deliver the SDIP in conjunction with the CCG to ensure 15% reduction in emergency admissions.
			2. CD/MSH review of elective admissions to prioritise if cancellations are imminent.	Capacity Report/Cancellation Lists Board Reports include elements of bed capacity etc Capacity Reports communicated after each Capacity Meeting. Level of cancellations via reporting to CCG and LAT.	Capacity team operating training and Capacity HUB area		MSH/medical staff not consistently engaged in Capacity Management Surges in Emergency surgical activity demand. Bed/Capacity Management approach/systems not aligned to predictive demand management within specialities/ wards locally. Understanding of policies by all staff. Surges in Emergency surgical activity demand.	Empower non-medical staff to improve MDT-led discharge (ongoing).

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
CONT. COR003 (OPO90) **Director Lead: Director of Operations** **Initial Risk Score: 20** Mitigating Risk Score: 12	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	3. New capacity management system partially eployed.	Operation of capacity hub, output of Capacity Meetings.			Operation of capacity hub, output of Capacity Meetings.	
			4. Discharge Co-ordinators Manage delayed discharges.	Delayed Discharge database managed, available and communicated.		Urgent Care Operational Group (weekly meeting) Variation in numbers of patients having their discharge delayed. Non- Dudley patients likely to have longer delay	Delayed Discharge database managed, available and communicated.	
			5..Escalation Policy and contingency capacity policy reviewed and deployed	Escalation Policy up-to-date, available and agreed.	Policy Ratified at Risk and Assurance Committee March 2014		Escalation Policy up-to-date, available and agreed.	
			6. Daily capacity meetings. Using capacity HUB, standardised meeting template	Operation of capacity hub, output of Capacity Meetings.	Capacity reports on the HUB (updated 4 times each day) shared widely internally		Operation of capacity hub, output of Capacity Meetings.	
			7. Work with primary care and commissioners to curtail urgent care demands, provision of virtual ward etc. Rapid response teams and other admission avoidance schemes.	Minutes of Urgent Care Working Group. CCG Board Papers. Integration Working Group (multi-agency) Minutes.			Minutes of Urgent Care Working Group.	
			9. Admit on the day of surgery to reduce pre-op LOS	Surgery LOS.			Surgery LOS.	
			10. IST recommendations roll out	Revised ECIST Action Plan delivery overseen by LOS Transformation Steering Group.			Revised ECIST Action Plan delivery overseen by LOS Transformation Steering Group.	Delivery of ECIST Action Plan.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR007 (OP080) **Lead Director : Director of Operations** **Initial Risk Score: 25** **Mitigating Risk Score: 16**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	1. Daily monitoring of the delayed discharges via the delayed list, ensuring its accuracy and that challenges by the ward to the patients care is being managed and escalated appropriately.	Escalation Meeting daily at 9.15am. Information available on the HUB	Bi weekly Urgent Care Working Group Minutes	Key Performance Targets Report (month 2) to F & P (June 2014) A/E target quarter target was failed in May and Quarter 1 target will now not be met	Disagreement regarding the responsibilities in the DISCO database.	
			2. Ward-based Discharge Team support and plan discharge. Use of estimated discharge at ward level. Escalation to Medical Service Head as appropriate.	Acute Medical Unit. Capacity Team: escalate to Director of Operations as appropriate.	Daily delays report circulated managers and Director or operations			
			3. Lead Nurse meetings with patients and relative to identify needs for discharge.	Provision of non-acute care.				
			4. Early notification to LA via Section 2 to prepare for patients likely needs	Section notifications.	Timeliness of section Notifications			
			5. Agreed health economy escalation plan. -Provision of training on compliance with the escalation plan. -Issue of letter to prepare patients and family for discharge arrangements	Escalation Plan.			Patient or relative exercising “choice” exacerbates problem.	
			6. Utilisation of independent company Care Home Select (CHS) to support patients/ relatives in identifying suitable 24-hour care placement. Matron/Lead Nurse ensure that understanding of discharge processes is provided by all nurses/ carers.	Integrated Care Group and Minutes.			DMBC overseeing a higher than agreed number of patients.	Evaluation of the benefit of external elements of the winter plan

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont.. **COR007 (OP080)** **Lead Director : Director of Operations** **Initial Risk Score: 25** **Mitigating Risk Score: 16**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	7. Daily multi-agency teleconference at Level 2 or above.	Delayed Discharge database managed, available and communicated.			Poor service cover from multi-agency Discharge Teams because of vacancy, sickness, leave etc resulting in further delays	
			8. MOA - Local Authority and PCT signed off.	MOA (Memorandum of Agreement). Early understanding of financial constraints from Local Authority and planned use of new re-ablement monies to increase current capacity and response from Local Authority. Working with CCG and LA to manage delayed discharge database, improve admission prevention SW input.	Bi weekly Urgent Care Working Group Minutes	Number of patients as per MOA is too high to prevent capacity issues.		Negotiate a reduction of agreed number of DTOC's patients as per MOA (MOA remains unagreed. Escalated to CCG/MBC/NHS leadership triumvirate for agreement for 2014/15.
			9. Directorate solutions to manage delayed discharge.	Delayed Discharge database managed, available and communicated.			No ubiquitous medical and support service cover across hospital. Inconsistent bed management processes.	Evaluation of the benefit of external elements of the winter plan
			10. Training of Bed Managers and Discharge Facilitators across Directorates.	Training Records.				
			11. Escalation of issue to Director level.		Compliance to escalation			
			12. Manager of the day indentified for each Directorate.					

	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***
COR055 ***Director Lead: Director of Operations*** ***Initial Risk Score 20*** *Mitigated risk Score 16*	*Cancellation of elective surgical patients due to excessive emergency admissions from medicine, trauma or surgery.*	*CQC Outcome 12 & 14*	*Matron review of elective admissions to prioritise elective admissions, if cancellations are imminent.*	*- Board Reports* *- Transformation Board* *– Length of Stay review report* *- Operational reports* *- Directorate in upper quartile for KPI efficiencies eg LOS.*	*Performance dashboard indicates same-day cancelled operations reducing*	*- Medicine patients continue to outlie.* *- Elective surgery is cancelled periodically due to capacity issues* *- 18 week RTT performance has dropped*	*- Lack of clear pathways and senior decision makers to ensure none pt pathways are offered low risk emergency surgical patients.*	*Implementation of full ECIST Action Plan (from Nov 13 and Feb 14). Revised 4-hour wait recovery plan based on ECIST visits in Nov 13 and Feb 14).* *Plan elective surgery during weeks, months and quarters with historically lower emergency demand* *Complete SAU improvement project* *CCG commissioned Urgent Care Centre reduces non-elective demand*

Risk Ref	Risk Description	Monitor / CQC / NHSLA	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont.. *COR055* ***Director Lead: Director of Operations*** ***Initial Risk Score 20*** *Mitigated risk Score 16*	*Cancellation of elective surgical patients due to excessive emergency admissions from medicine, trauma or surgery.*	*CQC Outcome 12 & 14*	*- Surgical capacity lead involved in trust wide daily capacity planning for emergency and elective demand*	*-18 week RTT report by specialty outcome, activity and expenditure reports for surgery*			*- Emergency (medical and surgical) admissions growing.*	
			- Visualisation ward boards to manage patient flow.		*Twice daily Boards rounds on Surgical Wards to review and challenge patient flow*		*- Outlier policy not followed*	
			- Surgical Capacity Team 24/7.	*- Outlier report (daily)* *- Capacity meeting reports indicating emergency and elective demand on hospital (4 times daily)*	*Dedicated HUB page updated four times a day*		*- Matrons control of capacity not available out of hours - Failure to repatriate Walsall and Wolverhampton vascular patients*	
			- Discharge Co-ordinators DISCO dedicated to surgery.	*Delayed Discharge database managed, available and communicated.*				
			- Escalation Policy.	*- Outlier report (daily)*			*- Escalation Policy not followed*	
			- Surgical patients admitted on the day of surgery, unless there is a clinical imperative to do otherwise	*Pre-op Length of Stay report (Surgery Directorate performance meeting)*	*Pre-op length of stay report to Surgical Performance Meeting April 2014 showed reducing number non complaince*		*- Demand above plan for the vascular surgery unit.*	
			- Training programme for medical secretaries to improve use of OASIS and knowledge of 18 week RTT pathways.					
			- Enhanced recovery embedded in urology, general surgery.					

Risk Ref	Risk Description	Monitor / CQC / NHSLA	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont.. *COR055* ***Director Lead: Director of Operations*** ***Initial Risk Score 20*** *Mitigated risk Score 16*	*Cancellation of elective surgical patients due to excessive emergency admissions from medicine, trauma or surgery.*	*CQC Outcome 12 & 14*	*-Nurses empowered to conditionally discharge patients*					
			- Hospital to home service to reduce re-admissions to urology					
			- Increased use of day case	*Day case utilisation report (Surgery Directorate performance meeting)*			*- Use of DCU for capacity*	
			- Medicine have purchased additional beds in the community				*- Difficulty in acquiring sufficient intermediate or step down beds for medical patients means that they remain in acute beds after they are MFFD.*	
			- C6 transferred to surgery with 20 additional beds & B4- 10 beds converted to inpatient care					
			- Lean action days held in November 2013 to review functionality of SAU in order to optimise alternative pathways and avoid admissions wherever clinically safe and appropriate to do so				*- Limited availability of Ultrasound scanning in SAU.*	
			- Ring fenced beds for vascular surgery				*- Repatriation challenges with vascular patients from other health economies.*	
			- Reporting of incidents through DATIX	*Incident report (surgery performance meeting)*				

Risk Ref	Risk Description	Monitor / CQC / NHSLA	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont.. *COR055* ***Director Lead: Director of Operations*** ***Initial Risk Score 20*** *Mitigated risk Score 16*	*Cancellation of elective surgical patients due to excessive emergency admissions from medicine, trauma or surgery.*	*CQC Outcome 12 & 14*	*- Exceptional use of WLI operating lists at times of improved capacity to recover 18wk performance*		*High level RTT Recovery Plan* *Weekly CCG assurance reports – number of patients waiting 18 weeks are reducing*			

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
COR061 **Director Lead: Director of Finance and Information** **Initial Risk Score 20** Mitigated Risk Score 12 **NEW RISK**	The Trust must sign a "viability statement" in relation to its long term clinical and financial sustainability, as part of the 5 year strategic plan submission. 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 able to sign that viability statement and submit a robust and complete 5 year plan.	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.	1. Board Workshop and Private Board papers on 5 year plan.	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	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. Conduct internal, exec-led mitigation planning sessions during June, to agree further, organisation-wide mitigations. These may include estate reconfigurations/alternative uses, community service rationalisation, further commercial assumptions, service marketing and elective expansion beyond current plan. Black Country Trust Finance Directors to arrange facilitated planning session(s) with respect to radical, sub-regional service configuration options and associated financial monitoring

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 3rd July 2014

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

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

SUMMARY OF KEY ISSUES:

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

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

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

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

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.					
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings					
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance	RIDDOR incidents are reported appropriately and discussed at the H&S Group	**CLOSED**
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing	This is part of the reporting requirements which will be followed should such an incident occur.	**CLOSED**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
	Nursing					
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the:	23	Director of Nursing and Human Resources		
		– Regular, comprehensive feedback on performance and concerns;	23		Nurses referred to NMC report to be taken to the Board.	**Open**
	Caring for the elderly - Approaches applicable to all patients but requiring special attention for the elderly					
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • The NHS should develop a greater willingness to communicate by email with relatives • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered	25	Director of Ops/Medical Director /Director of Finance & Information	All e-mails from patients relatives and nurses are responded to by the Executive team. Ward level will require more process. The trust plans to move to an Electronic Patient Record system in the future and will include this requirement in the system specification In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved discharge letter functionality specified by Francis in Autumn 2014.	
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations	i) Late night discharge reports are provided to clinical teams routinely to enable peer review and challenge ii) Review of the criteria for and protocol supporting patient moves at night as a requirement of managing bed capacity during periods of high escalation levels Discharge lounge is now appropriately staffed and furnished to provide care for patients awaiting discharge. This is now used daily and patient attendance numbers audited	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
242 243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director/ Director of Finance & Information	Not currently possible to record electronically. This functionality is specified in a replacement EPR solution being procured by the Trust In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014.	**Open**
					Paper charts are at each bedside.	
					Compliance with charts is audited via Nursing Care Indicators.	
	Information					
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way.	26	Director of Finance & Information	The requirements outlined here will be considered when reviewing the electronic Patient Information Systems. In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014. Information is currently shared and available via the manual systems in place across the Trust.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.				

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd July 2014

TITLE:	**Monthly Nurse/Midwife Staffing Position**		
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:

As outlined in the detailed paper submitted to the Board last month, 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 attached paper provides that information.

This information also needs to be placed on the Trust's website and linked to NHS Choices for public viewing. There is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. As this is a new requirement, the format may evolve as time progresses.

The paper indicates for the month of May 2014 when day and night shifts on all wards were (green) and were not (red, with patient to staff ratio) staffed to the planned levels for both registered and unregistered staff. The planned levels for each ward vary dependent on the types of patients and their medical specialities but the general wards are planned to be at least at 1:8 RN/patient during the day and other 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

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.

Following the first update last month, the attached chart provides more information than previously. The information on the chart is likely to evolve initially, making complex information clearer and more easily understandable, especially in the light that this information is shared with the general public.

The chart indicates for the month of May 2014 when day and night shifts on all wards were and were not staffed to the planned levels for both registered and unregistered staff. It can be seen from the chart (green) that the planned staffing levels were attained in the majority of cases. In a number of instances, despite attempts through the use of deployment of staff or the use of bank/agency staff, planned levels were not reached.

When shortfalls have occurred 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 has been undertaken. 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.

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS MAY 2014

WARD	RATIO RANGE	REG/UNREG	REASONS FOR SHORTFALLS IN STAFFING	MITIGATING ACTIONS
A1	1:16 night	RN	Unable to cover with bank staff	Registered Nurse (RN) input Temporary staffing requested but unable to fill
A2	1:10 night 1:10 day	RN RN	On both occasions temporary staffing cover did not attend; unable to cover due to short notice	On both occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe
A3	1:9 day x2 1:10 nights x4	RN UNREG	Short term sickness bank unable to fill Short term sickness	On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe
B1	1:10 day 1:24 night	RN UNREG	Short term sickness bank unable to fill Temporary staffing cover did not attend	On both occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. RN staffing situation improved as patients were discharged. Situation managed by NIC and declared safe
B3	1:9 day 1:13 day x2 1:9 day x2 1:13 night x3	RN UNREG	Short term sickness bank unable to fill Short term sickness bank unable to fill Short term sickness bank unable to fill Temporary staffing cover cancelled by individual	On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe
B4	1:9 day x10 1:12 day x2 1:12 day x4	RN UNREG	Vacancy, maternity leave, short term sickness and 1 incident of special leave bank unable to fill Short term sickness and 1 shift no requested from temporary staffing in error	On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe
B5	1:9 day 1:9 night 1:18 x4 day 1:36 night	RN UNREG	Short term sickness bank unable to fill Short term sickness bank unable to fill Short term sickness bank unable to fill Short term sickness, bank unable to fill	On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe

WARD	RATIO RANGE	REG/UNREG	REASONS FOR SHORTFALLS IN STAFFING	MITIGATING ACTIONS
C4	1:11 nights x3 1:22 day	UNREG	Short term sickness bank nor agency unable to fill	Care assessed and situation managed by Nurse in Charge
C6	1:10 day x2	UNREG	Compassionate leave granted with short notice on both occasions bank unable to fill	On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe
C7	1:9 day x3 1:12 night x2	RN	Vacancy; bank nor agency unable to fill	On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe
C8	1:9 day	UNREG	Vacancy; temporary staffing cover cancelled by individual	On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted no staff available. Situation managed by NIC and declared safe

		SHIFT																																															
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WARD	**STAFF**	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D
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EAU	Reg																																																	
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MHDU	Reg																																																	
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CRITICAL CARE*	Reg																																																	
NEONATAL **	Reg																																																	
MATERNITY ****	Reg																																																	
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* 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 staff

*** 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 care.

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

5	26		27		28		29		30		31	
N	D	N	D	N	D	N	D	N	D	N	D	N
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Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meetings held on 26h June 2014**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: S06 Enabling Objective			
SUMMARY OF KEY ISSUES: • **The Trust has experienced a poor start to the new financial year both operationally with a failure of the 4 hours ED target in April and a significant budget overspend**			
IMPLICATIONS OF PAPER:			
RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Failure to achieve the 4 hours A&E target in Q1** **Risk to 2014-15 Financial Plan**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **The Trust's performance in May threatens its Financial (CoS) and Governance ratings.** **The Trust remains on quarterly monitoring by Monitor.**
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners in 2014-15**
ACTION REQUIRED OF BOARD:			

Decision	Approval	Discussion	Other
			X

NB: Board members have been provided with a complete copy of agenda and papers

for this meeting.

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the Committee's major concern about the level of overspending in the Trust which is jeopardising financial stability in 2014-15 and a continued failure to achieve the 4 hours ED target.

The Dudley Group NHS
NHS Foundation Trust

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

Finance and Performance Committee Meeting held on 26th June 2014

1. Background

The Finance & Performance Committee of the Board met on 26th June 2014. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports. The Committee noted in particular the following matters:

2. Turnaround Programme Progress report

Mr Davies, Interim Turnaround Director, presented the Turnaround Plan for consideration and reported upon progress to date against the critical path presented to the previous Board of Directors Meeting.
The revised Plan identifies firm savings proposals of £18.8m, with an in-year impact of £10.9 (based upon a 74% delivery rate).

It was now forecast that as a result of scheme slippage in Month 2 the Programme was now likely to deliver in-year savings of £9.7m against the £10.9m Plan.

May has seen the formal launch of the Turnaround Programme by the Chief Executive and other Executive Directors.

Mr Davies said that the Trust had not experienced the degree of downturn in spending forecast in May, although spending was falling. The Committee would see the level of expenditure begin to fall further in June as new 'budget challenge meetings' commenced with overspending departments.

The QIA approval process for vacant posts had commenced and was working well.

The key to success in turnaround was identified as clear accountability for the achievement of agreed actions with crisp escalation where these fail. This will be a large feature of the process being instituted across the organisation.

The Committee noted the report and requested regular full reports to the Board of Directors.

3. Performance Targets and Standards

The Committee noted the following matters:

a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for May was 91.4% (April was also 91.4%) against a 95% target. The Trust has failed 4 of the last 5 quarters' targets. The Committee devoted a great deal of time to the analysis of key drivers and the Trust Recovery Plan. Mr Scott, Interim Director of Operations, discussed a range of new measures he is introducing to improve patient flow.

b) Never Events

The Trust had no 'never events' in May.

c) Telephone Appointments Line Service

CQSPE Committee requested that F&P Committee monitors TAL performance which has fallen well below contractual required compliance since October (April 38.75% compliance v 80% target). Main problem specialties are ophthalmology, ENT, Urology and GI. The Committee received assurances on rectification plans.

The Committee heard that Diagnostic waits remained a risk due to CT & non obstetric ultrasound staffing problems.

4. Workforce KPIs

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

a. Absence
The Trust absence rate for the month of April is 3.66% (3.63% previously) The 2014-15 target is 3.50% and YTD performance is 3.63%.

b. Turnover
Turnover continues to remain consistent and within target at 7.92% (7.87% previously)

c. Mandatory Training and Appraisals
The compliance rates for Mandatory Training have shown a small decrease on previous months to 77.9% (78.1% previously). No red rated subjects.

Appraisals have decreased this month to 73.71% (76.01% previously and a 85% 2014-15 target).

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

5. Financial Performance for 2 months ended 31st May 2014

The Trust has made a poor start to the year, posting a deficit of £2.2min April and £0.7m in May, resulting in a year to date deficit of £3.0m (equivalent to the planned deficit for Quarter 1 as a whole). The Committee noted that a continuation of the present run rate of spending and income would result in a deficit much higher than the £6.7m previously budgeted and reported to the Regulator.

NHS clinical income is lower than plan, since whilst levels of emergency and unplanned activity has significantly exceeded plan the Trust is falling behind more profitable elective activity plans and thus overall income targets.

The Committee expressed concern about the slippage on turnaround and CIP plans in the first quarter, with forecast cost savings plans now estimated to deliver £9.8m benefits in 2014-15, compared to the original plan of £10.2m.

In addition, the Director of Finance & Information warned the Committee of a much more aggressive stance being adopted by commissioners in respect of fines and penalties contained in the standard NHS acute contract.

The Trust's balance sheet and liquidity position remain relatively strong, although significant overspending is putting unnecessary strain on cash reserves.

Capital spending is broadly on plan.

The Committee noted the work of the Turnaround Director and the need for a strong delivery of identified savings if the budget is to be delivered.

6. Matters for the attention of the Board of Directors or other Committees

The Board is asked to note the report and to note the Committee's continued concerns about the trends in overspending and failure to achieve the 4 hours target in ED should be noted by the Board.

PA Assinder
Director of Finance & Information