The Dudley Group NHS
NHS Foundation Trust

# Annual Report and Accounts 2013/14

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**The Dudley Group NHS Foundation Trust**

Annual Report and Accounts 2013/14

Presented to Parliament pursuant to Schedule 7,
paragraph 25(4) of the National Health Service Act 2006

# Contents



**All information contained in this report was correct at the time of publication.**

The Trust would appreciate any feedback you would like to give on both the format and content of this report. You can do this by emailing communications@dgh.nhs.uk or telephoning 01384 244403 and speaking to a member of the Communications Team.

# Chairman's welcome

We have faced another very challenging year in 2013/14, both in the NHS as a whole and here at The Dudley Group NHS Foundation Trust. It has been an extraordinary year, characterised by multiple inspections, tighter than ever finances, pressure from ever increasing targets and being under the spotlight from the national and local press.

Last year saw us take part in two major inspections: the Sir Bruce Keogh Review team visited us in May 2013 and a routine inspection from the Care Quality Commission (CQC) was undertaken in March 2014. The Dudley Group was one of just two of the 14 Keogh trusts not placed into special measures. Paula discusses more about both reviews in her Chief Executive's overview on the coming pages.

Unfortunately we narrowly missed the nationally set target for admitting, treating or discharging 95 per cent of A&E patients within four hours of arrival, achieving 93.7% for the year as a whole. We also failed to meet our quality priority target for infection control, and only partially achieved our targets relating to patient experience, hospital pressure ulcers and nutrition.

More information about our performance against national targets and our quality priorities can be found in our Quality Report.

Despite these difficult times and ongoing challenges, we continue to deliver great services to our patients. I am incredibly proud of the dedication and hard work of all our staff, especially in a year which has tested us all. My personal thanks goes out to every single member of staff in the organisation for their commitment to the Trust and their relentless dedication to providing excellent patient care.

The Board of Directors maintains its constant focus on quality, whilst ensuring we remain financially stable. We have worked with our Council of Governors (many of whom are new in post) to ensure they are supported to do their role well in holding the Board of Directors to account for its decisions and improving contact with over 18,000 members of the Trust. It is also really pleasing to see that our public membership of over 13,000 continues to grow.

Next year we will continue our focus on providing our ever-popular behind the scenes tours and health fairs and hope to hold even more of these successful members' events in the coming year.

We celebrated the very best of the Trust at our annual Committed to Excellence awards evening in September 2013 and I was delighted to present Dr Mourad Labib, Consultant Chemical Pathologist, the award for outstanding achievement at the Trust.

The year ahead of us presents even greater challenges for the Trust than ever before. We will maintain a relentless focus on providing the highest quality of care to our patients and on continually improving the services we offer, both in our hospitals and out in the community.

**Chairman**

**John Edwards CBE**

# Chief Executive's overview

Before I start my overview of the year that was, I would like to say a huge thank you to every single member of staff working for the organisation across all our sites and out in the community for their incredible hard work in what has been an exceptionally challenging year for the Trust. Throughout the ups and downs of 2013/14 our staff have continued to deliver the best possible care and experience to our patients, rising to the challenge and working through the pressure.

I am proud to say that we continue to live and work by our values of care, respect and responsibility, constantly striving to be known as a high regarded healthcare provider where people matter. At the heart of everything we do are our patients; and one of our most important aims is to provide the best possible patient experience. To do that we want to create an environment that encourages our committed workforce to get things right for every patient, every time.

We had an interesting year with regards to infection control as despite both MRSA and C. difficile being at our lowest ever recorded levels, we failed the very challenging C. difficile target. We also did not meet the target we had set for ourselves in terms of ensuring our patients received enough mealtime assistance during their stay in hospital. This meant that our patient experience target for 2013/14 was only partially met. Our quality priority relating to pressure ulcers was also not fully met as we were unable to reduce stage three hospital acquired pressure ulcers by 25 per cent as per our target. We were pleased, however, to achieve our quality priority target for hydration and for community pressure ulcers, with only three stage three and four pressure ulcers developing on our community caseload. More information about our quality priorities can be found in our Quality Report from page eight.

A real boost to our Maternity Department, and to the Trust as a whole, has been the success of our lead community midwife Lucy Johnson in winning the JOHNSON'S® Baby Award for Evidence into Practice in the 2014 Royal College of Midwives Annual Midwifery Awards for her Mom2Mom breastfeeding support project. Our Council of Governors was also named NHS Governing Body of the Year at the regional NHS Leadership Recognition Awards 2013. Congratulations are also in order for Rachael Bailes, Senior HR Business Partner, Linzie Priestnall, Specialist Speech and Language Therapist and Jenny Bree, Matron for Trauma and Orthopaedics who were shortlisted at the same awards.

I was also thrilled when I received 2013's National NHS Staff Survey results to find out that more of our staff than ever before would recommend the Trust as a place to work or receive treatment. You can find out more about our results in the survey on page 37.

This year I introduced my face-to-face Chief Executive's Update sessions to give me an opportunity to speak to staff in person about good news, important issues facing the Trust and changes and developments to our services. I have really enjoyed the opportunity to see more staff face to face and to speak to members of the Trust I would not normally get the opportunity to talk with.

In the previous Annual Report I was disappointed to have to announce that we had found ourselves on the list of 14 hospitals to be reviewed by Sir Bruce Keogh for the quality of care and treatment delivered. The Keogh Review team visited the Trust in May 2013 and conducted an in depth inspection of our services and the quality of care we provide. The review team found no major issues and we were one of only two Keogh reviewed trusts that were not put into special measures and this was a great boost for us and endorsement of the care we provide.

There were some areas for improvement highlighted by the review team. We were asked to improve quality governance, staff engagement, our complaints processes and nurse staffing levels, and to continue our progress on the use of mortality indicators. We have now completed the actions we agreed with the review team and I am confident that this hard work will continue to provide improvement for many years to come.

The Care Quality Commission (CQC) carried out an inspection of the Trust in March 2014 as part of their new nationwide inspection regime which will see all NHS trusts in England receiving a visit. The inspection team looked at all areas of the Trust, including Russells Hall Hospital, Corbett and Guest outpatient centres and our community settings. We received some positive feedback from the team as well as areas for improvement. At the time of this report we are still awaiting the official report from the visit which will be published in June 2014.

We launched our strategy for nursing, midwifery and care giving this year, accompanied by our *The Way We Care* video which portrays our vision for care at the Trust. Hundreds of staff had their say on what the strategy should include and what we should expect of our staff on the front line. The final product which also incorporated the Chief Nursing Officer's Six Cs of nursing was unveiled in May 2013 and was a huge success with all staff at the Trust. Later in the year we also launched our Health Care Assistant code of conduct which provides clinical support workers and other support staff in the Trust with a guide on which to base the way they work and care for patients.

The year also saw the launch of our Learning Disability Strategy which further cemented our commitment to be an inclusive, accessible and safe place to access healthcare. The strategy was launched at an event attended by more than 200 members of staff and representatives from the wider Dudley health economy.

As we move into this coming year we face new pressure in terms of our financial position, but I am confident that we will rise to meet this together as one organisation in the same way that we tackled the challenges and tests last year.

**Chief Executive**

**Paula Clark**

# Strategic Report (incorporating the report of the Board of Directors)

The Dudley Group NHS Foundation Trust is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest.

Currently the Trust serves a population of around 450,000 people from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. The Trust provides the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The Trust also provides specialist adult community based care in patients' homes and in more than 40 centres in the Dudley Metropolitan Borough Council community.

At March 31st 2013 the Trust employed 4,163 full time equivalent members of staff making us a major employer in the Dudley borough. More information about our staff can be found from page 28 of this Annual Report.

The Trust's aim is to be a highly regarded healthcare provider for the Black Country and West Midlands offering a range of closely integrated acute and community based services driven by the philosophy that people matter.

Our strategic objectives are:

- To provide the best possible patient experience
- To develop and strengthen strategic clinical partnerships to maintain and protect our key services
- To deliver an infrastructure that supports delivery
- To become well known for the safety and quality of our services through a systematic approach to service, transformation, research and innovation
- To create a high commitment culture from our staff with positive morale and a 'can do' attitude
- To drive the business forward by taking opportunities to diversify beyond our traditional range of service and strengthen our existing portfolio

The Trust was authorised by Monitor, the independent regulator of NHS Foundation Trusts, to commence operation as an NHS Foundation Trust from 1st October 2008. On 1st April 2011 the Trust acquired the Adult Services arm of Dudley Primary Care Trust, transferring more than 400 whole time equivalent (WTE) staff to the Trust and increasing turnover by circa £20m per annum. In response to this important change the Trust sought from Monitor, and was granted, approval to change its name to The Dudley Group NHS Foundation Trust. In March 2013, Monitor issued a NHS Providers Operators licence (Ref 120124) to the Trust, in accordance with the 2012 Health and Social Care Act.

The Trust's hospitals form part of a Private Finance Initiative (PFI) with Summit Healthcare and its appointed service providers Interserve Facilities Management and Siemens Healthcare.

The Trust is run by a Board of Directors, which is accountable for its performance against its terms of authorisation, to a Council of Governors.

2013/14 has been another highly challenging year for the NHS in England as the service has worked to deliver the structural changes in the Health and Social Care Act 2012, respond to the lengthy set of recommendations contained in Lord Justice Francis' Second Report into Mid Staffordshire NHSFT and come to terms with continued reductions in real spending on the NHS.

In Dudley these trends have been exacerbated by the impact of the Chief Medical Officer's investigation into Dudley as one of the 14 sites with high reported mortality rates and by our local clinical commissioning group's ambitious plans to reduce levels of spending in the acute sector. Further, a 4% 'efficiency' reduction to NHS standard tariff has resulted in a further real terms cut to our income. As a result, we have delivered cost savings from improved efficiencies of circa £10m during the year, although much of this has been of a 'one off' nature and will need to be repeated in future years.

Against this challenging background our overall business achievements in 2013/14 have once again been commendable and can be summarised as:

- Financial surplus of £0.3m (before technical adjustments)
- Monitor financial rating of 3 (out of 5 maximum)
- Achievement of the 18-week national maximum waiting targets for both admitted and non-admitted patients
- Significant further investment in additional substantive clinical staff
- Further investment in buildings and specialist equipment

Page 66 of this Annual Report details our contractual arrangements with local commissioners for the provision of services for 2013/14 and details of our performance against key national priorities and performance targets can be found within the Quality Report on page 79.

During the financial year the following people served as directors of the Trust:

Executive directors: Paul Assinder, Richard Beeken, Richard Cattell*, Paula Clark, Paul Harrison, Denise McMahon.
**Richard Cattell is a non-voting executive director.*

Non-executive directors: John Edwards, David Badger, Ann Becke, David Bland, Jonathan Fellows, Richard Miner.

More information about our directors can be found from page 50 of this Annual Report. The Trust's accounting policy for pensions and other retirement benefits is set out from page 5 of the accounts. Details of senior employees' remuneration can be found in the Remuneration Report on page 84.

As at 31st March 2014 the gender breakdown of our executive directors, non-executive directors and employees of the Trust was as follows:

| | |
|---|---|
| Executive directors | Male: 4 |
| | Female: 2 |

| | |
|---|---|
| Non-executive directors | Male: 5<br>Female: 1 |
| All Trust employees | Male: 818<br>Female: 3,934 |

Whilst performance during 2013/14 across the range of targets and standards has once again been good, the Trust did experience problems in meeting the four hour A&E wait target in three quarters of the year and for the year in total. The Trust also experienced a single isolated 'never event' in Russells Hall Hospital's Operating Theatres Department; however, no patient harm was caused by the incident.

From April 2010, the Department of Health introduced a system of legal registration of service providers in England and now requires a clear demonstration and evidence of the achievement of standards of healthcare. In support of our application for registration from that date, the Trust made declarations to the Care Quality Commission (CQC) and shared its development plans in a number of clinical areas including the ongoing training of clinical staff (and the appropriate recording of this) and the improvement of the quality and availability of clinical notes. The Trust has operated within its CQC licence throughout the year.

The CQC undertook a full assessment of the Trust's services in spring 2014 and reported no immediate concerns. The Trust currently awaits their formal report and ranking.

In view of the impact of the UK recession on the local economy, the Trust has adopted a policy of settling the invoices of local suppliers promptly. In 2013/14 the Trust settled 99 per cent of trade invoices by value within 30 days.

As an NHS Foundation Trust no political or charitable donations have been made during 2013/14.

To promote improved patient safety, the Trust has continued its programme of directors' patient safety walkrounds and has worked closely with patient groups and Members and Governors of the Foundation Trust to develop a more responsive service to patients.

Once again, during 2013/14 the Board of Directors took the decision to invest heavily in front line clinical services to continually improve the quality of care to patients. The Trust has invested significantly in new buildings and equipment to the value of £5.7m. Of note is spending of £2.5m on new and replacement medical equipment, £0.9m on Information Technology, £0.4m on a new GI Unit and £0.4m on a Simulation Laboratory.

The directors' view is that investment in state-of-the-art IT functionality is crucial to the future clinical and business sustainability of the Trust. To this end, the Trust purchased the local PCT's Data Centre business in 2012/13 and have negotiated a major change to our local PFI agreement to bring IT services back in-house. The Trust has also commenced the process of procuring a new suite of clinical systems under the Programme Fusion banner which you can find out more about on page 21.

The Trust has one active subsidiary, Dudley Clinical Services Limited, whose principal activity is the provision of outpatient pharmacy services. In addition the

members of the Board of Directors are corporate trustees for Dudley Group NHS Charity. Following Treasury's agreement to apply IAS 27 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity, it effectively has the power to exercise control so as to obtain economic benefits. The Charity is therefore treated as a group entity and is consolidated. For both the subsidiary company and the Charity there are no items of risk or uncertainty that require reporting.

During the year, the Board of Directors has placed increased emphasis upon the importance of good communications with staff. Regular team briefings and a lively intranet facility has kept staff informed about changing clinical and business-related issues. In addition, the Chief Executive has established a programme of face to face and video-based briefing sessions for staff and all staff have been personally invited to a specific quality briefing with the Chief Executive in 2013/14.

During such sessions, staff have been appraised of the overall financial health and prospects of the Trust and wider NHS in England. The Board of Directors and Council of Governors continued to hold their meetings in public during the year.

In summary, 2013/14 has been a challenging year for the Trust in both a clinical and business sense but has also been a year of significant and sustained achievement.

The accounts contained in this Annual Report have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

After making enquiries, the directors have a reasonable expectation that The Dudley Group NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

**Signed** **Date: 22nd of May 2014**

**Paula Clark**
**Chief Executive**

# Our services

## Russells Hall Hospital

Anaesthetics
Anticoagulation
Audiology
Cancer Services
Cardiology
Clinical Haematology
Critical Care Unit
Day Case Surgery Unit
Dermatology
Diabetes and Endocrinology
Dietetics
Early Pregnancy Assessment Clinic
Emergency Assessment Unit
Emergency Department (Accident and Emergency)
Fracture clinics
Gastroenterology
Genito-urinary medicine
Head and Neck surgery including Ear, Nose and Throat (ENT) and Maxillofacial
Inpatient Wards
Maternity
Maxillofacial prosthetics
Medical and clinical inpatient services
Medical High Dependency Unit
Neurology
Obstetrics and Gynaecology
Older Persons and Stroke
Oncology
Ophthalmology
Orthodontics
Orthoptics
Orthotics
Outpatients
Paediatrics and Neonatology
Pain management
Pathology
Pharmacy
Phlebotomy (blood tests)Plastic surgery
Podiatry
Pre-operative assessment
Psychology
Radiology (X-ray, MRI and CT scanning)
Renal
Respiratory assessment
Respiratory medicine
Rheumatology
Skin lesion clinic (Care Plus private patient clinic)
Speech and Language Therapy
Surgery including breast, colorectal, upper and lower GI and vascular
Surgical Assessment Unit (for GP referrals)
Surgical pre-operative assessment
Surgical High Dependency Unit
Theatres
Therapy Services (including Physiotherapy and Occupational Therapy)
Trauma and Orthopaedics including fracture neck of femur unit
Urology
Women and Children's Outpatient Department

## Corbett Outpatient Centre

Abdominal Aortic Aneurysm Screening
Anaesthetics
Day Case Surgery Unit
Dietetic clinic
Multi-professional rehabilitation
Dudley Rehabilitation Service
Orthotics
Outpatient clinics including:
- Adult Genetics
- Cardiology
- Dermatology
- Gastroenterology
- Neurology
- Gynaecology
- Older Persons and Stroke
- Respiratory
- Rheumatology
- Trauma and Orthopaedics
- Urology

Pharmacy
Phlebotomy (blood tests)
Physiotherapy
Podiatry
Radiology (X-ray, Ultrasound scanning, DEXA bone scanning)
Speech and Language therapy
Wheelchair Service

## Guest Outpatient Centre

Abdominal Aortic Aneurysm Screening
Outpatient clinics including:
- Dermatology
- Gastroenterology
- Immunology
- Neurology
- Older People
- Pain Management
- Renal
- Respiratory
- Rheumatology
- Heart Failure Clinic
- Bladder Dysfunction Clinic

Multi-disciplinary team pain management programme
Pharmacy
Physiotherapy and Occupational Therapy
Radiology (X-ray and Ultrasound)
Respiratory Assessment
Speech and Language Therapy

## Community Services

Audiology
Blood Borne Virus
Chronic Obstructive Pulmonary Disease (COPD) respiratory nurse service
Care Home Practitioner Service
Community Ear, Nose and Throat (ENT)
Community Rapid Response Team (replaces Thunderburds)
Continence Service
Contraception and Sexual Health
Dermatology
Diabetes Specialist Team (Primary Care)
Dietetics
District nursing
Dudley Rehabilitation Service – this is a new integrated service which combines and replaces the following services:

- Community Neurology & Disability Support service which includes Parkinson's and Multiple Sclerosis nurses and the Integrated Living Team
- Community Stroke Rehabilitation Team
- Domiciliary Physiotherapy
- Primary Care Occupational Therapy
- Community Speech and Language Therapy

Heart Failure
Intermediate Care
Leg Ulcer clinic
Macmillan Community Palliative Care Team
Macmillan Multi-disciplinary Team
Outpatient Parental Antibiotic Therapy (OPAT) and oncology outreach
Palliative Care Support Team (Joint Agency)
Physiotherapy – Musculoskeletal Physiotherapy Service
Orthopaedic Assessment Service
Podiatric surgery
Podiatry
Tissue Viability
Virtual Ward

# Patient Safety

The Trust gives priority to the delivery of high quality care to all patients by ensuring that patient safety is at the heart of everything we do.

While it is important for us to meet national targets and to remain in financial balance, this must not be achieved at the expense of the safety of our patients. As part of this we ask all staff to complete incident forms if things do go wrong so that we can investigate the circumstances, learn lessons and change practice when needed.

We provide safe, high quality care to thousands of people every year but sometimes, despite our best efforts, things can and do go wrong. If a patient is harmed as a result of a mistake or error in their care, we believe that they and their family or those who care for them should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response. This is something that we call being open.

Being open, learning from our mistakes and changing practice contributes to the high quality of care we aspire to.

# Service changes, improvements and achievements

## Discharge Lounge

The Discharge Lounge on Ward C8 at Russells Hall Hospital received a facelift during 2013/14 and is, month after month, becoming better utilised by all wards in the hospital. The Discharge Lounge accepts patients from across the hospital, giving patients who are well enough to leave hospital somewhere less clinical to wait for their final discharge. The Trust's charity funded the lounge's refurbishment, providing new comfortable armchairs, furniture and a range of books and magazines.

As well as creating a more homely and relaxed setting for patients to wait, the lounge also helps the Trust manage capacity, making sure hospital beds are available for the patients who need them most.

## Emergency Care Intensive Support Team

The Trust was fortunate to receive support throughout the financial year from the Emergency Care Intensive Support Team (ECIST), a national team set up to provide support to health and social care communities in reviewing their system for urgent and emergency care.

ECIST has visited Dudley on a number of occasions to review specific service areas and offer recommendations for service improvements. Following recommendations from the visiting team, the Trust made a series of improvements and embarked on two exciting projects: the Ambulatory Emergency Care initiative and the Frail Elderly Short Stay Unit. Both schemes have proved successful during winter 2013/14 and have delivered improvements to patients' lengths of stay and provided a better patient experience.

The Trust continues to maintain contact with ECIST to continually review and improve emergency care pathways across the health economy.

## Patient Safety Huddle Boards

The Trust introduced Patient Safety Huddle Boards in 27 areas in Russells Hall Hospital in February 2014. The large dry wipe boards display important up-to-date information on topics such as staffing ratios, Friends and Family Test, key nursing contacts, infection control, and avoidable falls relevant to that area. The information is displayed on the ward in a visibly pleasing and easy to understand way so staff, patients and their families can easily find out information about the ward or area.

The boards also provide a base for twice daily handover meetings hosted by the lead nurse or shift lead, giving all staff on shift the opportunity to discuss any safety or Trust-wide issues, and also to share feedback with the other members of the team. A bespoke approach to designing the boards also meant that areas have their own personalised boards with information panels specific to their area and their patients' needs.

## Maternity Care Settings Fund

The Trust made a successful bid for a £41,640 government grant to make improvements to the Maternity Department. The grant was part of a £10m Department of Health scheme which distributed funding from the Maternity Care Settings Fund.

The money will be used to improve the service offered to bereaved parents and vulnerable women, namely by improving the 'quiet room' where parents receive bad news and counselling. One of the delivery suites will also become a dedicated bereavement suit for mothers having still births, using some of the funding to adapt and decorate this room appropriately.

The Trust will also be investing in 13 additional night beds and better facilities for birth partners who wish to stay with new mothers after giving birth. Following the successful installation of birth-related artwork in the Midwife Led Unit, money will also be used to introduce similar artwork in the Delivery Suite area.

## Ophthalmology service review

The Trust's Ophthalmology Department is in the process of undergoing a full service review to improve patient experience. Progress so far includes: the introduction of a partial booking system which prioritises patients with particular needs and reduces the number of rearranged appointments, the addition of evening clinics to accommodate the needs of working patients, the introduction of a Glaucoma patient support group and the revision emergency pathway to improve patient flow. The department is in the process of recruiting additional staff members to further improve this service.

## Learning Disability Strategy and dedicated liaison nurse

This year the Trust introduced a new role of Learning Disability Liaison Nurse to improve the Trust's provision for patients with learning disabilities and make it easier for them to access hospital and community services.

To further ensure patients with learning disabilities receive safe and appropriate care, and to firmly cement the Trust's commitment to being accessible and inclusive, a Trust-wide Learning Disabilities Strategy was also introduced. The strategy was built around the four principles of choice, independence, rights and inclusion and also reinforces the principles behind the Mental Capacity Act with staff and provides a set of standards that all Trust staff adhere to.

## Monitored Dosage Systems at discharge

This new service, developed in conjunction with Adam Myers Limited, was designed to improve patient experience for those patients requiring additional support when taking their medicines once they return home.

The Broadway Pharmacy, which is run by Adam Myers Limited, now provides a two week supply of medicines at discharge in a Monitored Dosage System and also informs the patient's previous community pharmacy and GP of the patient's new prescription requirements to ensure continuity of care.

Medicines are delivered to the hospital to enable nursing staff to discuss any medication issues with patients and their carers upon discharge home. A Monitored Dosage System helps to make sure patients always take the correct medication at the correct time.

## Novice Programme

The Trust's novice programme continues to be incredibly successful, producing a high calibre of candidates. In 2013/14 three novice programmes were ran, for which the Trust received a consistently high number of applicants. A total of 55 novices completed the programme and secure permanent positions within the Trust and a further 24 novices are due to start their training in June 2014.

The Trust fully supports all staff to further develop within their roles, and last year saw the first novice clinical support workers (CSWs) start their nurse training after two years with the Trust. Many novices who have not gone on to train to be a nurse have continued to progress by undertaking their Diploma Level 2 award in Clinical Healthcare Support as part of the CSW development pathway

This year the Trust also introduced a new initiative aimed at Clinical Support Workers who had care experience within residential and nursing homes environment. They had previously been unable to apply for a CSW post because of their lack of experience in an acute hospital setting, but their valuable experience and qualifications made them too good to miss out on.

The new CSW training scheme is the same as the novice programme and the Trust has already welcomed a cohort of 15 CSWs in permanent positions following a successful training period. A further 16 CSWs are due to begin training in May 2014.

## Single Point of Access

In September 2013 the Trust introduced its Single Point of Access (SPA) service, a new referral line tasked with making the referral process for patients to community nursing or rehabilitation services simpler and easier. Before SPA, patients had not always been referred to the most appropriate services for them or had not been referred to services that would have been of benefit.

The new service introduced a single telephone number for all referrals, with a team of trained administrators and clinicians on hand to establish the best and most appropriate services for each patient referred to them. Since its introduction, more than 80 per cent of the SPA's 1,929 referrals have been passed on to the correct service within just 15 minutes of the referral being made.

## Nurse recruitment in Spain and Portugal

After successful recruitment programmes in Madrid, Porto and Lisbon, the Trust successfully recruited 25 staff nurses. The new recruits joined the Trust in March 2014 and were partnered up with recent graduates who will be available to offer them support during their first few months.

2014/15 will also see the Trust welcome 15 further international nurses from Romania. The Trust will be returning to Spain and Portugal with a hope to recruit more nurses in the coming year.

## Urology Hospital to Home

The Trust's Urology Hospital to Home Service was introduced in September 2013 with the aim of reducing length of stay, avoiding inappropriate referrals to the Surgical Assessment Unit and Emergency Department and to enhance patient experience in relation to post operative catheter care and urological interventions.

The Hospital to Home Service provides a quality service to patients who are under the care of a urology consultant and/or who have recently undergone elective or emergency surgery, or who have required emergency interventions. The nursing team provides patients with information about catheter care, urology products, teaching, education and support within the surroundings of their own home. Patient feedback has been excellent and patients have found the service more personal and convenient, resulting in positive outcomes on their recovery post operatively.

## Programme Fusion

The Trust has invested in a new IT system which will see major electronic records changes and a move from paper-based systems to the technology of e-prescribing, diagnostics and the linking up of all patient records. The project's aim is to ensure information systems make the Trust's services safer, more efficient and more effective for patients, carers and staff.  Appropriate information will be shared to ensure the right information is available at the point of care using an electronic health record.

## Specialist nurses for Parkinson's and lung cancer

The new Macmillan Nurse Consultant for Lung Cancer role is part of a three-year investment in the lung cancer team by the cancer charity Macmillan Cancer Support and has enabled the Trust to set up nurse-led clinics to help reduce demand on consultant physicians and oncologists and enable patients to be seen more quickly. The post also provides access to emotional and psychological support for patients suffering from lung cancer.

The new Clinical Nurse Specialist for Parkinson's role focuses on caring effectively for people with Parkinson's during their stay in hospital. The role will provide help and support for patients with Parkinson's, offering holistic initial assessments, care planning and ongoing reviews while patients are in hospital and once they leave.

## The Way We Care: Our vision for nursing, midwifery and caregiving

In May 2013 the Trust launched its very own nursing strategy based on the Chief Nursing Officer for England's Six Cs of care, compassion, communications, competence, commitment and courage. As well as a pocket sized strategy and strategy summary document the Trust also produced a video which portrayed the vision for care at The Dudley Group through the words and faces of the Trust's own staff. You can view The Way We Care on the Trust website www.dudleygroup.nhs.uk or on The Dudley Group's channel on YouTube.

The Trust also launched the national Health Care Assistant Code of Conduct for clinical support workers which focuses on the invaluable work of CSWs at the Trust and provides an explanation of the type of care all support staff are expected to provide to patients.

# Your feedback

The Trust values and welcomes all feedback to help ensure it meets the needs and expectations of patients, their families and carers, staff, stakeholders, members and the Council of Governors.

The Trust has a number of systems in place for obtaining patient feedback:

- Lead nurse walkrounds allow time for real-time face-to-face patient feedback
- Governors provide feedback from members and wider communities
- Patient panels and listening events on specific topics
- NHS Choices and Patient Opinion online feedback
- Patient Advice and Liaison Service (PALS)
- Complaints data
- National surveys such as the Friends and Family Test
- Real-time surveys
- Liaison with the local Healthwatch, Health Scrutiny Committee and MPs
- Holding and attending community events

Patient feedback is a regular agenda item at the Board of Directors enabling both executive and non-executive directors to consider patient views alongside other performance information and every month the Board of Directors hears a patient story directly.

See pages 51 to 66 of the Quality Report (appended to this Annual Report) for more information about the Trust's priorities for patient experience.

No formal consultations with patients have taken place during the year; however, the Trust continues to involve patients in service improvements by asking for feedback, particularly when any changes are planned.

During the year, the Trust maintained close contact with Healthwatch and other patient groups in the area, and attended the Dudley Health Overview and Scrutiny Committee to present a number of items listed below:

| | |
|---|---|
| **July 2013** | Maternity services – managing future demand in Dudley<br>Keogh Review and mortality rates update |
| **September 2013** | Keogh Review update<br>Development of Vascular Services hub |
| **February 2014** | Quality accounts, progress on improvement priorities<br>Realignment of community physiotherapy clinics<br>Patient experience: Friends and Family Test and Strategy |

## Patient Advice and Liaison Service (PALS)

The Trust tries to make sure its service is the best it can be but sometimes, despite the Trust's best efforts, things can go wrong. The Patient Advice and Liaison Service is there to help when patients or relatives have concerns and, whenever possible, will try to help put things right.

The Patient Advice and Liaison Service acts as the first point of contact for patients who need help with a concern and will provide advice, support and information. During 2013/14 the team helped 550 people with a wide variety of concerns and queries. This is a 33 per cent decrease from 2012/13 (820 concerns in 2012/13).

**Why people contacted the Patient Advice and Liaison Service in 2013/14**

| | Concerns | Compliments/gifts |
|---|---|---|
| Quarter 1 (April to June 2013) | 100 | 287 |
| Quarter 2 (July to September 2013) | 115 | 429 |
| Quarter 3 (October to December 2013) | 124 | 274 |
| Quarter 4 (January to March 2014) | 211 | 1118* |
| **Total for 2013/14** | **550** | **2108** |

**In January 2014 the Trust changed the way it collects compliments and now proactively ask wards and departments to record and report the number compliments they receive every month.*

Main concerns related to appointments, discharge and transfers, records, communications and information, and clinical care.

## Complaints

The Trust believes it should do everything possible to address the concerns of patients, relatives and carers in a timely manner. During 2013/14, 99 per cent of the 330 complaints received were acknowledged within three working days. All complaints are assessed and, according to the complexity of the complaint, a timescale for response agreed.

The main purpose of a complaint response is to remedy situations as quickly as possible and to provide an explanation to complainants. The Trust tries to ensure each patient is satisfied with the response they receive. It is important that individuals feel their complaint has been fairly listened to and treated with respect, and that any issues have been resolved.

Complaints are an important source of information about how patients view services, and the Trust is committed to learning from the complaints raised and making changes to the benefit of all patients.

If local resolution fails, there is a one stage review by the Parliamentary and Health

Service Ombudsman. During the year, five complaints were investigated by the Health Service Ombudsman. Two of these complaints were upheld and compensation paid.

The number of complaints against patient activity during 2013/14 was 0.04 per cent, a decrease on 2012/13 which saw 0.05 per cent of complaints against patient activity (372 complaints in total). Main concerns related to medical care, diagnosis and tests, and communication, records and information.

Dependent on the type of complaint raised the Trust will either:

- Take immediate action to resolve an issue quickly and to the satisfaction of the complainant
- Arrange a face to face meeting with appropriate staff and the complainant to resolve issue(s) as quickly as possible
- Conduct a more detailed enquiry when complex issues are raised, with a written response sent from the Chief Executive

Following a review of the PALS and complaints process, the Trust has begun collecting feedback from past complainants to find out how they feel their complaint was dealt with. The Trust has done this by holding two listening events with complainants discussing three main areas: what the current process is like for the complainant, problems with the current process and how the process better can be made better. The events have been very successful and actions have already been taken as a result such as giving complainants a named coordinator to ensure consistency, and ensuring any medical terminology is fully explained in letters.

The Trust has also established an internal Complaints Review Group which is made up of a non-executive director, the chief executive, the head of communications and patient experience, the complaints manager, the director of nursing, the incidents manager, the interim deputy director of community services and community care and the deputy medical director. The group will:

- Oversee the implementation and review of findings and related action plans resulting from complaints investigations
- Ensure that good practice is shared across the Trust and externally
- Receive and review reports from directorates on complaints review and learning, ensuring this learning is shared across the Trust
- Monitor processes continually to improve the service user experience based on feedback to and from patients, carers and relatives.

For more information about complaints please see the Quality Report page 61.

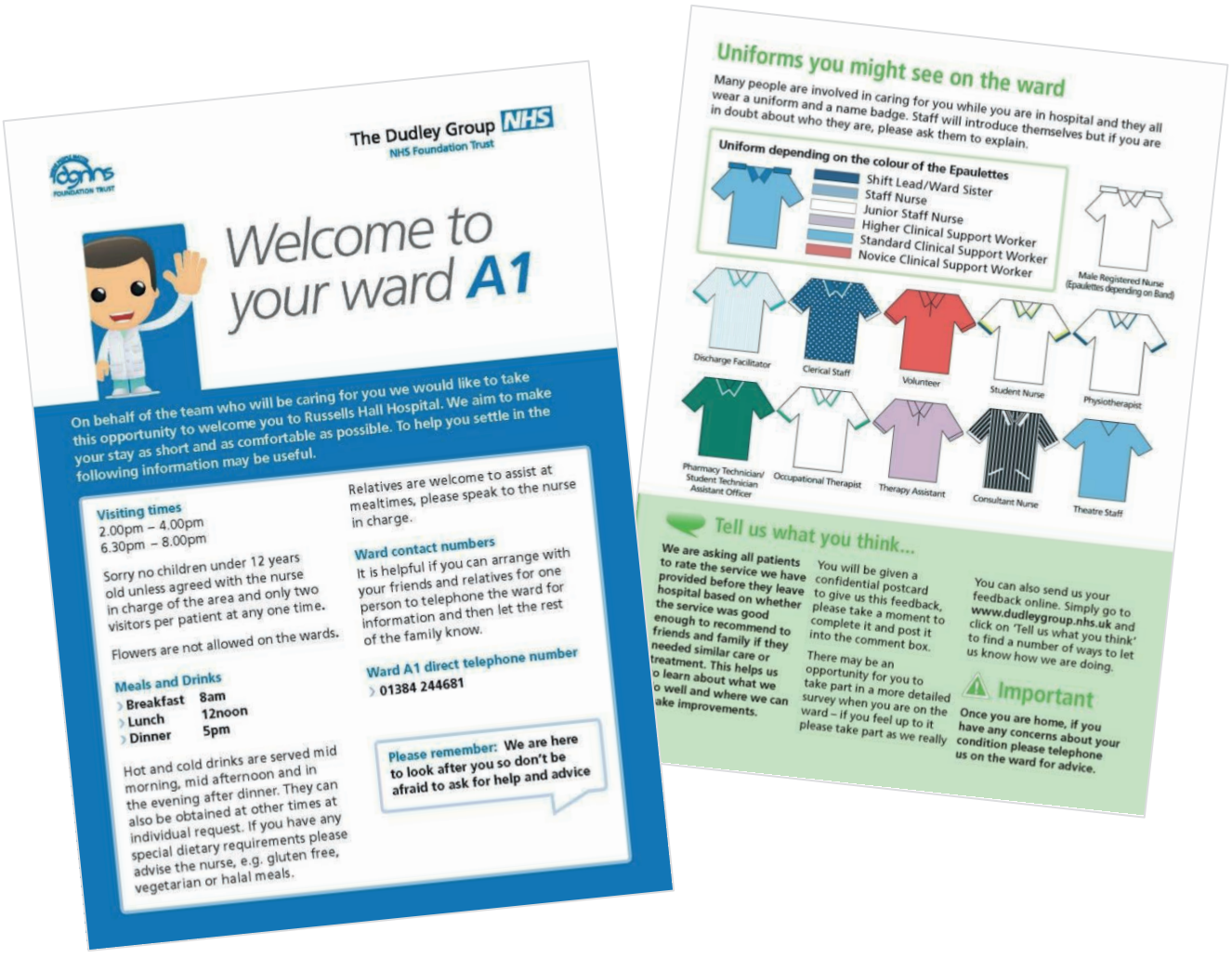
## Patient information

The Trust has a clear policy which details the process for developing, producing, ratifying and archiving all Trust patient information, ensuring information is kept up to date.

The Trust has hundreds of leaflets on various conditions and treatments, as well as aftercare advice. Information is available in plain English as well as large print, audio, Braille and alternative languages on request.

For patient information to pass through the Trust's policy checklist, patient involvement must have been sought to ensure the information is produced in a way that is useful to patients, does not contain jargon and has a consistent style.

Following the introduction of the bespoke Welcome to the Ward leaflets in 2012/13, the Trust has continued to develop the leaflets and roll them out to more areas of the hospital. The leaflets are now given to almost all inpatients on admission to their ward. The leaflets contain useful information such as visiting times, mealtime routines, uniforms, who's who and ward contact numbers for relatives and for patients who have health concerns once they go home.




## Trust volunteer service

More than 400 volunteers from the local community give their time on a regular basis to make a real difference to patients, visitors and staff at the Trust. The Volunteer Service is part of the Patient Experience team and is managed by the Volunteers' Coordinator.

Individuals volunteer for a variety of reasons including, the satisfaction of knowing they are doing something for others, the chance to make new friends, to gain experience of a busy hospital environment, to gain confidence and strengthen interpersonal skills.

Volunteers are asked to pledge a minimum of 100 hours. The Trust's volunteers range in age from 16 to 86.

Some of the tasks volunteers undertake include:

- Nutrition and hydration support
- Way-finding and escorting
- Reception enquiries
- Undertaking patient surveys
- Clerical support
- Patient friends
- Outpatient hosts
- Emergency Department hosts
- Chaplaincy
- Fundraising
- Hospital radio

The dedicated work of all the volunteers is highly valued by the Trust, and it is pleasing to realise that volunteers also get satisfaction from their role.

# About our staff

The Trust is a major employer in the Dudley borough with 4,163.39 full time equivalent (FTE, previously called WTE) staff, an increase of 186.01 from 2012/13.

The table below gives a breakdown of staff numbers by professional group.

| Staff group | Full time equivalent as at 31st March 2014 |
|---|---|
| Additional professional scientific & technical | 165.5 |
| Additional clinical services | 823.2 |
| Administrative and clerical | 819.4 |
| Allied health professionals | 290.8 |
| Estates and ancillary | 0.4 |
| Healthcare scientists | 118.4 |
| Medical and dental | 496.0 |
| Nursing and midwifery registered | 1440.7 |
| Students | 9.0 |
| **All staff** | **4163.4** |

***Note regarding full-time equivalent HR and finance difference in number***

*Human Resources reporting obtains the full-time equivalent (FTE) in post for a specific date where as Finance reporting (page 67) obtains the contracted FTE worked over a period of time. This means that if there are a number of employees who have left during a month, it is possible that the HR report will not pick this FTE up. It also means that if there are a number of leavers on a specific date the Finance report may not include this FTE. Therefore for an individual leaving mid way through March, Finance would show 0.5 FTE, whereas HR would show zero because there would be no one in post at 31/3. For an individual starting mid way through March, Finance would show 0.5 FTE, whereas HR would show 1.00 FTE because there is 1 person in post at 31/3. This is the reason for the slight difference in FTE being reported.*

## Staff health and wellbeing

Staff sickness rates for the year have fallen to 3.65 per cent set against a target of 3.50 per cent. The Trust turnover rate for year 2013/14 has remained steady at 7.84 per cent.

| | Staff sickness rate |
|---|---|
| Quarter 1 (April to June 2013) | 3.85% |
| Quarter 2 (July to September 2013) | 3.33% |
| Quarter 3 (October to December 2013) | 3.68% |
| Quarter 4 (January to March 2014) | 3.75% |
| **Total for 2013/14** | **3.65%** |

The Trust takes the health and safety of its staff very seriously and the health and safety team are particularly proud of the benefits achieved with the continuing reduction in reported accidents within the organisation. This is due to employee involvement, as well as heightening staff awareness by motivating them to take avoiding action when recognising a workplace hazard or the dangers of poor working practices.

The Trust's health and safety team is committed to raising occupational health and safety awareness amongst all of the Trust's employees and those of the Trust's partners. The Trust remains convinced that it can continue to lead rather than follow other organisations in the application of best practice in maintaining its occupational health and safety awareness programme in raising the standards of health and safety management and to recognise the efforts of all who have contributed to its success.

2013/14 also saw the expansion of the Trust's staff physiotherapy service which was originally only accessible via a referral from Occupational Health. Staff with musculoskeletal problems can now self-refer to the service by attending drop-in sessions. This has helped the Physiotherapy Department assess and treat staff members more quickly, which will hopefully result in the reduction of sickness absence due to musculoskeletal problems.

In 2013/14 five members of staff retired early on the grounds of ill health with a value of £374,000. This is a reduction compared to 2012/13 where eight members of staff retired early on the grounds of ill health with a value of £712,000.

## Equality and diversity

The Diversity Management Group has continued to work on the Trust's Equality and Diversity objectives which are part of a three-year action plan ending in 2015. Progress continues to be good with new training available to staff on how to help people with sight and hearing difficulties. These sessions are available to Trust staff as part of the annual training prospectus.

The Trust has continued with Equality Impact Assessments throughout 2013/14 which is in addition to the responsibilities under the single equality scheme which

changed in 2012 to remove the obligation for public sector organisations to complete them.

Mandatory training, which includes a module on equality and diversity, was completed by more than 80 per cent of all Trust staff in 2013/14. All new employees also complete this mandatory module during their induction.

The Trust has again been awarded the Two Ticks disability symbol – a national standard which recognises that the Trust is positive about employing disabled people.

The Diversity Management Group reviewed the Trust's employment statistics for 2011/12 in June 2013 against the equality and diversity characteristics and looked at the following people:

- Those who apply to work at the Trust
- Those who currently work at the Trust
- Those who leave the Trust's employment

The group found no areas for concern during their review.

The National Staff Survey 2013 also found the Trust to be in line with or better than the national average for the key findings relating to equality and diversity. More about the NHS National Staff Survey can be found on page 37.

The Trust is also continuing to invite all staff to update their personal equal opportunities data by completing a short online questionnaire. The information will be used for monitoring purposes and will help the Trust to analyse the profile and make up of employees in support of the Trust's equal opportunities policies.

**Disability employment statistics 2013/14**

| | % of all applications received | % of applicants shortlisted | % of applicants appointed |
|---|---|---|---|
| Disabled | 3.80% | 3.90% | 3.20% |
| Not disabled | 95.40% | 94.80% | 95.70% |
| Undisclosed | 0.80% | 1.30% | 1.10% |

*These figures are progressive, for example, 20% of applicants stated they had a disability. Of those 20%, 15% were shortlisted. Of those 15% shortlisted, 10% were appointed.*

## NHS workforce statistics 2013/14

An analysis of the Trust's workforce statistics indicates they are comparable with both the local Dudley population and other NHS integrated (acute and community) trusts. Historically, the Trust has seen a higher proportion of female workers than males, and this is typically reflected across other NHS integrated trusts.

| | | Percentage of workforce | |
|---|---|---|---|
| | | 1st April 2012 to 31st March 2013 | 1st April 2013 to 31st March 2014 |
| Age | Under 18 | - | 0.12% |
| | 18-19 | 0.35% | 0.53% |
| | 20-24 | 5.73% | 7.15% |
| | 25-29 | 12.94% | 14.27% |
| | 30-34 | 12.65% | 12.37% |
| | 35-39 | 11.58% | 11.04% |
| | 40-44 | 14.59% | 13.68% |
| | 45-49 | 14.98% | 14.49% |
| | 50-54 | 13.73% | 13.71% |
| | 55-59 | 8.55% | 8.26% |
| | 60-64 | 3.82% | 3.50% |
| | 65+ | 1.08% | 0.88% |
| Gender | Male | 16.60% | 18.88% |
| | Female | 83.20% | 81.12% |
| Ethnicity | White | 72.34% | 70.00% |
| | Mixed | 0.83% | 0.92% |
| | Asian or Asian British | 8.87% | 9.57% |
| | Black or Black British | 2.32% | 2.74% |
| | Other | 1.48% | 1.57% |
| | Not stated | 12.58% | 15.20% |

# Transformation and Service Improvement

There has been a programme of transformational service improvement running within the Trust for the past five years. The Board of Directors accepted that, whilst this programme had used the Lean methodology to drive incremental service improvement, major transformational change had not occurred. The NHS efficiency challenge and, in particular, the challenge encapsulated in the phrase 'more for less' now needs embracing by the whole health economy, of which the Trust is a major part.

To enable the transformational change required it was determined that a Transformation Programme Board, chaired by the Trust's chairman, was essential to drive the change agenda more vigorously. The Transformation Programme Board was established as a formal committee of the Board of Directors and met bi-monthly. The Clinical Commissioning Group (CCG) Chief Officer also attends the Programme Board. From April 2014 the committee will be replaced with the Service Improvement Committee. More information about changes to the Trust's committee structure can be found on pages 58 to 60.

The improvement goals for the programme each have their own steering group led by an executive director. The goals are:

- Urgent Care redesign
- Length of stay reduction
- Outpatient efficiency
- Long term condition management
- Responsive services (7/7 working)

Three priority projects were agreed: urgent care, outpatients and length of stay. Both Trust employees and the CCG accountable officer confirmed these had the greatest overlap of strategic objectives of both organisations.

## Length of stay project

This project's main aims were to oversee the changes in process and system internally to deliver a reduction in medical and surgical length of stay against national benchmarks. The following progress has been made:

- Significant investment in acute medical unit medical and nursing staff, together with improved patient flow processes and clinical handover, has reduced length of stay on the Emergency Assessment Unit (EAU) and ward C8. As a result, an increase in short stay medical admissions has been accommodated through the same number of assessment trolleys and spaces.

- The roll out of ambulatory (walking) emergency care principles in the former GP assessment area of EAU has led to a faster turnover of patients awaiting medical assessment, referred both by the Emergency Department (ED) and local GPs. The guiding principle of the service is “diagnose to admit not admit to diagnose” and the service is evaluating well since its inception in November 2013.

- Whiteboard rounds led by consultant medical staff have been rolled out across all medical wards. This is nationally accepted best practice and recommended by the Emergency Care Intensive Support team report from December 2012. Regular review of all inpatients on each ward now takes place before lunchtime each day. This has led to a clear identification of patients for earlier/timely discharge, an earlier resolution of diagnostic problems and improved use of the Discharge Lounge.

- Electronic whiteboards containing key patient care and patient flow information have been installed on all wards. This will now provide a key, user friendly platform to make available ‘real time’ bed availability information and enable internal patient transfers within the hospital to occur.

- The Elderly Care service has introduced a Frail Elderly Assessment Unit on ward A3. Established again in line with nationally accepted best practice, the unit aims to provide a rapid and complete assessment of physical and social care needs for frail elderly patients, led by elderly care specialist doctors and nurses, as soon as possible after their admission to the hospital. A rapid improvement in length of stay for patients in this speciality has immediately occurred.

Despite the developments and progress described above, the Trust still has further gains to make in length of stay, particularly in medical specialities and emergency surgery. The focus on making further improvements and to achieve upper quartile performance in this regard, will continue into 2014/15 and beyond.

## Urgent care project

This project has focused on working with Dudley Clinical Commissioning Group (CCG) on the development of a new model of care for urgent and emergency patients in the borough. A major public consultation process on the new model was completed by December 2013 by Dudley CCG. Central to the proposals will be a fully integrated urgent care centre being provided at Russells Hall Hospital, combining the current activities of the Dudley Borough Walk-in Centre at Holly Hall Clinic and the Russells Hall Hospital Emergency Department. The new urgent care centre is intended to be operational by April 2015.

## Outpatients project

Patients and carers have told the Trust that it needs to do more to improve outpatient services. More than 500,000 patient contacts take place in the Trust's outpatient services per annum. The key elements of the project and associated progress are:

- Referral management and process – clear improvement plan for Trust performance on making sure Choose & Book appointments are available. Clear capacity planning methodology has been developed which has highlighted where the Trust could manage capacity better to help reduce waiting times in key specialties.
- Case note availability – significant improvement in case note availability across the organisation, following the introduction of the 'Retrieval Of All Records' (ROAR) programme. The 98 per cent case note availability target is now being exceeded. This project was shortlisted for an HSJ efficiency award in September 2013.
- Introduction of daily 'safety huddles' in three major specialty outpatient departments where staff meet together to discuss the order of the day and any safety issues that may have occurred.
- Improvement is in process for increased capacity in the eye department.

# Listening to our staff

Communication and engagement in such a large 24/7 operation is always a challenge. The Trust has a number of ways in which it communicates with staff, patients and members depending on the target audience and the message. These include the ever popular Trust intranet – The Hub – where staff based in hospital or out in the community can access information on Trust issues, policies, finance, news and views from colleagues. It is also used as a forum to gather views from staff before decisions are made.

The popular staff and members magazine Your Trust continues to be published up to four times per year and is available on both the Trust's intranet and website as well as in printed form.

## Chief Executive's Update

The Chief Executive maintains a monthly CE Update to keep staff up to date on the Trust's strategic direction, new policies and other timely staff news. In response to feedback from staff face-to-face CE Update meetings were introduced in 2013/14. Staff of all bands, from both clinical and non-clinical areas, are encouraged to attend and are invited to ask questions at the end of each session.

As well as attending face-to-face meetings, staff can choose to watch the CE Update video on The Hub or read the text newsletter-style version of the update.

December 2013 saw the introduction by the Chief Executive of sessions to discuss the vision and values of the Trust with all staff. More than 3500 staff members attended one of more than 50 sessions held at various locations in the hospital, at outpatient centres and out in the community.

## Patient Safety Leadership Walkrounds

Staff can also get involved via the Patient Safety Leadership Walkrounds, an ongoing rota of visits to clinical areas where a non-executive and executive director, accompanied by a member of the governance team, talk to staff about current issues. Governors also take part in the walkrounds to talk to patients about their experiences. An action plan is then developed and followed up at the next walkround. More on the Patient Safety Leadership Walkrounds can be found in the Quality Report on page 67.

## Listening into Action

Listening into Action (LiA) has been running in the Trust for three and a half years. In that time, more than 30 departments ranging from front line staff on wards to office staff in support functions have been empowered by LiA to make changes to the way they work to improve patient care and experience.

In 2013 the Trust held three 'Where Staff Matter' Listening into Action events where staff were invited to discuss management and leadership, staff recognition, paperwork and targets – topics highlighted by the 'Where Staff Matter' survey.

In these sessions staff highlighted that the following was important to them:

- Having time to discuss issues with colleagues
- Receiving recognition and full support from management
- Having appropriate training made available
- Having access to appropriate facilities, equipment, space and IT resources

Feedback was passed onto management teams to act on at a local level.

In 2014/15 the Trust hopes to further use Listening into Action to encourage as many teams and departments as possible to take part to help make changes and improvements.

## Long Service Awards

The Trust continued to celebrate the dedication and commitment of its longest serving members of staff at the Long Service Awards ceremonies hosted by Chief Executive Paula Clark and Chairman John Edwards. Two events were held in 2013/14 and celebrated thousands of years of continuous service for The Dudley Group NHS Foundation Trust. Staff receive a long service certificate and commemorative badge when they reach milestone lengths of service ranging from 15 to 45 years. This year also saw the Long Service Awards open to Trust volunteers for the first time.

## National Staff Survey 2013

The 2013 Annual National NHS Staff Survey was completed throughout October and November 2013 with a sample of 844 randomly selected individuals invited to participate.

The results of the survey are used by the Care Quality Commission to compare with other Trusts.

The findings for the survey have been analysed at two levels:

- Compared to national average results for 2013
- Compared to last year's Trust results

**The results**

Below is a summary of the trust's results from the 2013 NHS Staff Survey, the full feedback report can be found at www.nhsstaffsurveys.com

The Annual National NHS Staff Survey is structured around four pledges taken from the NHS Constitution along with two further themes of 'equality and diversity' and 'staff satisfaction'.

Survey scores are displayed either as a percentage or as a score out of five.

- Percentage scores relate to the percentage of staff giving a particular response to one or a series of survey questions
- Scale summary scores are calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always one and the maximum score is five

The Trust achieved a response rate of 48 per cent in 2013 which is average for acute trusts in England and represents a significant improvement in comparison to the previous year's 36 per cent.

**Staff Survey response rates**

| Trust 2013 | National average 2013 | Trust 2012 | National average 2012 | Comparison to 2012 |
|---|---|---|---|---|
| 48% | 49% | 36% | 50% | Increase |

The Trust's score for overall staff engagement has improved since 2012 and puts it on a par with other acute trusts nationally.

| Overall staff engagement (the higher the score the better) | Score out of 5 | Ranking |
|---|---|---|
| Trust score 2013 | 3.73 | On average |
| Trust score 2012 | 3.64 | Below average |
| National average 2013 (for acute trusts) | 3.74 | |

### Top and bottom Key Findings

A summary of the top and bottom key findings from the survey are published by NHS England each year. Below are the five top and bottom key findings for the Trust.

| **Top five key findings (KF) overall** (those which compare most favourably with other acute trusts in England) | **Trust score** | **National average** (for acute trusts) | **Ranking** (compared with all acute trusts) | **Comparison to 2012** |
|---|---|---|---|---|
| KF12 Percentage of staff saying hand washing materials are always available *(the higher the score the better)* | 69% | 60% | Highest (best) 20% | No change |
| KF7 Percentage of staff appraised in the last 12 months *(the higher the score the better)* | 90% | 84% | Highest (best) 20% | Increase |
| KF8 Percentage of staff having well structured appraisals in last 12 months *(the higher the score the better)* | 43% | 38% | Highest (best) 20% | Increase |
| KF19 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months *(the lower the score the better)* | 21% | 24% | Lowest (best) 20% | No change |
| KF9 Support from immediate managers *(the higher the score the better)* | 3.72 | 3.64 | Highest (best) 20% | No change |

| **Bottom five key findings (KF) overall** (those which compare least favourably with other acute trusts in England) | **Trust score 2013** | **National average** (for acute trusts) | **Ranking** (compared with all acute trusts 2013) | **Comparison to 2012** |
|---|---|---|---|---|
| KF16 Percentage of staff experiencing physical violence from patients, relatives or public in last 12 months *(the lower the score the better)* | 20% | 15% | Highest (worst) 20% | No change |
| KF17 Percentage of staff experiencing physical violence from staff in last 12 months *(the lower the score the better)* | 4% | 2% | Highest (worst) 20% | No change |
| KF10 Percentage of staff receiving health and safety training in last 12 months *(the higher the score the better)* | 67% | 76% | Lowest (worst) 20% | Increase |
| KF14 Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the score the better)* | 88% | 90% | Lowest (worst) 20% | No change |
| KF22 Percentage of staff able to contribute towards improvements at work *(the higher the score the better)* | 66% | 68% | Below (worse than) average | No change |

There were no statistically significant negative changes to any Key Findings since the 2012 survey. Below are the four areas where there has been a significant positive change to findings since 2012.

| Where staff experience has improved most since 2012 | Trust score 2013 | Trust score 2012 |
|---|---|---|
| KF8 Percentage of staff having well structures appraisals in last 12 months *(the higher the score the better)* | 43% | 34% |
| KF7 Percentage of staff appraised in last 12 months *(the higher the score the better)* | 90% | 80% |
| KF10 Percentage of staff receiving health and safety training in the last 12 months *(the higher the score the better)* | 67% | 59% |
| KF24 Staff recommendation of the trust as a place to work or receive treatment *(the higher the score the better)* | 3.72 | 3.57 |

The Trust wanted to find out how more of staff felt about working at The Dudley Group NHS Foundation Trust and so decided to invite all employees to take part in a survey asking the same questions as the NHS Staff Survey.

To ensure confidentiality, employee engagement specialists VaLUENTiS collated and processed all completed surveys on the Trust's behalf.

Every single Trust employee was asked for their views. The Trust had an incredible response rate, with 2,323 members of staff completing the survey, representing 52.7 per cent of the workforce. By surveying more staff the Trust is able to get more detailed information. The Trust plans to use this more detailed data to plan actions appropriate to individual areas and staff groups to help build on improving scores and tackle areas of concern. Directorate management teams ensure actions are taken within their areas where any specific concerns are highlighted these form part of the Trust-wide action plan. Progress will be monitored through the Workforce and Staff Engagement committee to ensure sustained enthusiasm and progress.

It is wonderful to see that more staff than ever before would recommend the Trust as a place to work or receive treatment and hope that next year will see a further improvement in this area.

During 2014/15 the Trust will be rolling out the Staff Friends and Family Test. This is a national initiative for all NHS trusts which asks all staff:

- How likely are you to recommend the Trust to friends and family if they needed care or treatment?
- How likely are you to recommend the trust to friends and family as a place to work?

These scores will be published nationally by NHS England later in the year.

# Council of Governors and members

The Council of Governors was formed with effect from the 1st October 2008. The Council of Governors is responsible for holding the Board of Directors to account for its stewardship of the organisation. The majority of the Trust's governors are elected through the public membership to make up the Council of Governors consisting of 25 governors in total:

Public elected – 13 governors
Staff elected – 8 governors
Appointed from key stakeholders – 4 governors

Tables summarising the Council of Governors and the constituencies they represent can be found on page 42.

The Board of Directors works closely with the Council of Governors through regular director and non-executive director attendance at both full Council of Governor meetings and the committees of the Council. During 2013/14 a series of learning events and workshops have been run to enable non-executive directors, executive directors and governors to work and learn together. Non-executive directors are nominated attendees at the Council of Governors sub committees along with executive directors. This provides opportunities for detailed discussion and debate on strategy, performance, quality and patient experience and enables the governors to see non-executive directors function. Governors regularly attend Board of Directors meetings held in public.

The Board of Directors is accountable to the Council of Governors ensuring it meets its Terms of Authorisation. A Register of Interests confirming individual declarations for each governor is maintained by the Trust and is available on request by calling (01384) 321124 or emailing foundationmembers@dgh.nhs.uk

All the Trust's governors comply with the 'fit and proper' persons test as described in the Trust's provider licence issued by Monitor. The conditions outlined by Monitor are incorporated into the Foundation Trust Constitution.

## Council of Governor Committees

The Trust has developed a primary and secondary governance model which supports the Council of Governors and its committees to discharge their responsibilities effectively. Primary governance is the responsibility of the Board of Directors which is the decision maker and oversees the performance of the organisation. Secondary governance is the role of the governors and provides the framework to support their role of holding the Board of Directors to account.

The Council of Governors has established the following committees:

- Membership Engagement Committee
- Strategy Committee
- Governance Committee
- Remuneration Committee
- Appointments Committee

The Council of Governors has the following key responsibilities:

- Appointment and/or removal of the chair, including appraisal and performance management
- Appointment and/or removal of the non-executive directors
- Appointment of the external auditors
- Advising the Board of Directors on the views of members and the wider community
- Ensuring the Board of Directors complies with its Terms of Authorisation and operates within that licence
- Recruitment and engagement of Trust members
- Advising on strategic direction
- Receiving the NHS Trust's Annual Accounts, any report of the auditor on them, and the Annual Report at the Trust's Annual Members' Meeting

The implementation of the Health and Social Care Act 2012 saw some changes to the key duties and responsibilities of Governors from April 2013 including the following:

- Approving significant transactions which exceed 25% by value of FT assets, FT income or increase/reduction to capital value
- Approval of any structural change to the organisation worth more than 10% of the organisation's assets, revenue or capital by way of merger, acquisition, separation or dissolution
- Deciding whether the level of private patient income would significantly interfere with the Trust's principal purpose of providing NHS services
- Approving amendments to the Trust's Constitution

The Trust is working closely with the Council of Governors to continue the development of the governor role to reflect the requirements of the act and other best practice and guidance.

Ongoing training and development is provided by the Trust allowing experts from within and outside the Trust to work with the Council of Governors to identify key aspects of their role. This includes how they influence strategy within the Trust, how

they undertake their secondary governance duties and how they will engage with Members and the wider community so that their views and opinions can be heard.

## Council of Governors membership and meetings 2013/14

The Council of Governors meet a minimum of four times per year with meeting papers published to the Trust website at www.dudleygroup.nhs.uk Members and the wider public are welcome to attend and observe.

In the year 2013/14 the full Council met on six occasions including the Annual Members' Meeting held in September 2013.

| **Public Elected Governors** | **Constituency** | **Attendance at full council meetings 2013/14*** |
|---|---|---|
| David Stenson | Brierley Hill | 6/6 |
| Robert Edwards | Brierley Hill | 5/6 |
| Fred Allen | Central Dudley | 4/6 |
| Bill Hazelton | Central Dudley | 6/6 |
| Rob Johnson | Halesowen | 5/6 |
| Tarsem Sidhu (elected June 2013) | Halesowen | 4/5 |
| Subodh Jain (elected June 2013) | North Dudley | 1/5 |
| Brian Chappell (resigned March 2014) | North Dudley | 3/6 |
| Darren Adams | Stourbridge | 5/6 |
| Roy Savin | Stourbridge | 3/6 |
| Pat Price | Rest of the West Midlands | 5/6 |
| Diane Jones | South Staffordshire and Wyre Forest | 6/6 |
| Jason Whyley (resigned March 2014) | Tipton and Rowley Regis | 3/6 |
| **Staff Elected Governors** | **Staff Group** | |
| Anne Gregory (resigned March 2014) | Allied Health Professionals and Healthcare Scientists | 4/6 |
| Scott Burton (elected March 2014) | Allied Health Professionals and Healthcare Scientists | NA |
| Jackie Smith (end of term March 2014) | Allied Health Professionals and Healthcare Scientists | 3/6 |
| Ian Dukes | Medical and Dental | 2/6 |
| Karen Phillips (elected March 2014) | Non Clinical Staff | NA |
| Karen Jaunzems (resigned Dec 2013) | Non Clinical Staff | 4/6 |
| Joanne Hamilton | Nursing and Midwifery | 5/6 |
| Alison Macefield | Nursing and Midwifery | 6/6 |
| Julie Walklate | Nursing and Midwifery | 2/6 |
| Peter Marsh (resigned March 2014) | Partner Organisations' Staff | 3/6 |
| **Appointed Governors** | **Appointing organisation** | |
| Cllr Steve Waltho | Dudley Metropolitan Borough Council | 3/6 |
| Prof Martin Kendall (resigned Sept 2013) | University of Birmingham Medical School | 2/2 |
| John Franklin (appointed June 2013) | Dudley Council for Voluntary Service | 4/5 |
| Vacant | Dudley Clinical Commissioning Group | NA |

**Figures show number of meetings attended that were held during their term of office. The Council of Governors monitor attendance at full council meetings and committee meetings as agreed under the governors' code of conduct. In all instances above where governors have maintained less than the required attendance, the Council of Governors is satisfied that there was reasonable cause for non attendance.*

The Council of Governors may require one or more of the Board of Directors to attend a full Council of Governor's meeting to obtain information about the performance of the Trust's functions or the Board of Directors performance of their duties. This assists the Council of Governors to decide whether to propose a vote on the Trust's or Board of Directors performance.

Full Council of Governor meetings are regularly attended by key clinicians and senior staff from across the Trust providing presentations and question and answer sessions to help governors understand how the organisation works.

In 2013/14 members of the Board of Directors attended the following full Council of Governors meetings.

| **Director and Non-executive Director attendance at full Council meetings 2013/14*** | | **Attendance** |
|---|---|---|
| Paul Assinder | Director of Finance and Information | 5/6 |
| David Badger | Non-executive Director | 5/6 |
| Ann Becke | Non-executive Director | 1/6 |
| Richard Beeken | Director of Strategy, Performance and Transformation | 3/6 |
| David Bland | Non-executive Director | 0/6 |
| Paula Clark | Chief Executive Officer | 5/6 |
| John Edwards | Chairman | 6/6 |
| Jonathan Fellows | Non-executive Director | 0/6 |
| Paul Harrison | Medical Director | 2/6 |
| Denise McMahon | Director of Nursing | 1/6 |
| Richard Miner | Non-executive Director | 1/6 |
| Tessa Norris (left June 13) | Director of Community Services and Integrated Care | 1/6 |

*Board members are not required to attend all full Council of Governors meetings unless invited to do so to present on a specific topic.

## Governor resignations, elections and re-appointments

Governors reaching end of term of office or resigning during 2013/14:

| Governor | Constituency | Date |
|---|---|---|
| Professor Martin Kendall (Resigned) | Appointed: University of Birmingham Medical School | September 2013 |
| Karen Jaunzems (Resigned) | Staff: Non Clinical | December 2013 |
| Jackie Smith (Reached end of term) | Staff: Allied Health Professionals and Healthcare Scientists | March 2014 |
| Jason Whyley (Resigned) | Public: Tipton and Rowley Regis | March 2014 |
| Brian Chappell (Resigned) | Public: North Dudley | March 2014 |
| Peter Marsh (Resigned) | Staff: Partner Organisations | March 2014 |

During 2013/14, elections were held for vacancies in the following constituencies;

**Public** North Dudley
Halesowen

**Staff** Non Clinical
Allied Health Professionals and Healthcare Scientists

In accordance with the Trust's Constitution, the Trust uses the method of single transferable voting for all elections. This system allows voters to rank candidates in order of preference and, after candidates have either been elected or eliminated, unused votes are transferred according to the voters next stated preference.

Baker Tilly, Business Advisors and Auditors, was appointed by the Trust to oversee the election process. The process returned the following governors for a three year term:

| Governor | Constituency | Date elected |
|---|---|---|
| Subodh Jain | Public: North Dudley | June 2013 |
| Tarsem Sidhu | Public: Halesowen | June 2013 |
| Scott Burton | Staff: Allied Health Professionals and Healthcare Scientists | March 2014 |
| Karen Phillips | Staff: Non Clinical | March 2014 |

During 2013, nominations were received from governors to fill two vacancies arising on the Appointments Committee. Elections were held, returning David Stenson (Public elected Governor: Brierley Hill) and Joanne Hamilton (Staff elected governor: Nursing and Midwifery).

## Council of Governors Review 2013/14

Since authorisation, the Council of Governors has regularly conducted a review of its effectiveness in discharging its statutory and other duties. During 2013/14 the Council of Governors completed a review of its effectiveness and of its committees. This was led by the Chair of Governors who presented a report of the findings and recommendations to the full Council of Governors meeting held in November 2013.

The following items were highlighted as areas which are and working well but require continuing development:

- Effectiveness of Council of Governor meetings
- Effectiveness of Council Committees
- Improved NED Accountability/ visibility
- Executive Director engagement

Recurrent themes arising from the above items have been incorporated into the 'Developing the Governor Role Action Plan'.

The Council of Governors received the NHS Leadership Academy Governing Body of the Year Award 2013. This award recognised their dedication and commitment to providing continuity and leadership against a back drop of challenge and change.

## Chairs of Council of Governors Committees

| | |
|---|---|
| **Rob Johnson (Lead governor)** | Governance Committee<br>Appointments Committee (interim Chair) |
| **Bill Hazelton** | Membership Engagement Committee |
| **David Stenson** | Strategy Committee |
| **Darren Adams** | Remuneration Committee (Council of Governors committee) |

Executive and non-executive directors are assigned to individual Council of Governors committees to provide support and maintain a regular attendance throughout the year.

## Governor engagement with Trust members and local communities

The Trust encourages and supports governors in raising public and staff awareness of the work of the Trust and their role within their constituencies. The 'Out There' initiative continues to support governors to undertake their role in finding out what people think about the Trust and feedback their views to the Board of Directors.

During 2013/14 governors continued to reach out into their constituencies. They have participated in more than 28 events including attendance at a number of community and support groups such as GP patient panels and participation groups, Older Peoples Forum, team meetings, Community Forum meetings, 'Health Information' library sessions across the Dudley borough as well as visiting community groups from the black and minority ethnic groups in the borough.

Many of the Trust's governors also actively participate in Trust-led events such as the behind the scenes events which provide Trust members and members of the wider community an opportunity to learn more about areas of the Trust not normally seen.

## How to contact a governor or director of the Trust

There are several ways Trust members or members of the public can contact either their Governor or a member of the Board of Directors:

- Council of Governors meetings in public
- Board of Directors meetings in public
- Annual Members' Meeting
- Members events
- via the Foundation Trust office on email or by phone

For dates and times of these meetings and other members events, please visit the members section on the Trust website at www.dudleygroup.nhs.uk or contact the Foundation Trust office:

- Telephone: (01384) 321124
- Email: foundationmembers@dgh.nhs.uk or governors@dgh.nhs.uk
- Write to: Freepost RSEH-CUZB-SJEG, 2nd Floor C Block, Russells Hall Hospital, Pensnett Road, Dudley, DY1 2HQ

Several governors are also happy to be contacted directly and their details can be found on the members section of the Trust website or by calling (01384) 321124.

## Membership recruitment and engagement

The membership of the Trust comprises local people and staff who are directly employed by the Trust or its partner organisations. To be eligible for membership you must be over 14 years of age – there is no upper age limit. Full details of who is eligible to register as a member of the Trust is contained within the Trust Constitution which is available at www.dudleygroup.nhs.uk Any public members wishing to come forward as a governor when vacancies arise or vote in governor elections must reside in one of the Trust's constituencies. Staff are automatically included as members within the staff groups as set out on page 49 unless they choose to opt out.

During 2013/14, the Trust has continued to promote membership to local communities and the importance of having a voice by encouraging them to share their experiences with the Trust. All events held during 2013/14 have been successful in terms of promoting the Trust and have also been successful in increasing membership as a whole. The table below shows the most successful recruitment activities during 2013/14.

| Event/activity | New Members recruited |
|---|---|
| Halesowen College student events | 430 |
| The Dudley Group volunteers and forms returned from patient appointment letters | 263 |
| Dudley College student events | 97 |
| Trust led behind the scenes and open day events | 42 |

As at the 31st March 2014 the Trust had a total of 13,619 public members.

### Membership growth

| Membership sector | 31/03/2013 actual | 31/03/2014 actual |
|---|---|---|
| Public | 13,122 | 13,619 |
| Staff | 5,167 | 5,151 |
| Total | 18,289 | 18,770 |

The recruitment strategy for 2013/14 continued to focus on developing opportunities to maintain a public membership target of no less than 13,000, and refine recruitment activity to target any identified areas of shortfall to ensure the Trust's membership continues to reflect the diversity of the communities the Trust serves and the protected characteristics as set out in the Equality Act 2010. The Trust's strategy also included developing more opportunities for engaging with members to gain feedback that the Trust can use to improve the patient experience.

The 'Meet your Experts' health fair events and behind the scenes tours continue to prove a real success with both Trust members and members of the wider community. They create a unique opportunity to learn about the services provided by the Trust and visit areas not normally seen by the general public. Some of the event's younger guests who may be considering a career in healthcare say that the tours are inspiring.

During 2013/14 the Trust hosted five member events including behind the scenes tours at Russells Hall Hospital and open day events at Corbett and Guest outpatient centres. More than 350 Trust members and their guests attended the events and learned more about;

Hip and knee replacement services, April 2013
Services offered at the Corbett Outpatient Centre, June 2013
The Vascular Hub at Russells Hall Hospital, September 2013
Services offered at the Guest Outpatient Centre, November 2013
Maternity, Neonatal and Children's Ward, March 2014

All members continue to receive information and updates about the Trust via the Your Trust newsletter. More information about the Trust and the latest news can be found on the Trust website at www.dudleygroup.nhs.uk

The members' area of the Trust website also contains information about being a member and the contribution they make to the ongoing success of the organisation. Members can:

- Be involved in shaping the future of healthcare in Dudley by sharing their views*
- Vote in governor elections*
- Stand for election to represent their constituency**
- Attend behind the scenes tours and member events
- Participate in public meetings, Public and Patient Involvement panels and focus groups
- Fundraise for the Dudley Group NHS Charity

** excluding those living Outside of the West Midlands*
*** Candidates must be minimum 16 years old*

## Membership report as at 31st March 2014

| Public Constituencies | Number of Members |
|---|---|
| Brierley Hill | 1,733 |
| Central Dudley | 2,347 |
| Halesowen | 1,176 |
| North Dudley | 1,407 |
| Outside of the West Midlands | 220 |
| Rest of the West Midlands | 1,579 |
| South Staffordshire and Wyre Forest | 1,241 |
| Stourbridge | 1,697 |
| Tipton and Rowley Regis | 2,219 |
| **Total Public Members** | **13,619** |
| **Staff Constituencies** | **Number of Members** |
| Allied Health Professionals and Healthcare Scientists | 644 |
| Medical and Dental | 459 |
| Nursing and Midwifery | 2487 |
| Non Clinical | 899 |
| Partner Organisations | 662 |
| **Total Staff Members** | **5,151** |

| Breakdown by age | As at 31st March 2014 |
|---|---|
| 0-16 years | 15 |
| 17-21 years | 2,959 |
| 22+ years | 10,645 |
| **Breakdown by gender** | |
| Male | 5,005 |
| Female | 8,614 |
| **Breakdown by ethnicity** | |
| White | 10,879 |
| Mixed | 342 |
| Asian or Asian British | 983 |
| Black or Black British | 339 |
| Other | 58 |
| Not stated | 1,018 |

# Board of Directors

The Board of Directors was established and constituted to meet legal minimum requirements as stated in the Health and Social Care (Community Health and Standards) Act 2003, and the requirements of the NHS Foundation Trust Code of Corporate Governance published by Monitor.

A Board evaluation process is in place to enable the Board to undertake formal annual evaluation of its own performance and that of its committees and individual directors, in line with the Combined Code.

The Board of Directors Nominations Committee works closely with the Council of Governors' Appointments Committee to review the balance and appropriateness of Board members' skills and competencies. Board effectiveness is assessed annually and the process is monitored by the Governors' Appointments Committee.

The Board is satisfied that the balance experience and skill set of Board members remains fit for purpose.

Non-executive directors can only be removed by a 75 per cent vote of the Council of Governors following a formal investigatory process, and the taking of independent legal advice, in accordance with guidance issued by Monitor.

All executive and non executive directors comply with the "fit and proper" persons test as described in Condition G4 of the provider licence issued by Monitor. The conditions outlined by Monitor are incorporated into the Trust's Foundation Trust Constitution.

A Register of Directors' Interests is held by the Board Secretary and is available for inspection on request.

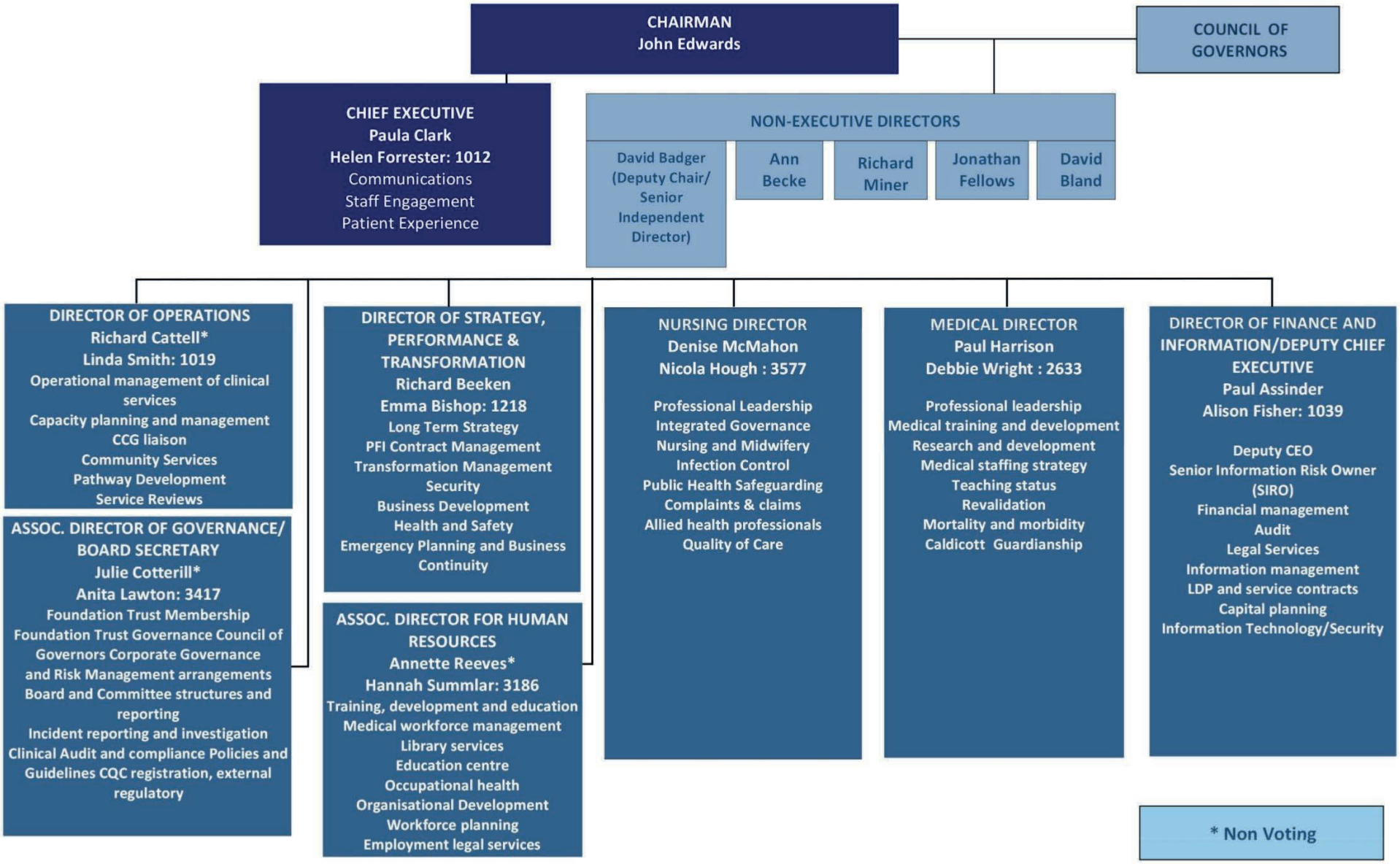
**Directors in post during the financial year**

| Position | Name | Commencing | End |
|---|---|---|---|
| Chairman | John Edwards | 01/11/2010 | 31/10/2016 |
| Chief Executive | Paula Clark | 01/10/2009 | |
| Director of Finance and Information | Paul Assinder | 22/08/2005 | |
| Director of Strategy, Performance and Transformation | Richard Beeken | 15/06/2010 | 25/05/2014 |
| Director of Operations | Richard Cattell | 08/04/2013 | |
| Medical Director | Paul Harrison | 01/06/2006 | |
| Nursing Director | Denise McMahon | 12/05/2008 | |
| Non-executive Director/Deputy Chairman and Senior Independent Director | David Badger | 01/12/2002 | 30/11/2015 |
| Non-executive Director | Ann Becke | 01/11/2005 | 31/10/2014 |
| Non-executive Director | Jonathan Fellows | 25/10/2007 | 30/09/2014 |
| Non-executive Director | David Bland | 01/08/2010 | 31/07/2014 |
| Non-executive Director | Richard Miner | 01/10/2010 | 30/09/2014 |

More detailed information about each director can be found on the following pages.

# BOARD OF DIRECTORS STRUCTURE

The Dudley Group NHS
NHS Foundation Trust



**John Edwards CBE – Chairman**
John joined the Trust on 1st November 2010. He is the former Chief Executive Officer of Advantage West Midlands (AWM), the regional development agency. In 2008, John was awarded a CBE for services to the regional economy.

John is a Quantity Surveyor and Project Director by profession and spent his early career in the private sector. He joined the Rural Development Commission, where he worked in a number of operational roles and finally as Chief Executive. Continuing his interest in economic development and regeneration, John joined Business in the Community in 1998 as Managing Director of Regeneration.

John joined AWM in 2000 where he oversaw an investment budget of £350m. AWM was independently evaluated by the National Audit Office as an excellent organisation achieving the maximum 4 star rating and by PWC as the most effective of the Regional Development Agencies with every £1 invested delivering over £8 of benefit for the West Midlands.

Since 2008 he has continued to advise both government bodies and private companies on strategic economic regeneration policies and their impacts. John is a Principal Fellow at the University of Warwick's Warwick Manufacturing Group (WMG) where he Chairs the International Institute for Product and Services Innovation (IIPSI) Board. John is also a member of the Board developing the National Automotive Innovation Campus (NAIC) a joint venture between WMG, Jaguar Land Rover and TATA Motors.

## Non-executive Directors

**David Badger – Non-executive Director, Deputy Chairman and Senior Independent Director**
David was appointed as a Non Executive Director in 2002 following many years' experience of public service in local authority and community regeneration settings. David led many education, training and health initiatives which involved local communities through the development of stakeholder groups as well as community participation in strategic planning.

Management roles included direct responsibility for major capital and revenue budgets, Private Finance Initiatives for schools, school governance and financing and human resources.

Appointed as Deputy Chairman and Senior Independent Director of the Trust in 2008, David is committed to the continuing development of the Trust and the relationship with the local community. To this end he is particularly keen to promote and support relationships between the Board of Directors, governors and members.

David is Chair of the Finance and Performance Committee.

**Ann Becke – Non-executive Director**
Ann brings to the Trust 26 years experience in global sales and marketing as Head of Professional Services for BT and has been a non-executive director for the Trust for the past seven years. She is Chair of the Workforce and Staff Engagement Committee, a member of the Audit Committee and the Clinical Quality, Safety and Patient Experience Committee.

Ann is the lead for Safeguarding, both within the Trust and the wider health economy and a member of Dudley Clinical Education Centre's Charity and represents the Trust on the Dudley Children's Partnership Board. She is also NED lead for complaints and also for West Midlands Ambulance Service. Ann also takes a keen interest in the patient environment through the Art and Environment Committee.

A graduate in World Class Service Management from Leeds University, she is a trained coach and mentor and was instrumental in setting up a global BT external client ‘women in business' network to promote talent in the boardroom. Ann brings to the Board much experience in the delivery of inspirational leadership, customer satisfaction and diversity.

Ann is Chair of the charity Chernobyl Children's Lifeline (Wolverhampton/Kinver Link) and is actively involved in both the local and business community raising awareness and significant funding.

**David Bland – Non-executive Director**
David joined the Trust in August 2010 and brings extensive senior level experience, particularly in running complex multi-site service businesses. He has a strong mix of strategic and operational skills developed during many years of international consultancy work.

From his time in the hospitality industry with Bass plc and Intercontinental Hotels Group plc, David brings a real understanding of how to deliver excellent and consistent customer service. He is currently Chair of the Clinical Quality, Safety and Patient Experience Committee and a member of the Risk Committee.

More recently, David has been working with a number of private equity-backed companies, as well as acting as a mentor to several young people starting businesses with the Prince's Trust. He is also a non-executive director on the Board of the British Chambers of Commerce.

**Jonathan Fellows – Non-executive Director**
Jonathan joined as a non-executive director in October 2007 prior to the Trust achieving authorisation by Monitor as an NHS Foundation Trust the following year. He has held executive director roles on the boards of large publicly listed companies including Central Independent Television plc and Lloyds Chemists plc and from 1998 to date has successfully led and grown a number of retail sector businesses backed by private equity.

Jonathan has extensive experience of raising finance, particularly for major capital projects, as well as developing business strategy and improving customer service, PR and communications.

He is a Fellow of the Chartered Association of Certified Accountants and a member of the Association of Corporate Treasurers. As well as being Chair of the Trust Audit Committee, Jonathan is a member of both the Finance and Performance and Charitable Funds committees.

**Richard Miner – Non-executive Director**
Richard is a Chartered Accountant by profession and has worked for many years with entrepreneurial and growing businesses, having held senior positions in both practice and industry.

He is Regional Director in the Midlands for FD Solutions, a leading national provider of flexible finance director services.

He was previously a non-executive director at NHS Birmingham East and North where he chaired the Audit Committee and the World Class Commissioning Programme Board.

Richard became a non-executive director in May 2012 following two years as an associate non-executive director. Richard is Chair of Dudley Clinical Services Limited, the new pharmacy subsidiary and also a member of the Finance and Performance and Audit Committees. Richard also chairs the Charitable Funds Committee.

## Executive Directors

**Paula Clark – Chief Executive**
Paula joined the Trust as Chief Executive on 1st October 2009 from Burton Hospitals NHS Foundation Trust where she was Chief Executive from 2005.

She is the Chair of the Black Country Local Education and Training Council and member of the Health Education West Midlands Board. She has recently joined Wolverhampton University as a Governor. Paula has worked in the NHS for 23 years, with more than 15 years at Chief Executive level.

Her career in the NHS has spanned a wide range of sectors, including Chief Executive of Erewash Primary Care Trust and senior roles at Southern Derbyshire Health Authority, Nottingham City Hospital and Derbyshire Ambulance Service.

Before joining the NHS, Paula began her career in sales and marketing in the pharmaceutical industry following which she lectured in business studies, public relations and marketing in further education.

**Paul Assinder – Director of Finance and Information**
Paul brings to the Board over 30 years of experience in financial management and audit in large commercial and NHS organisations, with well over 20 years as Finance Director. Paul has significant experience of Board level challenges, including negotiating a major Private Finance Initiative deal to a financial close.

Today, as the Director of Finance and Information for The Dudley Group, one of his roles is to develop and implement the financial aspects of the Trust's strategy. While championing the highest financial, audit and governance standards, Paul is also interested in developing clinical performance and accountability frameworks. He is leading the Trust's Service Line Performance Management Initiative. Paul was selected as one of the inaugural members of the prestigious NHS Top Leaders Programme in 2011.

Qualified as a chartered and certified accountant, with a degree in Economics and Management, Paul has written widely and lectured on NHS and general finance matters. He is a member of a wide range of professional bodies and networks, a visiting lecturer to the University of Wolverhampton and is a past national president and trustee of the Healthcare Financial Management Association.

**Richard Beeken – Director of Strategy, Performance & Transformation**

Richard joined the Trust in June 2010 from South Staffordshire and Shropshire Healthcare NHS Foundation Trust where he spent two-and-a-half years as Chief Operating Officer.

Richard has held a variety of senior positions within the NHS since graduating from the NHS Management Training Scheme, this being his third Executive Director post.

He has worked as Divisional Manager of Surgical Services at Royal Wolverhampton Hospitals and Chief Operating Officer at Birmingham Children's Hospital before moving to South Staffordshire and Shropshire Healthcare NHS Foundation Trust as Chief Operating Officer in 2007.

Richard is responsible for service delivery in the Trust's clinical services, delivered through the clinical directorate structure, as well as leading on the Trust-wide Transformation programme which aims to deliver efficiency and quality gains in the future through effective service redesign. Richard is also the executive director responsible for facilities and estates through the management of the PFI contract.

**Richard Cattell – Interim Director of Operations***

Richard joined the Trust in June 2007 as Head of Pharmacy. His subsequent managerial roles include Clinical Director, Clinical and Specialist Support Services and Deputy Operations Director before his interim appointment to the position of Director of Operations in April 2013.

Richard is responsible for service delivery, improvement and performance management in the Trust's clinical services, delivered both in community and hospital settings. His role covers all areas of the operation of an integrated trust from emergency and elective access to staff management and budgetary control.

**Richard Cattell is a non-voting director and therefore his attendance is not listed in the Board of Directors attendance table on page 61.*

**Paul Harrison – Medical Director**
As Medical Director and Consultant Haematologist, Paul has a varied role with both clinical and managerial responsibilities and has been a member of the Trust Board of Directors since 2006.

His medical background as a Haematologist has given him wide clinical experience and he is a Fellow of both the Royal College of Physicians and the Royal College of Pathologists. He is particularly interested in medical education and has served as Regional Specialty Advisor for both the Royal College of Physicians and the Royal College of Pathologists.

He has previously chaired both the Regional Training Committee and the national Haematology Specialty Advisory Committee. He has been an examiner for the Royal College of Pathologists. Paul currently sits on the Royal College of Physicians' Regional Advisers and Specialty Representatives Group and is a CPD Approver for the Royal College of Physicians. He is called upon to lecture and advise on a variety of clinical, managerial and professional topics.

Key operational achievements have involved the establishment of new services in Dudley. These include a nurse-led open access deep vein thrombosis diagnostic/treatment service and a peripheral blood stem cell transplantation programme. He also reconfigured working practices in the Haematology department to develop a fully integrated team-based approach by medical staff.

**Denise Mcmahon – Director of Nursing**
A nurse for 30 years, Denise started her nurse training in 1978 at Walsall Manor Hospital having been a nurse cadet for two years.

Denise was a senior nurse in medicine and then a general manager for medicine and surgery until she became Deputy Nurse Director in 1997. Two years later, she moved to the Royal Orthopaedic Hospital in Birmingham as Director of Nursing and Operations and then on to Kettering General in 2001 as Director of Nursing and Midwifery.

In addition to her corporate responsibilities as Nursing Director, specific responsibilities include professional leadership for the nursing and midwifery strategy and Director of Infection Prevention and Control, a role in which she has considerable experience. She also holds the executive director lead role for Governance.

Denise is passionate about patient care and has continued to do clinical shifts throughout her career.

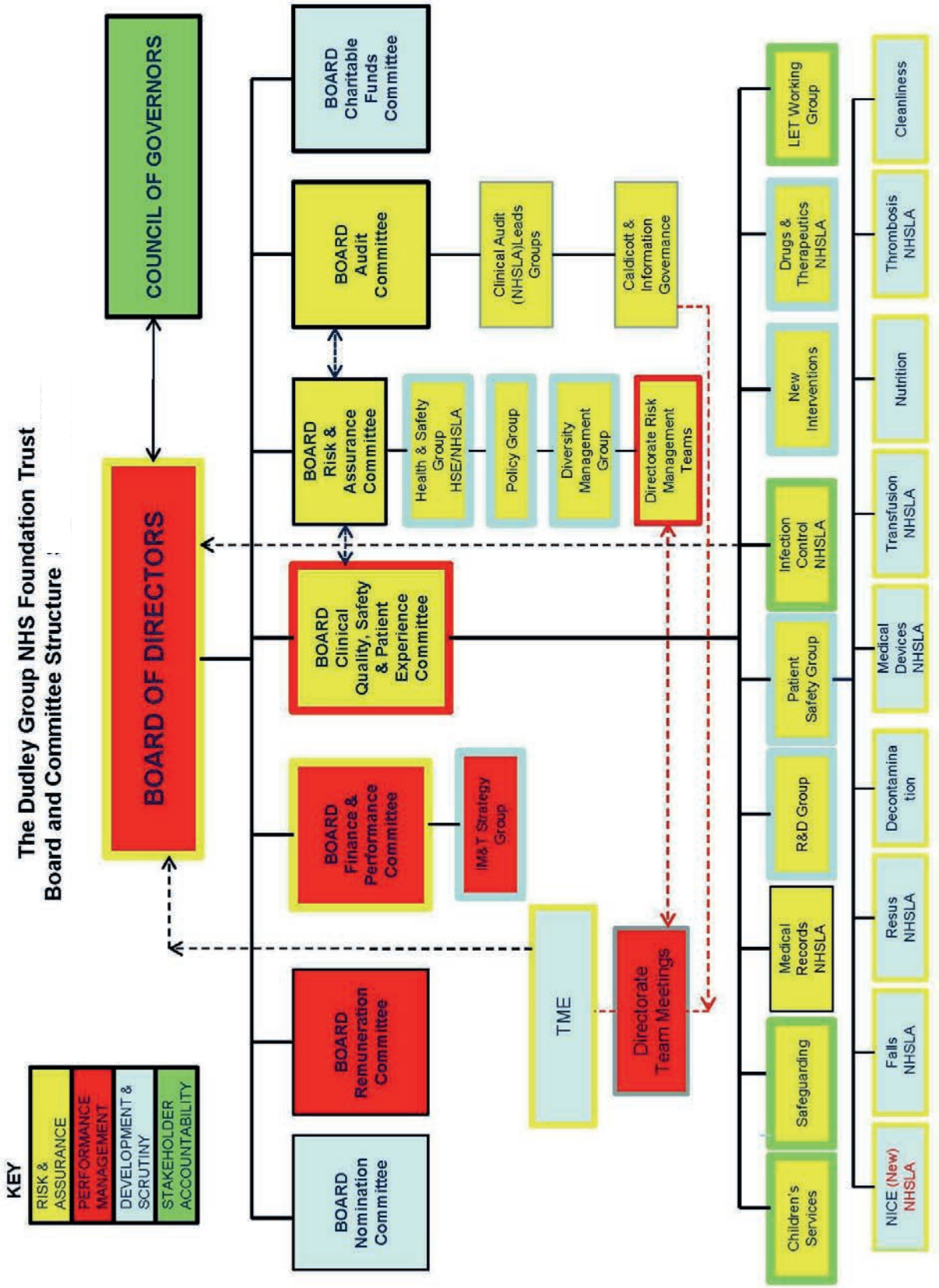
## Board of Directors Committees and attendance

The committee structure was reviewed by the Board of Directors during 2013/14 in response to recommendations from the external auditor Deloitte.

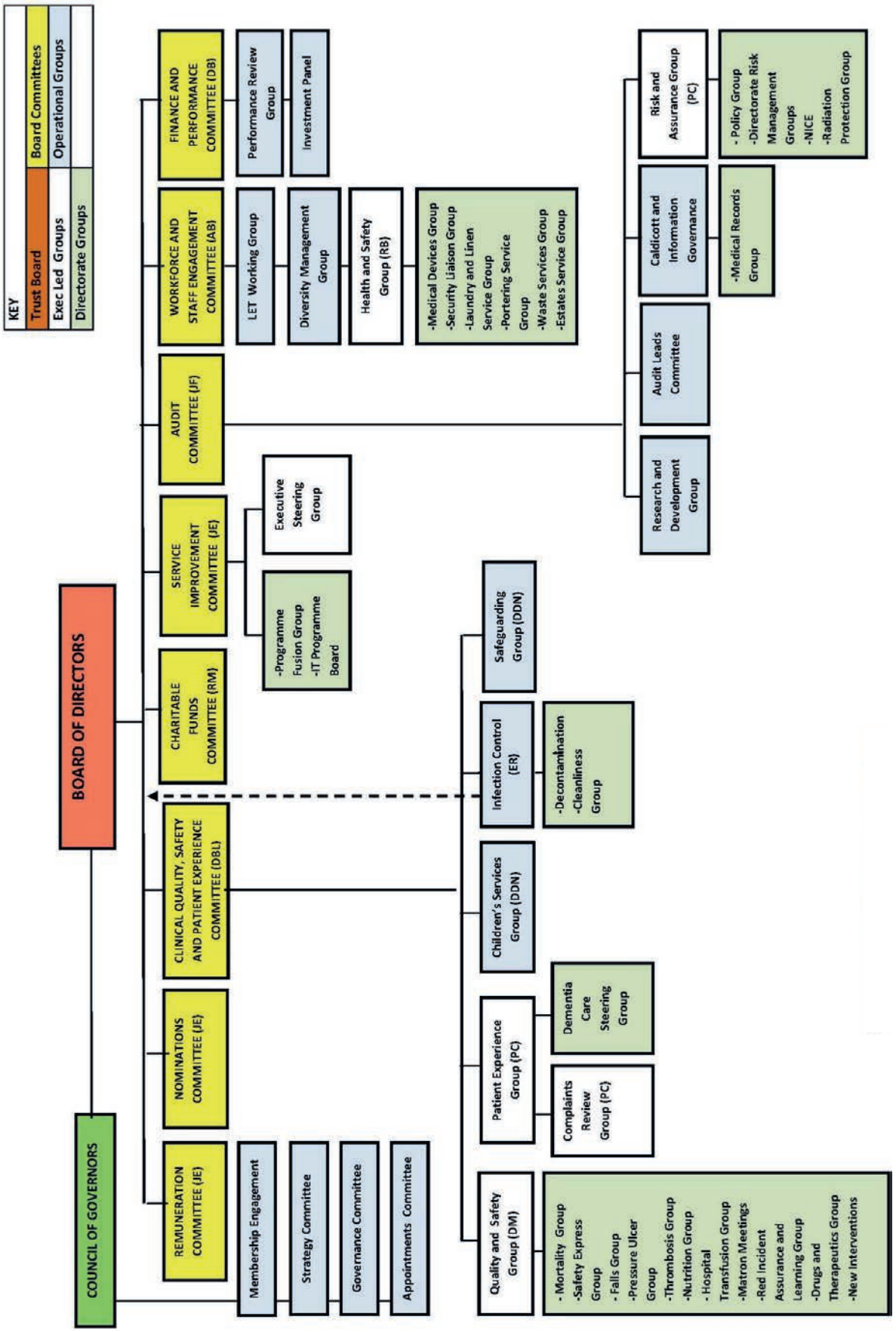
It was decided that the Risk of Assurance Committee should no longer be a committee of its own and should instead be replaced by a Risk and Assurance Group which reports to the Audit Committee.

It was also agreed that two additional committees would be introduced: the Service Improvement Committee and the Workforce and Staff Engagement Committee. The Terms of Reference for all committees were reviewed and updated to reflect the changes.

**Structure used in 2013/14**



## New structure as of 1st April 2014



## Board of Directors

The Board of Directors meets monthly in public and carries out its business in accordance with an agreed agenda setting process and an annual cycle of business.

All directors, both executive and non-executive, have joint responsibility for every decision made during Board meetings.

The Board of Directors met 11 times during 2013/14:

| Attendance at Board of Directors meetings | | Attendance out of 11 |
|---|---|---|
| John Edwards | Chairman | 11 |
| David Badger | Non-executive Director/Deputy Chairman/ Senior Independent Director | 10 |
| Ann Becke | Non-executive Director | 10 |
| David Bland | Non-executive Director | 11 |
| Jonathan Fellows | Non-executive Director | 9 |
| Richard Miner | Non-executive Director | 11 |
| Paula Clark | Chief Executive | 10 |
| Paul Assinder | Director of Finance and Information | 8 |
| Richard Beeken | Director of Strategy, Performance & Transformation | 11 |
| Paul Harrison | Medical Director | 9 |
| Denise McMahon | Director of Nursing | 9 |

## Audit Committee

The Audit Committee is a Sub Committee of the Board of Directors. The Committee provides the Board of Directors with an objective view of the effectiveness of internal control systems in operation within the Trust. It receives regular reports from the Trust's internal and external auditors. The Committee also ensures that statutory obligations, legal requirements and codes of conduct are followed

During the financial year, the Audit Committee reviewed the Trust's Accounting Policies. This included a number of changes in 2013/14 relating to the consolidation of Dudley Group NHS Charity and Dudley Clinical Services Limited into the Trust's accounts.

In addition, revisions to the accounting policies included the areas of Provisions, Segmental Reporting, Public Dividend Capital, Corporation Tax and accounting policies that have yet to be adopted. The Audit Committee considered reports relating to these changes and approved the proposed changes for the 2013/14 financial year.

The members were non-executive directors Jonathon Fellows (Chair), Ann Becke and Richard Miner. The Trust's Finance Director, Paul Assinder, and the Trust's auditors also attend all meetings.

The Audit Committee has met four times during the year:

| Audit Committee membership | | Attendance out of 4 |
|---|---|---|
| Jonathan Fellows | Non-executive Director (Committee Chair) | 4 |
| Ann Becke | Non-executive Director | 4 |
| Richard Miner | Non-executive Director | 3 |
| **In attendance** | | |
| Paula Clark | Chief Executive | 2 |
| Paul Assinder | Director of Finance and Information | 4 |
| Denise McMahon | Director of Nursing | 3 |
| Deloitte LLP | External auditors representative | 4 |
| RSM Tenon/Baker Tilly* | Internal auditors representative | 4 |

**RSM Tenon became Baker Tilly in October 2014*

The Trust has a policy in place for the approval of additional services by the external auditor to ensure that the independence of the external auditor is not compromised where work outside the audit code has been purchased.

Details of the value of both audit and non-audit services provided by Deloitte LLP can be found on page 19 of the accounts.

**Nomination Committee**

The Nomination Committee holds at least one scheduled meeting per year. Ad-hoc meetings can be called by the Trust Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Trust Chair.

The Committee operates to review and evaluate the Board structure and expertise, as well as to agree a job description and person specification for the appointments of the Chief Executive and Executive Directors. The Committee also identifies and nominates suitable candidates for such vacancies and recommends its proposed appointment for Chief Executive to the Council of Governors. One meeting was held during 2013/14 on the 5th December 2013.

| Nomination Committee membership | | Attendance out of 1 |
|---|---|---|
| John Edwards | Chairman (Committee chair) | 1 |
| David Badger | Non-executive Director | 1 |
| David Bland | Non-executive Director | 1 |
| Ann Becke | Non-executive Director | 1 |
| Richard Miner | Non-executive Director | 1 |
| Jonathan Fellows | Non-executive Director | 1 |
| Paula Clark | Chief Executive | 1 |
| **In attendance** | | |
| Annette Reeves | Associate Director of Human Resources | 1 |
| Paul Harrison | Medical Director | 1 |

# Regulatory Ratings

The Trust set the 2013/14 regulatory ratings plan based on the annual risk assessment of the financial year. During 2013/14 Monitor changed from the Compliance Framework to the Risk Assessment Framework. This replaced the Financial Risk Rating with a Continuity of Service Rating. Analysis for each area of rating compared with that expected in the annual plan is summarised below:

## Financial risk/continuity of service rating

The Trust planned for a rating of '3' in the annual plan on the basis of both the financial risk rating and the continuity of service rating. The Trust entered the financial year with a challenging cost improvement programme. This was also on the back of a reduction in the amount of income the Trust would receive as a result of changes to the Payment By Results (PBR) system and local commissioning intentions. In addition the Trust incurred premium costs to deliver activity over that planned.

Outside of Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) restructuring costs of £2.7m were the main reason for the variance from the net plan. The Trust's overall performance for the year showed an EBITDA Margin of £22.23m, 7.0 per cent, equivalent to £1.1m below plan, a net surplus before restructuring costs of £0.3m (£0.2m below plan) and a net deficit after restructuring of £2.3m (£2.8m below plan). Although the Trust encountered a difficult 2013/14 financially the Trust was still able to deliver a rating of '3' on the Trust's final outturn.

## Governance risk rating

The Trust planned for a rating of 'Amber-Green' in the annual plan, reflecting the fact that in Quarter 4 of 2012/13 the Trust breached the A&E maximum waiting time of 4 hours from arrival to admit/transfer/discharge (95 per cent) target and identified the risk of further failure in Q1 of the new year. In fact the Trust failed the A&E target in Q1, Q3 and Q4 and for the 2013/14 year as a whole. This was a common trend seen across the NHS as providers struggled to maintain the A&E target due to increased demand and increased acuity of patients presenting.

In addition, the Trust failed to meet its projected number of C. diff cases in Q2, Q3 and Q4.The actual performance of the Trust in this area for the year was an improvement on the previous year (43 cases compared to 56 in 2012/13); however, the Trust was set a very challenging annual target of 38 cases and failed to meet the trajectory of these cases on the three occasions. The regulator Monitor has sought assurance around the number of avoidable infections within this total of 43 and is satisfied that this is well within annual target.

The Trust was one of 14 trusts chosen to be reviewed as part of the Keogh Review triggered by high mortality rates. Following the publication of the report on 16th July 2013 an action plan was agreed with the Keogh Review team and Monitor at a risk summit which has been implemented to Monitor's satisfaction. Following a review of the issues faced by the Trust, a 'green' rating was given from Monitor at the end of Q4.

| 2013/14 | Annual Plan 2013/14 | Q1 2013/14 | Q2 2013/14 | Q3 2013/14 | Q4 2013/14 |
|---|---|---|---|---|---|
| Under the Compliance Framework | | | | | |
| **Financial risk rating** | 3 | 3 | 3 | | |
| **Governance risk rating** | Amber-Green | Amber-Green | Green | | |
| Under the Risk Assessment Framework | | | | | |
| **Continuity of service rating** | | | | 3 | 3 |
| **Governance rating** | | | | Green | Green |

| 2012/13 | Annual Plan 2012/13 | Q1 2012/13 | Q2 2012/13 | Q3 2012/13 | Q4 2012/13 |
|---|---|---|---|---|---|
| Under the Compliance Framework | | | | | |
| **Financial risk rating** | 3 | 3 | 3 | 3 | 3 |
| **Governance risk rating** | Amber-Red | Green | Green | Green | Amber-Red |

# Financial Performance

In line with the wider NHS, the Trust has faced a challenging year financially in 2013/14. Total income has increased by 6%, to £316.2 million, above the previous year, reflecting a small increase in funded clinical activity but a real terms reduction to overall funding levels.

The Trust recorded Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) of £22.2 million, which equates to 7 per cent of turnover. Under the regulator's (Monitor) new Continuity of Service Risk Rating, the Trust achieved an acceptable rating of 3 for the year.

The 6% increase in income earned in 2013/14 largely relates to additional emergency admissions to Russells Hall Hospital above the contract agreed at the start of the year with local commissioners. As a result, the Trust had difficulty accommodating all planned clinical admissions during the year and waiting lists have grown marginally as a result. The Trust also saw modest growths in new outpatient and community attendances during the year. The number of births at Russells Hall Hospital was marginally lower than previous years. Modest income growth and spending on drugs and clinical supplies generally correlate to these activity trends.

Of greater note; however, is significant additional spending on front line clinical staff during 2013/14. Whilst total headcount grew by 170 WTE during the year, +4.3%, *(unqualified nursing grades in post grew by 9.8% and medical staff by 5.2%)* spending on temporary, bank and agency staff exceeded previous record levels with spend of £10.1m for the year in total. Table 1 below summarises the Trust Performance for the year:

**Table 1: Trust Financial Performance 2013/14**

| | Plan | Actual | Variance |
|---|---|---|---|
| | £000's | £000's | £000's |
| Income | 309,700 | 316,236 | 6,489 |
| Expenditure | (286,352) | (294,009) | (7,613) |
| **EBITDA** | **23,348** | **22,227** | **(1,123)** |
| | | | |
| **Net Surplus from operations** | **500** | **351** | **(149)** |
| **Restructuring Costs** | **0** | **(2,700)** | **(2,700)** |
| **Net Deficit for year** | **500** | **(2,349)** | **(2,849)** |
| | | | |
| | | | |
| EBITDA Margin | 7.7% | 7.0% | (0.7%) |
| EBITDA % Plan Achieved | 100.0% | 95.2% | (4.8%) |
| Net Return After Financing | 0.2% | 0.1% | (0.1%) |
| IS Surplus Margin | 0.2% | (0.7%) | (0.9%) |
| Liquidity Days | 31.9 | 30.4 | (1.5) |
| | | | |
| **CoSRR Rating*** | | | |
| Debt Service Cover | 1.26x | 1.24x | (0.02x) |
| Liquidity | 19.0 | 18.2 | (0.8) |

**During 2013/14 Monitor changed to the 'Continuity of Service Risk Rating'*

## 1. Income and Expenditure

Table 2, below, compares the original planned income and expenditure with the outturn position for 2013/14.

**Table 2: Trust performance against Annual Plan 2013/14**

| | Plan | Actual | Variance | Notes |
|---|---|---|---|---|
| | £000's | £000's | £000's | |
| NHS Clinical Income | 285,336 | 290,931 | 5,595 | **1** |
| Other Clinical Income | 7,490 | 6,564 | (926) | |
| Other Operating Income | 16,874 | 18,741 | 1,820 | **2** |
| **Total Income** | **309,700** | **316,236** | **6,489** | |
| Pay Spend | (183,928) | (185,210) | (1,282) | **3** |
| Non-pay Spend | (102,424) | (108,799) | (6,330) | **4** |
| **Total Expenditure** | **(286,352)** | **(294,009)** | **(7,612)** | |
| | | | | |
| **EBITDA** | **23,348** | **22,225** | **(1,123)** | |
| | | | | |
| **Net Surplus from operations** | **500** | **351** | **(149)** | |
| **Restructuring Costs** | **0** | **(2,700)** | **(2,700)** | **5** |
| **Net Deficit for year** | **500** | **(2,349)** | **(2,849)** | |

**Notes to Table 2**

1. Activity Income

The enactment of the 2012 Health and Social Care Act significantly changed the commissioning landscape in the NHS in 2013/14 with the demise of local Primary Care Trusts (PCTs) and the establishment of a much more fragmented system. Whilst in previous years well over 80% of the Trust's activity had been commissioned by Dudley PCT, and the PCT had coordinated the vast majority of contracts with neighbouring PCTs, from April 2013 individual contracts covering previous Dudley PCT activity were split into new contractual arrangements with Dudley Clinical Commissioning Group, Dudley Metropolitan Borough Council and NHS England. These changes were replicated across other former PCT areas.

In addition to working with a more fragmented customer base in 2013/14, structural changes to the NHS national standard contract for service and the standard NHS Tariff, made the contractual process, and the in-year monitoring of a greater number of ever more complex agreements much more onerous than previously. This adversely impacted credit control and cash flow.

Contracts entered into with commissioners for 2013/14 generally reflected activity flows seen in previous years, abated for so called "commissioning intention" reductions. Whilst some changes to GP referral activity and emergency flows can be seen in some specialties, the Trust has generally seen a steady increase in emergency referrals to Russells Hall Hospital from all sources, with a consequent displacement of planned elective activity. Financially this represents a damaging trend, since the tariff structure and the nature of the Trust's cost base means that

whilst the Trust tends to generate a small operating margin on elective activity, emergency admissions (often of patients with complex dependencies and multiple clinical conditions) incur a financial loss to the Trust (Table 3).

Continuation of these activity trends, combined with growing delays in the Trust's ability to discharge patients to third party organisations and a significant rise in headcount and front line pay costs, represents something of a 'perfect storm' for the future.

**Table 3: Activity against Annual Plan 2013/14**

| | Annual Plan | Outturn | Variance | Growth (%) |
|---|---|---|---|---|
| Accident & Emergency attendances | 99,228 | 95,375 | (3,853) | (3.9)% |
| Elective spells | 49,869 | 48,438 | (1,431) | (2.9)% |
| Non-elective spells* | 40,023 | 41,044 | 1,021 | 2.6% |
| Outpatient attendances/ procedures | 490,277 | 509,705 | 19,428 | 4.0% |
| Community attendances | 406,459 | 418,693 | 12,234 | 3.0% |

**Excludes all maternity activity.*

2. Other Operating Income

The Trust successfully attracted other operating income in excess of planned levels, notably for training and education, research and development and reimbursement from the insurance industry for road traffic accidents. Although there is no longer a private patient cap in place for the Trust, there was no growth in private income in comparison to the previous year. Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust confirms that it has met this requirement and that the income received in 2013/14 had no impact on its provision of goods and services for the purposes of the health service in England.

3. Pay Spend

During the year, the Board of Directors sanctioned additional spending on front line clinical staff. At 31st March, headcount stood at 4,158 WTE, the highest number of people ever in post in the Trust. This represents an increase of 197 WTE on 1st April 2013, an increase of 4.3% over a 12 months period when activity in virtually all clinical specialties was broadly flat.

Of note were increases in:

- Medical & Dental staff of +25 WTE, 5.2%
- Qualified nurses of +25 WTE, 1.8%
- Unqualified nursing staff of +57 WTE, 9.8%
- Scientific & Therapies staff of 35 WTE, 4.8%

In addition to such growth in front line substantive staff over the period, the Trust incurred crippling expenditure on temporary staffing to supplement employed grades.

Of note are the following areas of temporary spend by category:

- External nursing agencies £7.1m
- Internal Nurse Bank £10.0m
- Locum doctor agencies £3.0m
- Staff Overtime £1.3m
- Waiting List Initiative Payment to Doctors £1.7m

4. Non-Pay Spend

Additional non-pay spending has occurred as a direct result of additional activity with significant unplanned spends occurring on high cost drugs, various clinical supplies/ disposables, medical equipment, pacemakers, surgical instruments, dialysis and patient appliances. In addition, non-pay spend has also increased on computer equipment, additional cleaning linked to greater infection control, rent, rates and legal expenses.

5. Surplus/(Deficit)

The Trust returned a small operating surplus for the year of £351k and a technical deficit of £2.3m after restructuring costs of £2.7m are taken into account in respect of a negotiated termination of the Trust's PFI IT Service and the costs of a mutually agreed resignation scheme.

## 2. Capital spending

In 2013/14 the Trust invested £5.7 million on new facilities and equipment. £377k was invested in an upgrade to the GI Unit to bring it up to the latest statutory level and enhance the experience of patients within this area. In addition £346k was invested in a simulation laboratory to provide medical students with state of the art training facilities. The Trust also spent £2.5m on new and replacement medical equipment and £887k on Information Technology. Both of these investments improving the efficiency of the services the Trust provides.

| **Investment 2013/14** | **Amount** |
|---|---|
| | **£000's** |
| Simulation Laboratory | 346 |
| Imaging Equipment Replacement | 560 |
| Other Medical Equipment | 2,532 |
| GI Unit Enhancement | 377 |
| Information Technology | 887 |
| Imaging Equipment Enabling Works | 151 |
| Other Works including PFI Lifecycle | 803 |
| **Total** | **5,656** |

## 3. Cashflow

The Trust ended the year with a healthy cash balance of £26.2 million, all held within the Government Banking Service. This will be used to support planned capital expenditure over the next three years.

The Trust maintained, but did not utilise, a committed working capital facility with Barclays Bank of £10m.

During 2013/14 the Trust continued its policy of paying all local suppliers at the earliest opportunity to support the local economy during these difficult economic times. The Trust continues to perform strongly against the best practice payment policy target of 95 per cent compliance. During 2013/14 the Trust paid 99 per cent of non-NHS invoices in value terms and 98 per cent in quantity terms.

## 4. Better payment code of practice

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is the later.

| | 2013/14 | | 2012/13 | |
|---|---|---|---|---|
| | Number | £000 | Number | £000 |
| Total non-NHS trade invoices paid in the year | 55,090 | 131,368 | 49,554 | 115,650 |
| Total non-NHS trade invoices paid within target | 53,986 | 129,555 | 49,073 | 115,060 |
| Percentage of non-NHS trade invoices paid within target | 98% | 99% | 99% | 99% |

## 5. Audit

As far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. This guidance discusses how public sector organisations should charge for information.

## 6. Countering Fraud & Corruption

The Trust takes its responsibility towards countering fraud and corruption in the NHS very seriously.

The Trust's Fraud and Corruption Policy lays down its absolute commitment to maintaining an honest, open and well-intended atmosphere within the Trust. This commitment is the cornerstone of an anti-fraud culture, championing the deterrence and prevention of fraud and the rigorous investigation of any cases of fraud or corruption. Where fraud is proven, the Board will apply all available sanctions eg. disciplinary/criminal action, and use of the civil law to recover funds.

## 7. Off Payroll engagements

During 2013/14 the Trust had one off-payroll engagement ≥ £220 per day with an individual who is not a director of the Trust. This arrangement includes contractual clauses allowing the Trust to seek assurances from that individual that their personal tax obligations have been properly discharged. The Trust has not taken on any further off such engagements during 2013/14.

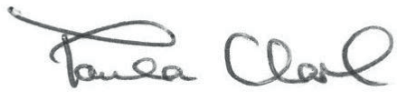
# Accounts

## For the period 1st April 2013 to 31st March 2014

## Foreword to the accounts

These accounts for the period 1st April 2013 to 31st March 2014 have been prepared by The Dudley Group NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.

**Signed** **Date: 22nd of May 2014**



**Paula Clark**
**Chief Executive**

## Statement of Accounting Officer's responsibilities for The Dudley Group NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed The Dudley Group NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Dudley Group NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis,
- make judgements and estimates on a reasonable basis,
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements,
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance, and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

**Signed** **Date: 22nd May 2014**

**Paula Clark**
**Chief Executive**

## Statement of Directors' responsibilities In respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury,
- make judgements and estimates which are reasonable and prudent,
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

**Signed** **Date: 22nd May 2014**

**Paula Clark**
**Chief Executive**

**Signed** **Date: 22nd May 2014**

**Paul Assinder**
**Director of Finance and Information**

# Annual Governance Statement

## Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Dudley Group NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Dudley Group NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the Annual Report and Accounts.

## Capacity to handle risk

The Director of Nursing has Board level responsibility for the Trust's risk management policies and processes. The Board of Directors has established a Risk and Assurance Committee, chaired by a non-executive director, which meets quarterly to review corporate and directorate specific risks and associated mitigation plans and oversees the effective operation of the Trust's risk register. It is in place to challenge the levels of assurance throughout the organisation and to ensure the effective management and mitigation of risks. Additionally, each directorate of the Trust operates independent Risk Management Groups that report to the Risk and Assurance Committee, focussing on risks at an operational level.

The Trust has a comprehensive induction and training programme, supplemented by e-learning training packages and ad hoc learning opportunities for staff. Collectively, these cover a wide range of governance and risk management topics for both clinical and non-clinical staff in all disciplines and at all levels in the organisation. Additionally, training can be provided by the governance team on the wider risk management and governance agenda. Good practice is disseminated through the existing matrons forums, directorate risk groups and via the Board Committee reporting structure.

## The risk and control framework

The Board of Directors provides leadership on the management of risks, determining the risk appetite for the organisation and ensuring that the approach to risk management is consistently applied. Focusing on the corporate risks, the Board takes assurance from the Risk and Assurance and Audit Committees determining the total risk impact the Trust is prepared to accept in the delivery of its strategic objectives.

The Trust's Risk Management Strategy and Policy provides guidance on the identification and assessment of risk and on the development and implementation of action plans. The directorates undertake continuous risk assessments to maintain risk registers and to implement agreed action plans. Risks are assessed by using a 5x5 risk matrix where the total score is an indicator of the seriousness of the risk and the overall risk rating. Action plans to address or manage risks are recorded in the risk register and managed at directorate and/or Board level. Regular reports to the Risk and Assurance Committee confirm the progress made.

Each level of management, including the Board, reviews the risks and controls for which it is responsible. The Board and Board Committees monitor the progress against actions to minimise or mitigate risks in accordance with the Risk Management Strategy.

Papers received at the Board and at Board Committees identify the risks to the achievement of Trust objectives and link to the risk register. The Trust uses a dedicated action monitoring system to record and monitor all risks across the organisation including the current and mitigated risk scores and progress against identified action plans. In addition to the operational risk registers (reported to Risk and Assurance Committee) and managed at directorate level, the directors manage corporate risks. Positive assurance to date confirms the effectiveness of the management and control of these risks. Action plans are in place to address any perceived gaps in control or assurance.

The reporting framework requires all risks to be identified on Board and Committee front summary sheets providing an ongoing record of emerging issues.

The Trust has also introduced a number of arrangements to monitor quality governance and improvements in quality. These include the use of performance dashboards, a clinical audit programme, the review and introduction of Quality Care Indicators, Nursing Care Indicators and robust monitoring against local and national targets for Healthcare Associated Infections (HCAI).

Nursing Care Indicator audits measure the quality of care given to patients and the monthly audits of key nursing interventions and associated documentation are published, monitored and reported to the Board of Directors by the Director of Nursing. This is supported by the implementation of real-time surveys, capturing the views of patients and using these to make improvements. The Trust also continues to monitor the hospital standardised mortality ratio (HSMR) to ensure it is consistent with national levels.

Regular reports on the progress against key quality priorities provide assurance that these are actively managed and progressed at an operational level. Additionally, matrons and heads of service attend the Board on rotation to discuss quality issues and the operational risks to the achievement of their objectives. Internal audit also provides an independent opinion on the adequacy of the arrangements for ensuring compliance with the Care Quality Standards.

Information risks are managed and controlled through the risk management process. The Trust has a Caldicott and Information Governance Group (CIGG) which reports to the Audit Committee and whose remit is to review and monitor all risks and incidents relating to data security and governance. The Trust complies with the NHS

Information Governance Toolkit and is currently achieving a minimum of Level 2 performance for all areas, which is deemed satisfactory performance by the Department of Health. The Trust has an action plan in place to ensure that Level 3 is achieved in all areas during 2014/15, which is the maximum level of compliance. The Deputy Medical Director is the Trust's Caldicott Guardian and the Director of Finance and Information has Board level responsibility for Information Governance and is the Trust's Senior Information Risk Owner (SIRO).

The Board Assurance Framework identifies the risks to the achievement of the Trust's objectives and the independent assurance mechanisms that relate to the effectiveness of the Trust's system of internal control. It supports the Corporate Governance Statement and is informed by partnership working across the health care region and through working with the Dudley Clinical Commissioning Group (CCG), Council of Governors, community wide safeguarding boards and other stakeholders. The Board Assurance Framework focuses on those risks scoring 20–25 only as follows:

**Nurse staffing levels**
The skill mix and retention of staff is monitored and proactive vacancy management for both graduate and novice programmes continues. There has been significant investment in the workforce and bank and agency staff are used to support wards.

**Management of diabetes patients**
The Board monitors progress through Incident reports, the National External Diabetes Annual Audit and update reports.

**Failure to deliver financial balance in 2013/14, as a result of efficiency abatement to NHS Tariff and clinical cost pressures**
Directors take personal responsibility for the delivery of cost improvement projects. The Board monitors progress through Finance and Performance Committee.

**Delayed discharge/transfer**
The Board monitors the continuing partnership arrangements to improve services for patients on discharge or transfer to the community.

**Failure to maintain the 18 week pathway**
The Board monitors progress through Board/Finance and Performance Committee 18 week reports and directorate dash boards.

**Urgent care demands exceeds capacity**
The Trust is working in partnership with the Dudley CCG to reduce the emergency admissions and empower non-medical staff to improve multi-disciplinary team led discharge. The Board monitors progress through Board/Finance and Performance reports.

During 2013/14, the work of the internal auditors and the Board review of the Assurance Framework and supporting governance processes identified some perceived gaps in control which have been reported as part of the ongoing monitoring arrangements. These are considered to be operational in nature and are

supported by action plans which address weaknesses and ensure continuous improvement of the systems in place.

In April 2013 the Trust received confirmation from Sir Bruce Keogh that The Dudley Group had been identified as one of 14 trusts that would receive a rapid response review in May 2013 into the quality of care and treatment provided and specifically the Summary Hospital-level Mortality Index and the Hospital Standardised Mortality Ratio.

The review process was designed to determine whether there were any sustained failings in the quality of care and treatment provided to patients. The resulting report indicated that "the Trust was on an improvement journey in relation to quality and patient experience". There were examples of good practice and areas for improvement. Resulting actions have been closely monitored by the Board of Directors and Monitor.

A high level review of the effectiveness of the Trust quality governance arrangements was also undertaken as part of this review. The report indicated that the governance structure was complex and information flows required improvement to enable greater challenge from the Board and sub committees on the quality priorities.

The Trust commissioned Deloitte LLP to undertake an independent review of the effectiveness of Board Governance and Quality Governance. The review found areas of good practice but made recommendations to revise the Committee structure and reporting lines. Detailed action plans were developed and reporting structures reviewed and revised to strengthen reporting lines and clarify accountability throughout the organisation. The Board approved a new Committee structure which has been implemented with effect from 1st April 2014.

In accordance with Schedule 7 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) only directors may be members of the board committees. All Committees of the Board are chaired by non-executive directors. Each committee chair provides a formal summary of key issues arising from the Committee to the full Board of Directors. The Deloitte report confirmed that there was "appropriate dedicated time to receiving and discussing updates from each Committee" at the Board.

Additional recommendations arising from the Keogh Review have also strengthened the reporting structure at operational level, clarifying accountability and reporting lines and further embedding governance and risk management across the organisation. The establishment of quality dashboards and regular performance review meetings has raised awareness of risk and governance related matters and provided a robust reporting and review framework. The revised arrangements have enhanced Board oversight of risk, quality and assurance processes. Both the Board of Directors and Monitor have monitored the implementation of recommendations arising from the Keogh and Deloitte reviews.

The Trust informs and engages with its key stakeholders in relation to risk through a number of forums which include a regular joint contract/clinical quality review meeting with the Trust's host commissioners and the sharing of performance reports including key risks with the Trust's Council of Governors. Key stakeholders include

Dudley CCG, our PFI partner Summit Healthcare (Dudley) Ltd, voluntary groups, the Council of Governors, the FT members, patient groups, patients, the local community and the Local Authority Select Committee on Health and Adult Social Care.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

On the 16th July 2013 the CQC undertook an unannounced inspection in response to concerns that one or more of the essential standards of quality and safety were not being met. A CQC pharmacist inspected the medicine management systems on the Emergency Admission Unit (EAU) and ward C8. She also visited the Pharmacy Department. The CQC confirmed that "we found that arrangements were in place to ensure that medicines were managed safely".

"The provider was meeting this standard. People were protected against the risks associated with medicines because the provider was ensuring that appropriate arrangements were in place to manage medicines."

In October 2013 the Trust received confirmation from Professor Sir Mike Richards, Chief Inspector of Hospitals, that the Trust had been selected for an inspection under the new inspection arrangements on 26th – 28th March 2014. As part of the ongoing refinement of the Acute Hospitals Inspection framework the CQC also undertook the following pilot studies during this inspection:

- Tracking patients with complex needs or in vulnerable circumstances; and
- Complaints.

The final report and recommendations arising from the inspection and the initial Trust rating are expected in early June 2014.

As an employer with staff entitled to be members of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all of the organisation's obligations under equality and diversity and human rights legislation are complied with.
The Foundation Trust (in partnership with its PFI provider) has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

## Review of economy, efficiency and effectiveness of the use of resources

The Trust produces detailed Annual Plans incorporating both service and quality initiatives and reflecting service, operational requirements and financial targets in respect of income and expenditure and capital investments. These include the Trust's plan for improving productivity and efficiency in order to minimise income

losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. The Plan incorporates projections for the next two years which facilitates forward planning in the Trust. Financial plans are approved by the Board of Directors, supported by the Finance and Performance Committee, prior to submission to Monitor.

The in-year resource utilisation is monitored by the Board and its committees via a series of detailed reports covering finance, activity, capacity, human resource management and risk. Clinical risk assessments are conducted on individual savings proposals that may impact on the provision or delivery of clinical services. The Trust has faced a challenging year financially in 2013/14. The Trust has recognised the further challenge going forward into 2014/15 and has instigated a turnaround programme to ensure that the Trust is financially sustainable going forward.

Performance review meetings assess each directorate's performance across a full range of financial and quality matrices which, in turn, forms the basis of the monthly integrated performance report to the Finance and Performance Committee. Quarterly reports are submitted to Monitor from which Continuity of Service and Governance risk ratings are assigned. The Trust received a Continuity of Service risk rating of 3 from Monitor for the 2013/14 financial year and a governance rating of green. The Trust breached the A&E maximum waiting time of four hours from arrival to admission/transfer/discharge (95%) target in three quarters of the financial year and failed to meet its projected number of C. difficile cases in Q2, Q3 and Q4. Despite this, Monitor were satisfied that the action plans in place within the Trust to address these issues were adequate and did not take any further regulatory action.

The key processes embedded within the Trust to ensure that resources are used economically, efficiently and effectively, centre around a robust budget setting and control system which includes activity related budgets and periodic reviews during the year which are considered by executive directors and the Board of Directors. The budgetary control system is complemented by Standing Financial Instructions, a Scheme of Delegation and Financial Approval Limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis. The Finance and Performance Committee also receive a monthly report showing the Trusts performance against CQUIN, Monitor and CQC targets.

As Accounting Officer, I have overall accountability for delivery of the Annual Plan and I am supported by the executive directors with delegated accountability and responsibility for delivery of specific targets and performance objectives. These are formally reviewed and monitored monthly by the Board of Directors and its Committees. Independent assurance on the use of resources is provided through the Trust's internal audit programme, Audit Committee and external agencies such as Monitor, External Audit and the CQC.

## Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Board of Directors has taken the following measures to ensure the Quality Report presents a balanced view and has appropriate controls to ensure the accuracy of data:

**Governance and leadership**
The executive and non-executive directors have a collective responsibility as a Board to ensure that the governance arrangements supporting the Quality Accounts and Report provide adequate and appropriate information and assurances relating to the Trust's quality objectives. Board sponsors are nominated for all quality priorities providing visible board leadership of specific quality initiatives.

Whilst the Chief Executive has overall responsibility for the quality of care provided to patients the implementation and co-ordination of the quality framework is delegated to the Nursing and Medical Directors who have joint responsibility for reporting to the Board of Directors on the development and progress of the quality framework and for ensuring that the Quality Strategy is implemented and evaluated effectively.

**Policies**
High quality organisational documentation are an essential tool of governance which will help the Trust achieve its strategic objectives, operational requirements and bring consistency to day to day practice. A common format and approved structure for such documents helps reinforce corporate identity, helps to ensure that policies and procedures in use are current, and reflects an organisational approach. A standard approach ensures that agreed practice is followed throughout the organisation, with regard to the development of approved documentation all procedural documents are accessible to all relevant staff supporting the delivery of safe and effective patient care.

**Systems and processes**
The systems and processes which support the development of the quality accounts focus on engagement activities with public, patients and staff and utilising the many media/data capture opportunities available.

The Trust reviews its quality priorities annually engaging with governors, staff, members of the public and partner organisations. A questionnaire was also made available both at a Trust open day and on the Trust website. Members of the public and local statutory and voluntary bodies were informed that their views were also welcome.

The topics were agree by the Board of Directors on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Care Indicators) and a national perspective (e.g. reports from national bodies e.g. Age Concern, CQC findings etc). These topics were endorsed by a Listening into Action event on the Quality Account, hosted by the Chief Executive and Director of Nursing, attended by staff, governors, Foundation Trust members and others from the following organisations: Dudley LINK, Dudley CCG, Dudley Metropolitan Borough Council (MBC), Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC).

**People and skills**
In addition to the leadership provided by the Board of Directors, Clinical Directorate Management Teams, led by clinical directors and co-ordinated by general managers, are accountable for, and ensure that a quality service is provided within, their respective directorates and areas of authority. They are required to implement the Quality Strategy, providing safe, effective and personal care and ensure that patients have a positive experience and are treated with courtesy, respect and kindness.

Training opportunities are available for clinical and non-clinical staff and competency is monitored as part of the Trusts appraisal system. External reviewers provide independent opinions on the appropriateness and adequacy of training.

The Board of Directors ensures that quality improvement is central to all activities. This is achieved by routine monitoring, participation in national improvement campaigns, celebrating success with our staff awards and proactively seeking patient views on our services.

**Data use and reporting**
The Trust has robustly utilised existing data collection and reporting arrangements to monitor progress against the quality priorities and identify trends. Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectives of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by the comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Risk and Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the systems is in place.

The Board Assurance Framework and the Trust‘s risk management arrangements provide me with evidence that the controls to manage the risks to the Trust achieving its principal objectives have been reviewed and are effective. My review is also informed by the work of external and independent assessors and advisors including the Care Quality Commission.

During 2013/14, the work of the internal auditors and the Board review of the Board Assurance Framework and supporting governance processes identified some internal control weaknesses and perceived gaps in control which have been reported as part of the ongoing monitoring arrangements. These are considered to be

operational in nature and are supported by action plans which address weaknesses and ensure continuous improvement of the systems in place.

The Head of Audit confirmed that “Based on the work undertaken in 2013/14, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives and that controls are generally being applied consistently”.  Some weaknesses were identified as a result of their work and they advised:

“Whilst we have issued four red opinions during the year and taking into account the actions undertaken by the Trust within the year in my view neither these on their own or in combination with other weaknesses within the other reports collectively, would lead us to provide an overall negative opinion at the year-end. Based on the work we have undertaken on the Trust’s system of internal control we do not consider that within these areas there are any issues that need to be flagged as significant internal control issues within the AGS.”

## Conclusion

The Board Assurance Framework and effectiveness of the systems of internal control in relation to the Quality Report are consistent with the Trust‘s overall system of internal control and the Board has been assured that the Quality Report presents a balanced view and that the data is accurate. I believe that the Annual Governance Statement is a balanced reflection of the actual control position. No significant internal control issues have been identified.

**Signed** **Date: 22nd of April 2014**

**Paula Clark**
**Chief Executive**

# Remuneration report

**Remuneration Committee (unaudited information)**

The Remuneration Committee is a Sub Committee of the Board which determines the appropriate levels of remuneration for the executive directors. The members were Chairman John Edwards and non-executive directors David Badger, Ann Becke, Jonathan Fellows, Richard Miner and David Bland.

Remuneration levels are normally determined by reference to such factors as those applying in equivalent organisations in the NHS, changes in responsibility, performance, salary increases agreed for other NHS staff and guidance issued by the Secretary of State.

One meeting was held during 2013/14 in January 2014.

| Remuneration Committee membership | | Attendance out of 1 |
|---|---|---|
| John Edwards | Chairman (Committee Chair) | 1 |
| David Badger | Non-executive Director | 1 |
| Ann Becke | Non-executive Director | 1 |
| David Bland | Non-executive Director | 1 |
| Jonathan Fellows | Non-executive Director | 1 |
| Richard Miner | Non-executive Director | 1 |
| **In attendance** | | |
| Paul Assinder | Director of Finance and Information | 1 |
| Annette Reeves | Associate Director of Human Resources | 1 |
| Julie Cotterill | Associate Director for Governance | 1 |

Remuneration for executive directors does not include any performance-related elements.

No significant financial awards or compensation have been made to past senior managers during the period of this report.

The terms and conditions for the executive directors and senior managers of the Trust are included in their individual contracts of employment which includes notice periods and any termination arrangements.

In compliance with guidance issued by the Secretary of State for Health, the Trust Board of Directors had a pay freeze for the four years period in 2009/10 to 2012/13 and received a 1% pay award in 2013/14.

No payments have been made to third parties for services of a senior manager.

**Salary and Pension entitlements of Senior Managers** **2013/14**

**A) Remuneration**

| Name and Title | Note | 2013-14 | | | | 2012-13 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Salary (bands of £5,000) | Other remuneration (bands of £5,000) | * Benefits in Kind (Rounded to the nearest £100) | All Pension Related Benefits (bands of £2,500) | Salary (bands of £5,000) | Other remuneration (bands of £5,000) | * Benefits in Kind (Rounded to the nearest £100) | All Pension Related Benefits (bands of £2,500) |
| | | £000 | £000 | £00 | £000 | £000 | £000 | £00 | £000 |
| Paula Clark, Chief Executive | | 180-185 | | | 60-62.5 | 175-180 | | | 55-57.5 |
| Paul Assinder, Director of Finance & Information | | 140-145 | | | 25-27.5 | 140-145 | | | (20-22.5) |
| Paul Harrison, Medical Director | | 65-70 | 110-115 | | 72.5-75 | 60-65 | 100-105 | | (15-17.5) |
| Richard Beeken, Director of Operations & Transformation | | 120-125 | | | 30-32.5 | 120-125 | | | 0-2.5 |
| Denise McMahon, Director of Nursing | | 120-125 | | | 20-22.5 | 120-125 | | | (27.5-30) |
| John Edwards, Chairman | | 45-50 | | 2,800 | | 45-50 | | 1,100 | |
| David Badger, Non-exec | | 15-20 | | 300 | | 15-20 | | | |
| Kathryn Willietts, Non-exec | a | | | | | 0-5 | | | |
| Ann Becke, Non-exec | | 10-15 | | 200 | | 10-15 | | 200 | |
| Jonathan Fellows, Non-exec | | 10-15 | | | | 10-15 | | | |
| David Bland, Non Exec | | 10-15 | | 400 | | 10-15 | | 900 | |
| Richard Miner, Non Exec | | 10-15 | | | | 10-15 | | 100 | |
| Aggregate Total | | 725 -780 | 110-115 | 3,700 | 207.5-220 | 715 -775 | 100-105 | 2,300 | (7.5-10) |

Note:-

* Benefits in kind relate to leased cars in respect of the Executive Directors and home to base travel reimbursement for Non Executive Directors

a Kathryn Williets left 30 April 2012

The Trust is required to disclose the relationship between the remuneration of the highest paid Director and the median remuneration of the other Trust employees. The banded remuneration of the highest paid Director of the Trust for 2013/14 is £180,000 - £185,000 (2012/13 £175,000 - £180,000). This was 7.9 times (2012/13 7.9 times) the median remuneration of the workforce, which was £20,000 - £25,000 (2012/13 £20,000 - £25,000).
In 2013/14, there were no (2012/13 nil ) employees who received remuneration in excess of the highest paid Director.
Total remuneration includes salary, non consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

**B) Pension Benefits**

| Name and Title | Note | Real increase in pension at age 60 (bands of £2,500) | Real increase in lump sum at age 60 (bands of £2,500) | Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2013 To nearest £1,000 | Real Increase in Cash Equivalent Transfer Value To nearest £1,000 | Cash Equivalent Transfer Value at 31 March 2014 To nearest £1,000 |
|---|---|---|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Paula Clark, Chief Executive | | 2.5 - 5.0 | 7.5 - 10.0 | 50 - 55 | 155 - 160 | 997 | 108 | 1,105 |
| Paul Assinder, Finance Director | | 0 - 2.5 | 2.5 - 5.0 | 55 - 60 | 165-170 | 1,063 | 79 | 1,142 |
| Richard Beeken, Director of Operations & Transformation | | 0 - 2.5 | 2.5 - 5.0 | 25 - 30 | 85 - 90 | 392 | 40 | 432 |
| Paul Harrison, Medical Director | 1 | 2.5 - 5.0 | 7.5 - 10.0 | 55 - 60 | 175 - 180 | 956 | 108 | 1,064 |
| Denise McMahon Nursing Director | | 0 - 2.5 | 2.5 - 5.0 | 55 - 60 | 165 - 170 | 999 | 70 | 1,069 |

Note:-
1 Medical Director figures shown include accrued benefits and contributions in respect of full salary, which will include both management and medical contributions.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and

**C) Director and Governor Expenses**

The Trust is required to disclose the expenses paid to Directors, Non Executive Directors and Governors.
The band of the expenses paid for 2013/14 was £10,00 - £12,500 (2012/13 £7,500 - £10,000)

Signed

Paula Clark
Chief Executive

Date: 22nd May 2014

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF THE DUDLEY GROUP NHS FOUNDATION TRUST

We have audited the financial statements of The Dudley Group NHS Foundation Trust for the year ended 31 March 2014 which comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Equity and the Statement of Cash Flows and the related notes 1 to 32. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of The Dudley Group NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

### Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group's and the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

### Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2014 and of the Group's and the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

**Opinion on other matters prescribed by the National Health Service Act 2006**

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

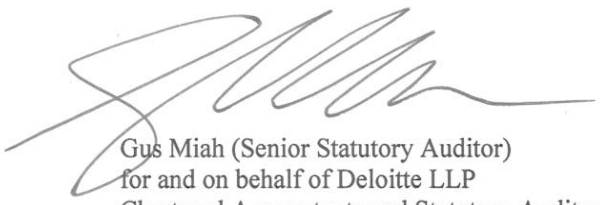
**Matters on which we are required to report by exception**

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

**Certificate**

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.



Gus Miah (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
22 May 2014

## Consolidated Statement of Comprehensive Income

| | Note | Group Year Ended 31 March 2014 £'000 | Group Year Ended 31 March 2013 £'000 | Foundation Trust Year Ended 31 March 2014 £'000 | Foundation Trust Year Ended 31 March 2013 £'000 |
|---|---|---|---|---|---|
| Operating Income from operations | 3 & 4 | 316,868 | 299,107 | 316,456 | 298,441 |
| Operating Expenses of operations | 5 | (306,466) | (283,728) | (305,926) | (283,212) |
| **OPERATING SURPLUS / (DEFICIT)** | | **10,402** | **15,379** | **10,530** | **15,229** |
| **FINANCE COSTS** | | | | | |
| Finance income | 9 | 187 | 548 | 134 | 485 |
| Finance expense - financial liabilities | 10 | (10,759) | (10,472) | (10,759) | (10,472) |
| PDC Dividends payable | | (2,254) | (2,344) | (2,254) | (2,344) |
| **NET FINANCE COSTS** | | **(12,826)** | **(12,268)** | **(12,879)** | **(12,331)** |
| Corporation tax expense | 11 | (13) | 0 | 0 | 0 |
| **Surplus/(Deficit) from operations** | | **(2,437)** | **3,111** | **(2,349)** | **2,898** |
| **SURPLUS/(DEFICIT) FOR THE YEAR** | | **(2,437)** | **3,111** | **(2,349)** | **2,898** |
| **Other comprehensive income** | | | | | |
| **Will not be reclassified to income and expenditure:** | | | | | |
| Impairments | | (318) | 0 | (318) | 0 |
| Revaluations | | 3,321 | 0 | 3,321 | 0 |
| **May be reclassified to income and expenditure where certain conditions are met:** | | | | | |
| Fair Value gains/(losses) on Available-for-sale financial instruments | 14 | 29 | 102 | 0 | 0 |
| **TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR** | | **595** | **3,213** | **654** | **2,898** |

The notes on pages 5 to 39 form part of these accounts.
All income and expenditure is derived from continuing operations.

There are no Minority Interests in the Group, therefore the deficit for the year of £2,437,000 (2012/13 surplus of £3,111,000) and the Total Comprehensive Income of £595,000 (2012/13 £3,213,000) is wholly attributable to the Trust.

## Consolidated Statement of Financial Position

| | Note | Group | | | Foundation Trust | | |
|---|---|---|---|---|---|---|---|
| | | 31 March 2014 | 31 March 2013 | 1 April 2013 | 31 March 2014 | 31 March 2013 | 1 April 2013 |
| | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Non-current assets** | | | | | | | |
| Intangible assets | 12 | 1,150 | 1,284 | 581 | 1,148 | 1,281 | 576 |
| Property, plant and equipment | 13 | 218,083 | 218,509 | 219,000 | 218,083 | 218,509 | 219,000 |
| Other Investments | 14 | 1,127 | 1,146 | 1,044 | 0 | 0 | 0 |
| Trade and other receivables | 17 | 9,924 | 9,314 | 8,733 | 9,924 | 9,314 | 8,733 |
| **Total non-current assets** | | 230,284 | 230,253 | 229,358 | 229,155 | 229,104 | 228,309 |
| **Current assets** | | | | | | | |
| Inventories | 16 | 3,159 | 3,088 | 2,837 | 2,896 | 3,088 | 2,837 |
| Trade and other receivables | 17 | 17,926 | 7,332 | 6,390 | 18,114 | 7,318 | 6,289 |
| Other financial assets | 15 | 207 | 256 | 814 | 0 | 0 | 0 |
| Cash and cash equivalents | 24 | 27,821 | 34,322 | 36,887 | 26,165 | 32,906 | 36,346 |
| **Total current assets** | | 49,113 | 44,998 | 46,928 | 47,175 | 43,312 | 45,472 |
| **Current liabilities** | | | | | | | |
| Trade and other payables | 18 | (19,666) | (15,774) | (15,166) | (19,329) | (15,728) | (15,135) |
| Borrowings | 23 | (5,344) | (4,978) | (4,897) | (5,344) | (4,978) | (4,897) |
| Provisions | 21 | (2,945) | (430) | (706) | (2,945) | (430) | (706) |
| Other liabilities | 19 | (1,809) | (245) | (2,048) | (1,809) | (245) | (2,048) |
| **Total current liabilities** | | (29,764) | (21,427) | (22,817) | (29,427) | (21,381) | (22,786) |
| **Total assets less current liabilities** | | **249,633** | **253,824** | **253,469** | **246,903** | **251,035** | **250,995** |
| **Non-current liabilities** | | | | | | | |
| Borrowings | 23 | (142,069) | (146,855) | (151,365) | (142,069) | (146,855) | (151,365) |
| **Total non-current liabilities** | | (142,069) | (146,855) | (151,365) | (142,069) | (146,855) | (151,365) |
| **Total assets employed** | | **107,564** | **106,969** | **102,104** | **104,834** | **104,180** | **99,630** |
| **Financed by** | | | | | | | |
| **Taxpayers' equity** | | | | | | | |
| Public Dividend Capital | | 22,579 | 22,579 | 20,927 | 22,579 | 22,579 | 20,927 |
| Revaluation reserve | | 55,608 | 52,649 | 52,709 | 55,608 | 52,649 | 52,709 |
| Income and expenditure reserve | | 26,699 | 28,952 | 25,994 | 26,647 | 28,952 | 25,994 |
| **Other equity** | | | | | | | |
| Charitable Fund reserves | | 2,678 | 2,789 | 2,474 | 0 | 0 | 0 |
| **Total Taxpayers' and Others equity** | | **107,564** | **106,969** | **102,104** | **104,834** | **104,180** | **99,630** |

The financial statements were approved by the Board of Directors and authorised for issue on their behalf by:

Signed•…… Date: 22nd May 2014

Paula Clark

Chief Executive

## Consolidated Statement of Changes in Equity

for the Year Ended 31 March 2014

| | Group | | | | | Foundation Trust | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ……• Taxpayers•Equity• …… | | | | | ……• Taxpayers•Equity• …… | | | |
| | Public Dividend Capital | Revaluation Reserve | Income and Expenditure Reserve | Charitable Fund Reserves ** | Total | Public Dividend Capital | Revaluation Reserve | Income and Expenditure Reserve | Total |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Taxpayers' and Other Equity at 1 April 2012** | **20,927** | **52,709** | **25,994** | **0** | **99,630** | **20,927** | **52,709** | **25,994** | **99,630** |
| Prior period adjustment * | 0 | 0 | 0 | 2,474 | 2,474 | 0 | 0 | 0 | 0 |
| **Taxpayers' and Other Equity at 1 April 2012 - restated** | **20,927** | **52,709** | **25,994** | **2,474** | **102,104** | **20,927** | **52,709** | **25,994** | **99,630** |
| Surplus / (Deficit) for the year | 0 | 0 | 2,835 | 276 | 3,111 | 0 | 0 | 2,835 | 2,835 |
| Transfers between reserves | 0 | (59) | 59 | 0 | 0 | 0 | (59) | 59 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations - property, plant and equipment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Fair Value gains/(losses) on available -for-sale financial investments | 0 | 0 | 0 | 102 | 102 | 0 | 0 | 0 | 0 |
| Public Dividend Capital Received | 1,652 | 0 | 0 | 0 | 1,652 | 1,652 | 0 | 0 | 1,652 |
| Other reserve movements | 0 | (1) | 1 | 0 | 0 | 0 | (1) | 1 | 0 |
| Consolidation adjustment | 0 | 0 | 63 | (63) | 0 | 0 | 0 | 63 | 63 |
| **Taxpayers' and Other Equity at 31 March 2013** | **22,579** | **52,649** | **28,952** | **2,789** | **106,969** | **22,579** | **52,649** | **28,952** | **104,180** |
| | | | | | | | | | |
| **Taxpayers' and Other Equity at 1 April 2013** | **22,579** | **52,649** | **28,952** | **2,789** | **106,969** | **22,579** | **52,649** | **28,952** | **104,180** |
| Surplus / (Deficit) for the year | 0 | 0 | (2,324) | (113) | (2,437) | 0 | 0 | (2,376) | (2,376) |
| Transfers between reserves | 0 | (44) | 44 | 0 | 0 | 0 | (44) | 44 | 0 |
| Impairments | 0 | (318) | 0 | 0 | (318) | 0 | (318) | 0 | (318) |
| Revaluations - property, plant and equipment | 0 | 3,321 | 0 | 0 | 3,321 | 0 | 3,321 | 0 | 3321 |
| Fair Value gains/(losses) on available -for-sale financial investments | 0 | 0 | 0 | 29 | 29 | 0 | 0 | 0 | 0 |
| Public Dividend Capital Received | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other reserve movements | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Consolidation adjustment | 0 | 0 | 27 | (27) | 0 | 0 | 0 | 27 | 27 |
| **Taxpayers' and Other Equity at 31 March 2014** | **22,579** | **55,608** | **26,699** | **2,678** | **107,564** | **22,579** | **55,608** | **26,647** | **104,834** |

* The prior period adjustment represents the application of IAS27 Consolidated and Separate Financial Statements from 2013/14 which incorporate Dudley Group NHS Charity into the Trust Accounts.

** Charitable Fund Reserves comprise Unrestricted Funds £518,000 (2012/13 £367,000; 2011/12 £328,000 ); Restricted Funds £2,168,000 (2012/13 £2,375,000; 2011/12 £2,103,000)and Endowment Funds £nil (2012/13 £47,000; 2011/12 £43,000). Unrestricted Funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the Charity objectives, Restricted Funds have restrictions imposed by the Donor, and Endowment Funds are held as capital by the Charity to generate income for charitable purposes but cannot themselves be spent.

## Consolidated Statement of Cash Flows
for the Year Ended 31 March 2014

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | 31 March 2014 | 31 March 2013 | 31 March 2014 | 31 March 2013 |
| **Cash flows from operating activities** | £'000 | £'000 | £'000 | £'000 |
| Operating surplus/(deficit) from continuing operations | 10,402 | 15,379 | 10,530 | 15,229 |
| **Operating surplus/(deficit)** | **10,402** | **15,379** | **10,530** | **15,229** |
| **Non-cash income and expense:** | | | | |
| Depreciation and amortisation | 9,183 | 8,859 | 9,183 | 8,859 |
| (Gain)/Loss on Disposal | 12 | 2 | 12 | 2 |
| Non-cash donations/grants credited to income | (198) | (98) | (198) | (98) |
| (Increase)/Decrease in Trade and Other Receivables | (10,525) | (1,960) | (10,729) | (1,960) |
| (Increase)/Decrease in Inventories | (71) | (251) | 192 | (251) |
| Increase/(Decrease) in Trade and Other Payables | 3,348 | 1,344 | 3,109 | 1,344 |
| Increase/(Decrease) in Other Liabilities | 1,564 | (1,803) | 1,564 | (1,803) |
| Increase/(Decrease) in Provisions | 2,515 | (276) | 2,515 | (276) |
| Tax (paid) / received | 0 | 0 | 0 | 0 |
| NHS Charitable funds - net cash flows from investing activities | 188 | 725 | 0 | 0 |
| **NET CASH GENERATED FROM/(USED IN) OPERATIONS** | 16,418 | 21,921 | 16,178 | 21,046 |
| **Cash flows from investing activities** | | | | |
| Interest received | 142 | 480 | 142 | 480 |
| Purchase of financial assets | (389,000) | (258,000) | (389,000) | (258,000) |
| Sales of financial assets | 389,000 | 258,000 | 389,000 | 258,000 |
| Purchase of intangible assets | (175) | (967) | (175) | (967) |
| Sales of intangible assets | 0 | 0 | 0 | 0 |
| Purchase of Property, Plant and Equipment | (4,231) | (8,309) | (4,231) | (8,309) |
| Sales of Property, Plant and Equipment | 23 | 8 | 23 | 8 |
| **Net cash generated from/(used in) investing activities** | (4,241) | (8,788) | (4,241) | (8,788) |
| **Cash flows from financing activities** | | | | |
| Public dividend capital received | 0 | 1,652 | 0 | 1,652 |
| Capital element of PFI Obligations | (4,980) | (4,889) | (4,980) | (4,889) |
| Interest element of PFI Obligations | (10,759) | (10,472) | (10,759) | (10,472) |
| PDC Dividend paid | (2,939) | (1,989) | (2,939) | (1,989) |
| **Net cash generated from/(used in) financing activities** | (18,678) | (15,698) | (18,678) | (15,698) |
| **Increase/(decrease) in cash and cash equivalents** | **(6,501)** | **(2,565)** | **(6,741)** | **(3,440)** |
| **Cash and Cash equivalents at 1 April** | 34,322 | 36,887 | 32,906 | 36,346 |
| **Cash and Cash equivalents at 31 March** | **27,821** | **34,322** | **26,165** | **32,906** |

## 1. Accounting Policies and Other Information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2013/14 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

**Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

### 1.1 Consolidation

The group financial statements consolidate the financial statements of the Trust and all of its subsidiary undertakings made up to 31st March 2014. The income, expenses, assets, liabilities, equity and reserves of the subsidiaries have been consolidated into the Trust's financial statements and group financial statements have been prepared.

**Subsidiaries**

Subsidiary entities are those which the Foundation Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year. Where subsidiaries' accounting policies are not aligned with those of the Foundation Trust then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

**NHS Charitable Fund**

The NHS Foundation Trust is the corporate trustee to Dudley Group NHS Charity. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients and its staff.

Prior to 2013/14, the FT ARM permitted the NHS Foundation Trust not to consolidate the charitable fund. From 2013/14, the Foundation Trust has consolidated the charitable fund and has applied this as a change in accounting policy.

The charitable fund's statutory accounts are prepared to 31st March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances gains and losses.

### 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Income is recognised in the period in which services are provided, for patients whose treatment straddles the year end this means income is apportioned across financial years on the basis of length of stay. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

### 1.3 Expenditure on Employee Benefits

**Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be•determined•at•the•reporting•date•by•a•formal•actuarial•valuation,•the•FReM•requires•that•"the•period•between•formal valuations•shall•be•four•years,•with•approximate•assessments•in•intervening•years".•An•outline•of•these•follows:

**a) Accounting valuation**

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

**b) Full actual (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

**c) Scheme provisions**

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The•Scheme•is•a•"final•salary"•scheme.•Annual•pensions•are•normally•based•on•1/80th•for•the•1995•section•and•of•the•best•of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up•to•a•maximum•amount•permitted•under•HMRC•rules.•This•new•provision•is•known•as•"pension•commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling•their•duties•effectively•through•illness•or•infirmity.•A•death•gratuity•of•twice•final•year's•pensionable•pay•for•death•in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members•can•purchase•additional•service•in•the•NHS•Scheme•and•contribute•to•money•purchase•AVC's•run•by•the•Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

## 1.4 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## 1.5 Property, Plant and Equipment

**Recognition**

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and;
    - has an individual cost of at least £5,000; or
    - the items form a group of assets which collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under the same managerial control; or
    - form part of the initial equipping and setting up cost of a new building or refurbishment of a ward or unit, and the items collectively have a cost of at least £5,000.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

**Measurement**

Valuation

All Property, Plant and Equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

For property assets the frequency of revaluations will be at least every five years, in line with Monitor's view.

The fair value of land and buildings are determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of modern equivalent cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets under construction are valued at cost and are subsequently revalued by professional valuers when they are brought into use if factors indicate that the value of the asset differs materially from its carrying value. Otherwise, the asset should only be revalued on the next occasion when all assets of that class are revalued.

Subsequent expenditure

Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the income statement in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits expected to be obtained from use of an item of property, plant and equipment and where the cost of the item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates its non-current assets on a straight line basis over the expected life of the assets after allowing for the residual value. Useful lives are determined on a case by case basis. The typical lives for the following assets are:

| Asset Category | Useful Life (years) |
|---|---|
| Buildings | As per valuer's estimate |
| Engineering Plant & Equipment | 5 - 15 |
| Medical Equipment | 5 - 15 |
| Transport Equipment | 7 |
| Information Technology | 5 - 8 |
| Furniture & Fittings | 5 - 10 |

Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon reclassification. Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

**De-recognition**

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;

  the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is derecognised when scrapping or demolition occurs.

**Donated, Government Grant and other grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

**Private Finance Initiative (PFI) transactions**

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual issued by Monitor, are accounted for as 'on statement of Financial Position' by the Trust. The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a lifecycle element, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The lifecycle element is established on the lifecycle plan contained within the financial model. Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively. Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

## 1.6 Intangible Assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

**Software**

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the license and their useful lives.

**Measurement**

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

**Amortisation and impairment**

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

| Asset Category | Useful Life (years) |
|---|---|
| Software Licences | 2 - 10 |

### 1.7 Government Grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups or NHS Trusts for the provision of services. Grants from the Department of Health, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is credited to income at the same time, unless the grant has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grant, in which case, the grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

### 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

### 1.9 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

### 1.10 Financial Instruments and Financial Liabilities

**Recognition**

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods•or•services),•which•are•entered•into•in•accordance•with•the•Trust's•normal•purchase,•sale•or•usage•requirements,•are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. Regular way purchases or sales are recognised and de-recognised, as applicable, using the settlement date. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

**De-recognition**

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

**Classification and Measurement**

Financial•assets•are•categorised•as•'Fair•Value•through•Income•and•Expenditure'•or•Loans•and•Receivables.•Financial•liabilities are•classified•as•'Fair•value•through•Income•and•Expenditure'•or•as•'Other•Financial•Liabilities'.

**Financial•assets•and•financial•liabilities•at•'Fair•Value•through•Income•and•Expenditure'**

Financial•assets•and•financial•liabilities•at•'fair•value•through•income•and•expenditure'•are•financial•assets•or•financial•liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are•embedded•in•other•contracts•but•which•are•not•'closelyrelated'•to•those•contracts•are•separatedout•from•those•contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

**Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.•They•are•included•in•current•assets.•The•Trust's•loans•and•receivables•comprise:•current•investments,•cash•and•cash equivalents,•NHS•receivables,•accrued•income•and•'other•receivables'.•Loans•and•receivables•are•recognised•initially•at•fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

**Available for sale financial assets**

Available for sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available for sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available for sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in ' Finance Costs' in the Statement of Comprehensive Income.

**Other Financial liabilities**

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

**Impairment of financial assets**

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

## 1.11 Leases

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

**Operating leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

**Leases of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

## 1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's long term discount rate of 2.2% (2012/13 2.2%) in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.8% (2012/13: 2.35%) in real terms.

**Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 17, but is not recognised in the Trust accounts.

**Non-clinical risk pooling**

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

## 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## 1.14 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services and National Loans Fund deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1st April 2013, and (iv) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'preaudit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

## 1.15 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

## 1.16 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

### 1.17 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 30 to the accounts in accordance with the•requirements•of•HM•Treasury's *Financial Reporting Manual* .

### 1.18 Corporation Tax

The Trust is a Health Service Body within the meaning of S519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to remove the exemption in relation to specified activities of a Foundation trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non-public sector source.

The tax expense on the Statement of Comprehensive Income comprises current and deferred tax due to the Trust's trading commercial subsidiaries. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the Statement of Financial Position date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the Statement of Financial Position liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on taxable temporary differences arising on the initial recognition of goodwill or for temporary differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred asset is realised or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

### 1.19 Critical accounting judgements and key sources of estimation and uncertainty

In•the•application•of•the•Trust's•accounting•policies,•management•is•required•to•make•judgements,•estimates•and•assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process•of•applying•the•Trust's•accounting•policies•and•that•have•the•most•significant•effect•on•the•amounts•recognised•in•the financial statements.

- Accounting for PFI
- Application of IFRIC 4 Determining whether an Arrangement contains a Lease
- Application of IFRIC12 Service Concession Arrangements

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

- Valuation of Non- Current Assets
- Provisions
- Settlement of Over Performance with Healthcare Purchasers

### 1.20 Accounting Standards that have been issued but have not yet been adopted

The following standards and interpretations have been adopted by the European Union. These are not expected to impact upon the Trust financial statements.

- IFRS 9 Financial Instruments (Uncertain)
- IFRS 10 Consolidated Financial Statements (effective 2014/15)
- IFRS 11 Joint Arrangements (effective 2014/15)
- IFRS 12 Disclosure of interests in other Entities (effective 2014/15)
- IFRS 13 Fair Value Measurement (effective 2013/14 but not adopted by HM Treasury)
- IAS 27 Separate Financial Statements (effective 2014/15)
- IAS 28 Associates and Joint Ventures (effective 2014/15)
- IAS 32 Financial Instruments (effective 2014/15)

### 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

### 1.22 Transfers of functions to/from other NHS/Local Government Bodies

For functions that have been transferred to the Trust from another NHS Body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to their fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation/Amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.
For functions that the Trust has transferred to another NHS/Local Government Body, the assets and liabilities are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Foundation Trust's policies are applied after initial recognition and are adjusted directly in taxpayers' equity. There have not been any transfers during 2013/14.

## 2 Segmental Analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating Segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker as defined by IFRS 8) as follows:

**Healthcare Services**

The Board as 'Chief Operating Decision Maker' has determined that Healthcare Services operate in a single operating segment, which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The Trust has identified segments in line with the thresholds in IFRS 8, applying the requirement of the ARM to consider expenditure instead of income as income is not analysed between segments in our monthly finance report to the Trust Board. Following a significance test of the expenditure segments the Trust found that there were six significant operating segments subject to the external reporting requirements of IFRS 8. Applying the aggregation criteria to the Trust's six significant operating segments found that in all cases the segments had similar economic characteristics, the nature of the services are similar, the nature of the production process are similar, the type or class of customer for the services are similar, the methods used to provide the services are similar and the nature of the regulatory environment is similar.
The Trust's significant operating segments satisfy all of the criteria listed for an aggregation to be deemed appropriate. The six significant operating segments of the Trust are all active in the same business – the provision of healthcare, and all operate within the same economic environment – the United Kingdom. Given that the purpose of disclosing segmental information is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments, reporting a single segment of "Healthcare" would be consistent with the core principle of IFRS 8, as it would show the singular nature of both the business activity and the economic environment of the Trust.

Income from activities (medical treatment of patients) is analysed by customer type in note 3 to the accounts on page 17. Other operating income is analysed in note 4 to the accounts on page 18 and materially consists of revenues from healthcare, research and development, medical education, and the provision of services to other NHS bodies. Total income by individual customers within the whole of HM Government and considered material, is disclosed in the related parties transactions note 27 to the accounts on page 35.

**Dudley Clinical Services Limited**

The company is a wholly owned subsidiary of the Trust and provides an Outpatient Dispensing service. As a trading company, subject to an additional legal and regulatory regime (over and above that of the Trust), this activity is considered to be a separate business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of the company's revenue is inter segment trading with the Trust which is eliminated upon the consolidation of these group financial statements. The quarterly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table below.

**Dudley Group NHS Charity**

The Trust Board are corporate trustees for Dudley Group NHS Charity. Following Treasury's agreement to apply IAS 27 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity, it effectively has the power to exercise control so as to obtain economic benefits. The Charity is therefore treated as a group entity and is consolidated. As this is a change in the accounting policy, the prior year has been restated. The consolidation is for reporting purposes only and does not affect the charities' legal and regulatory independence and day to day operations. Some of the charity's expenditure is inter segment trading with the Trust which is eliminated upon the consolidation of these group financial statements. The quarterly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table below.

| Year ended 31 March 2014 | Healthcare Services £000 | Dudley Clinical Services Ltd £000 | Dudley Group NHS Charity £000 | Inter Group Eliminations £000 | Total £000 |
|---|---|---|---|---|---|
| Total segment revenue | 316,456 | 2,038 | 665 | (2,291) | 316,868 |
| Total segment expenditure | (305,926) | (1,973) | (858) | 2,291 | (306,466) |
| **Operating Surplus** | 10,530 | 65 | (193) | 0 | 10,402 |
| Net Financing | (10,625) | 0 | 53 | 0 | (10,572) |
| PDC Dividends Payable | (2,254) | 0 | 0 | 0 | (2,254) |
| Taxation | 0 | (13) | 0 | 0 | (13) |
| **Retained surplus - before non-recurring items** | (2,349) | 52 | (140) | 0 | (2,437) |
| Non-recurring items | 0 | 0 | 0 | 0 | 0 |
| **Retained surplus/(deficit)** | (2,349) | 52 | (140) | 0 | (2,437) |
| Reportable Segment assets | 276,330 | 610 | 2,763 | 0 | 279,703 |
| Eliminations | 0 | 0 | 0 | (306) | (306) |
| **Total assets** | 276,330 | 610 | 2,763 | (306) | 279,397 |
| Reportable Segment liabilities | (171,496) | (558) | (85) | 0 | (172,139) |
| Eliminations | 0 | 0 | 0 | 306 | 306 |
| **Total liabilities** | (171,496) | (558) | (85) | 306 | (171,833) |
| **Net assets/liabilities** | 104,834 | 52 | 2,678 | 0 | 107,564 |

| Year ended 31 March 2013 | Healthcare Services £000 | Dudley Clinical Services Ltd £000 | Dudley Group NHS Charity £000 | Inter Group Eliminations £000 | Total £000 |
|---|---|---|---|---|---|
| Total segment revenue | 298,441 | 0 | 729 | (63) | 299,107 |
| Total segment expenditure | (283,212) | 0 | (579) | 63 | (283,728) |
| **Operating Surplus** | 15,229 | 0 | 150 | 0 | 15,379 |
| Net Financing | (9,987) | 0 | 63 | 0 | (9,924) |
| PDC Dividends Payable | (2,344) | 0 | 0 | 0 | (2,344) |
| Taxation | 0 | 0 | 0 | 0 | 0 |
| **Retained surplus - before non-recurring items** | 2,898 | 0 | 213 | 0 | 3,111 |
| Non-recurring items | 0 | 0 | 0 | 0 | 0 |
| **Retained surplus/(deficit)** | 2,898 | 0 | 213 | 0 | 3,111 |
| Reportable Segment assets | 272,416 | 0 | 2,835 | 0 | 275,251 |
| Eliminations | 0 | 0 | 0 | 0 | 0 |
| **Total assets** | 272,416 | 0 | 2,835 | 0 | 275,251 |
| Reportable Segment liabilities | (168,236) | 0 | (46) | 0 | (168,282) |
| Eliminations | 0 | 0 | 0 | 0 | 0 |
| **Total liabilities** | (168,236) | 0 | (46) | 0 | (168,282) |
| **Net assets/liabilities** | 104,180 | 0 | 2,789 | 0 | 106,969 |

**3 Revenue from Activities**

| **By Commissioner** | Year Ended 31 March 2014 £'000 | Year Ended 31 March 2013 £'000 |
|---|---|---|
| NHS Foundation Trusts | 254 | 0 |
| NHS Trusts | 1,219 | 37 |
| Strategic Health Authorities * | 0 | 146 |
| CCG's and NHS England * | 291,706 | 0 |
| Primary Care Trusts * | 0 | 279,982 |
| Local Authorities | 2,265 | 184 |
| NHS Other | 146 | 78 |
| Non NHS: Private patients | 75 | 46 |
| Non-NHS: Overseas patients (chargeable to patient) | 28 | 62 |
| NHS injury scheme (was RTA) | 1,105 | 1,451 |
| Non NHS: Other | 147 | 5 |
| **Total income from activities** | **296,945** | **281,991** |

* In the reorganisation of the NHS at the end of March 2013, Strategic Health Authorities and PCT's ceased to exist and were replaced by NHS England and CCG's.

| **By Activity** | Year Ended 31 March 2014 £'000 | Year Ended 31 March 2013 £'000 |
|---|---|---|
| Acute Trusts | | |
| Elective | 48,450 | 49,836 |
| Non Elective | 91,920 | 90,735 |
| Outpatient | 46,003 | 47,754 |
| A&E | 10,364 | 10,464 |
| Other NHS Clinical Income | 70,119 | 55,938 |
| Community Trusts | | |
| Income from PCT's * | 0 | 21,647 |
| Income from CCG's and NHS England * | 20,980 | 0 |
| Income not from CCG's NHS England or PCT's | 872 | 183 |
| **Income at Tariff** | **288,708** | **276,557** |
| Private Patients | 75 | 46 |
| Other clinical income | 8,162 | 5,388 |
| **Total income from activities** | **296,945** | **281,991** |

* In the reorganisation of the NHS at the end of March 2013, Strategic Health Authorities and PCT's ceased to exist and were replaced by NHS England and CCG's.

3.3 Income from Commissioner Requested Services and Non-Commissioner Requested Services

| | Year Ended 31 March 2014 £'000 | Year Ended 31 March 2013 £'000 |
|---|---|---|
| Income from Commissioner Requested Services | 266,856 | 254,727 |
| Income from Non Commissioner Requested Services | 21,852 | 21,830 |
| Income from Activities | 288,708 | 276,557 |
| Other Operating Income | 8,237 | 5,434 |
| Total Income | 296,945 | 281,991 |

As an NHS Foundation Trust, the majority of income in respect of patient care is received under Payment By Results (PBR), which is intended to reimburse Trusts based on the actual activity delivered using the National Tariff of procedure prices.

The Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide (Commissioner Requested Services). All of the income from activities before private patient income shown above is derived from the provision of those services.

Other NHS Clinical Income comprises the following services pathology; rehabilitation; community support services; radiology; renal services; patient transport services; and high cost drugs / devices / appliances.

### 3.4 Private Patient Income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statement disclosures that were provided previously are now no longer required.

### 4 Other Operating Revenue

| | Year ended 31 March 2014 £'000 | Restated * Year ended 31 March 2013 £'000 |
|---|---|---|
| Research and development | 681 | 751 |
| Education and training | 8,955 | 8,074 |
| Charitable and other contributions to expenditure | 198 | 108 |
| Non-patient care services to other bodies | 4,115 | 1,855 |
| Profit on disposal of intangible fixed assets | 0 | 0 |
| Profit on disposal of land and buildings | 0 | 0 |
| Profit on disposal of other tangible fixed assets | 22 | 4 |
| Income in respect of Staff Costs | 1,140 | 1,784 |
| NHS Charitable Funds incoming resources excluding investment income | 665 | 729 |
| Other | 4,147 | 3,811 |
| **Total other operating income** | **19,923** | **17,116** |

Other income is derived from Staff Recharges £509,000 (2012/13 £1,784,000); Pharmacy Drugs £1,247,000 (2012/13 £925,000); settlement of an insurance claim £365,000 (2012/13 £ 214,000) and numerous other small amounts.

* The restatement represents the application of IAS27 Consolidated and Separate Financial Statements from 2013/14 which incorporate Dudley Group NHS Charity into the Trust Accounts.

## 5 Operating Expenditure

| 5.1 Operating Expenses | Year ended 31 March 2014 £'000 | Restated * Year ended 31 March 2013 £'000 |
|---|---|---|
| Services from NHS Foundation Trusts | 139 | 148 |
| Services from NHS Trusts | 150 | 85 |
| Services from CCG's and NHS England | 11 | 0 |
| Services from other NHS Bodies | 59 | 103 |
| Purchase of healthcare from non NHS bodies | 771 | 72 |
| Employee Expenses - Executive directors | 911 | 802 |
| Employee Expenses - Non-executive directors | 129 | 129 |
| Employee Expenses - Staff | 185,272 | 173,416 |
| NHS Charitable funds - employee expenses | 37 | 0 |
| Drug costs (non inventory drugs only) | 26,838 | 25,250 |
| Drugs Inventories consumed | 1,849 | 1,733 |
| Supplies and services - clinical (excluding drug costs) | 24,118 | 21,954 |
| Supplies and services - general | 1,997 | 1,957 |
| Establishment | 3,524 | 1,764 |
| Research and development | 0 | 0 |
| Business Travel | 774 | 720 |
| Transport | 2,502 | 2,536 |
| Premises | 4,596 | 3,465 |
| Increase / (decrease) in bad debt provision | (1) | 71 |
| Rentals under operating leases - minimum lease receipts | 65 | 130 |
| Depreciation on property, plant and equipment | 8,814 | 8,597 |
| Amortisation on intangible assets | 369 | 262 |
| NHS Charitable funds - Depreciation and amortisation on charitable fund assets | 1 | 2 |
| Audit fees | | |
| Audit services | 90 | 90 |
| Non-audit fees ** | 9 | 6 |
| Clinical negligence | 8,369 | 6,460 |
| Loss on disposal of intangible fixed assets | 23 | 2 |
| Loss on disposal of land and buildings | 11 | 0 |
| Loss on disposal of other property, plant and equipment | 0 | 4 |
| Loss on disposal of assets held for sale | 0 | 0 |
| Consultancy costs | 967 | 347 |
| Other | 33,285 | 33,115 |
| NHS Charitable funds Other resources expended | 787 | 508 |
| **TOTAL** | **306,466** | **283,728** |

Other•expenditure•includes•£31,779,000•(2012/13•£27,710,000)•in•relation•to•payments•to•the•Trust's•PFI•Partner•for•services provided and numerous other small amounts.

* Restated - following the application of IAS27 Consolidated and Separate Financial Statements from 2013/14 which incorporate Dudley Group NHS Charity into the Trust Accounts and therefore 2012/13 has been restated to reflect this.

** Non-audit fees include the auditing of accounts of Dudley Group NHS Charity and the subsidiary Dudley Clinical Services Limited.

5.2 The Late Payment of Commercial Debts (interest) Act 1998

During the year 2013/14 (2012/13 £ nil) the Trust was not charged interest for the late payment of commercial debts.

**6 Operating Leases**

| 6.1 Payments recognised as an expense | Year ended 31 March 2014 £'000 | Year ended 31 March 2013 £'000 |
|---|---|---|
| Minimum lease payments | 65 | 130 |
| | 65 | 130 |
| Total future minimum lease payments | | |
| Payable: | | |
| Not more than one year | 64 | 61 |
| Between one and five years | 134 | 186 |
| After 5 years | 0 | 0 |
| Total | 198 | 247 |

**7 Directors' Remuneration and other benefits**

| | Year ended 31 March 2014 £'000 | Year ended 31 March 2013 £'000 |
|---|---|---|
| Aggregate Remuneration | 899 | 882 |
| Employer Contributions to a pension scheme | 108 | 103 |
| | 1,007 | 985 |

## 8 Employee Expenses and Numbers

8.1 Employee Costs

| | Year Ended 31 March 2014 | | | | Year Ended 31 March 2013 | | | |
|---|---|---|---|---|---|---|---|---|
| | Total | Permanent | Other Government | External to Government | Total | Permanent | Other Government | External to Government |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Salaries and wages | 148,750 | 148,750 | 0 | 148,750 | 142,147 | 112,980 | 29,167 | 112,980 |
| Social security costs | 11,457 | 11,457 | 11,457 | 0 | 11,135 | 10,437 | 698 | 10,437 |
| Pension costs - defined contribution plans | | | | | | | | |
| Employer's contributions to NHS Pensions | 17,073 | 17,073 | 17,073 | 0 | 15,760 | 15,370 | 390 | 15,370 |
| Agency/contract staff | 8,903 | 0 | 0 | 8,903 | 5,176 | 0 | 0 | 5,176 |
| NHS Charitable fund staff | 37 | 37 | 0 | 37 | 0 | 0 | 0 | 0 |
| Total | 186,220 | 177,317 | 28,530 | 157,690 | 174,218 | 138,787 | 30,255 | 143,963 |

8.2 Average Number of Persons Employed

| | Year Ended 31 March 2014 | | | Year Ended 31 March 2013 | | |
|---|---|---|---|---|---|---|
| | Total | Permanent | Other | Total | Permanent | Other |
| Medical and dental | 516 | 485 | 31 | 463 | 427 | 36 |
| Administration and estates | 802 | 802 | 0 | 762 | 697 | 65 |
| Healthcare assistants and other support staff | 1,076 | 1,076 | 0 | 1,016 | 1,016 | 0 |
| Nursing, midwifery and health visiting staff | 1,425 | 1,425 | 0 | 1,399 | 1,148 | 251 |
| Nursing, midwifery and health visiting learners | 9 | 9 | 0 | 10 | 10 | 0 |
| Scientific, therapeutic and technical staff | 273 | 273 | 0 | 261 | 254 | 7 |
| Agency and contract staff | 75 | 0 | 75 | 37 | 0 | 37 |
| Bank staff | 324 | 0 | 324 | 323 | 0 | 323 |
| Total | 4,500 | 4,070 | 430 | 4,271 | 3,552 | 719 |

8.3 Employee Benefits

Employees benefits include payment of salaries/wages and pension contributions. There were no other employee benefits paid in 2013/14 (2012/13 £ nil).

8.4 Retirements due to Ill-health

During the period 2013/14 there were 5 (in 2012/13 there were 8) early retirements from the Trust on the grounds of ill-health.
The estimated additional pension liabilities of these ill-health retirements will be £373,657 (2012/13 £712,163).
The cost of these ill-health retirements will be borne by the Pensions Scheme, and therefore there is no liability or provision in the Trust accounts.

8.5 Sickness Absence

The detail of staff sickness / absence from work for the year are:

| | 2013/14 | 2012/13 |
|---|---|---|
| Absence Full Time Equivalent (FTE) | 54,199 | 59,072 |
| Available Employee Time (FTE) for the year | 1,483,831 | 1,423,819 |
| Sickness Rate | 3.65% | 4.15% |

8.6 Other Compensation Schemes and Exit Packages

The Trust's expenditure includes local MARS scheme payments to 6 members of staff totalling £94,000 (2012/13 14 staff £247,000); contractual payments in lieu of notice to 6 members of staff totalling £19,000 (2012/13 no payments); and an exit payment following an Employment Tribunal to 1 member of staff totalling £13,000 (2012/13 no payments) but does not include any payments relating to redundancy packages (2012/3 no payments).

| Exit Package Cost Band (including any special payment element) | Number of compulsory redundancies | Cost of compulsory redundancies | Number of other departures agreed | Cost of other departures | Total Number of Exit Packages | Total Cost of Exit Packages | Number of Departures where special payments have been made | Cost of special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| | Number | £'000 | Number | £'000 | Number | £'000 | Number | £'000 |
| < £10,000 | 0 | 0 | 8 | 34 | 8 | 34 | 0 | 0 |
| £10,000 - £25,000 | 0 | 0 | 4 | 60 | 4 | 60 | 0 | 0 |
| £25,001 - £50,000 | 0 | 0 | 1 | 32 | 1 | 32 | 0 | 0 |
| £50,001 - £100,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 0 | 0 | 13 | 126 | 13 | 126 | 0 | 0 |

**9 Finance Revenue**

| | | Restated * |
|---|---|---|
| | Year ended | Year ended |
| | 31 March | 31 March |
| | 2014 | 2013 |
| | £'000 | £'000 |
| Interest on bank accounts | 134 | 485 |
| Interest on available for sale financial assets | 0 | 0 |
| Interest on held-to-maturity financial assets | 0 | 0 |
| NHS Charitable funds: investment income | 53 | 63 |
| | 187 | 548 |

* Restated - following the application of IAS27 Consolidated and Separate Financial Statements from 2013/14 which incorporate Dudley Group NHS Charity into the Trust Accounts and therefore 2012/13 has been restated to reflect this.

| **10 Finance Costs - Interest Expense** | Year ended 31 March 2014 £'000 | Year ended 31 March 2013 £'000 |
|---|---|---|
| Finance Costs in PFI obligations | | |
| Main Finance Costs | 5,927 | 6,106 |
| Contingent Finance Costs | 4,832 | 4,366 |
| | 10,759 | 10,472 |

**11 Taxation recognised in Statement of Comprehensive Income**

The activities of the subsidiary company Dudley Clinical Services Limited have given rise to a corporation tax liability recognised in the Statement of Comprehensive Income of £65,000 (2012/13 £nil). The activities of the Trust do not incur corporation tax.

| **UK Corporation Tax Expense** | Year ended 31 March 2014 £'000 | Year ended 31 March 2013 £'000 |
|---|---|---|
| **Current tax expense** | | |
| Current year | 13 | 0 |
| Adjustments in respect of prior years | 0 | 0 |
| **Total income tax expense in Statement of Comprehensive Income** | 13 | 0 |

| **Reconciliation of effective tax rate** | Year ended 31 March 2014 £'000 | Year ended 31 March 2013 £'000 |
|---|---|---|
| Effective tax charge percentage | 20.00% | 0 |
| Tax if effective tax rate charged on surpluses before tax | (485) | 0 |
| **Effect of:** | | |
| Surpluses not subject to tax | 498 | 0 |
| **Total income tax charge for the year** | 13 | 0 |

The subsidiary company falls under the 'small profits' rate for corporation tax and tax rates are not planned to change from 20% for future financial years.

## 12 Intangible Assets

| 2013/14 | Group Computer Software | Total |
|---|---|---|
| | £'000 | £'000 |
| Gross Cost as at 1 April 2013 | 3,270 | 3,270 |
| Prior period Adjustments | 0 | 0 |
| Gross Cost as at 1 April 2013 restated | 3,270 | 3,270 |
| Transfers by Absorption | 0 | 0 |
| Additions Purchased | 175 | 175 |
| Additions Donated | 61 | 61 |
| Disposals | 0 | 0 |
| Gross Cost as at 31 March 2014 | 3,506 | 3,506 |
| | | |
| Amortisation as at 1 April 2013 | 1,986 | 1,986 |
| Prior period Adjustments | 0 | 0 |
| Amortisation as at 1 April 2013 restated | 1,986 | 1,986 |
| Transfers by Absorption | 0 | 0 |
| Provided during the Year | 370 | 370 |
| Disposals | 0 | 0 |
| Amortisation as at 31 March 2014 | 2,356 | 2,356 |
| | | |
| Net Book Value | | |
| Purchased at 1 April 2013 | 1,281 | 1,281 |
| Donated at 1 April 2013 | 3 | 3 |
| Total at 1 April 2013 | 1,284 | 1,284 |
| | | |
| Net Book Value | | |
| Purchased at 31 March 2014 | 1,095 | 1,095 |
| Donated at 31 March 2014 | 55 | 55 |
| Total at 31 March 2014 | 1,150 | 1,150 |

| 2012/13 | Group Computer Software | Total |
|---|---|---|
| | £'000 | £'000 |
| Gross Cost as at 1 April 2012 | 1,862 | 1,862 |
| Prior period Adjustments * | 5 | 5 |
| Gross Cost as at 1 April 2012 restated | 1,867 | 1,867 |
| Transfers by Absorption ** | 564 | 564 |
| Additions Purchased | 854 | 854 |
| Additions Donated | 0 | 0 |
| Disposals | (15) | (15) |
| Gross Cost as at 31 March 2013 | 3,270 | 3,270 |
| | | |
| Amortisation as at 1 April 2012 | 1,286 | 1,286 |
| Prior period Adjustments | 0 | 0 |
| Amortisation as at 1 April 2012 restated | 1,286 | 1,286 |
| Transfers by Absorption ** | 451 | 451 |
| Provided during the Year | 264 | 264 |
| Disposals | (15) | (15) |
| Amortisation as at 31 March 2013 | 1,986 | 1,986 |
| | | |
| Net Book Value | | |
| Purchased at 1 April 2012 | 581 | 581 |
| Donated at 1 April 2012 | 0 | 0 |
| Total at 1 April 2012 | 581 | 581 |
| | | |
| Net Book Value | | |
| Purchased at 31 March 2013 | 1,284 | 1,284 |
| Donated at 31 March 2013 | 0 | 0 |
| Total at 31 March 2013 | 1,284 | 1,284 |

A separate schedule for the Trust intangible assets has not been produced as the NHS Charity intangible assets represent just £2,000 (31 March 2013 £3,000) of the net book value held by the Group and the subsidiary does not have any intangible assets.

* The prior period adjustment represents the application of IAS27 Consolidated and Separate Financial Statements from 2013/14 which incorporate Dudley Group NHS Charity into the Trust Accounts.

** The Trust purchased an IT Data Centre from Dudley PCT on 1st January 2013. This involved the purchase of both intangible (£113k) and tangible (£1,498k) assets totalling £1,611k. This transaction has been treated as a 'transfer by absorption' for accounting purposes. The Trust transferred staff by TUPE arrangements from Dudley PCT and also inherited a number of IT contracts for both the provision of IT services to other NHS bodies and maintenance contracts in relation to the infrastructure to provide these services. At the point of transfer the financial position of this service was breakeven. The Trust received an allocation of PDC of £1,611k to purchase the assets. This was therefore treated as a circular flow of funds within the NHS.

## 13 Tangible Assets

13.1 2013/14

| | Group | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Total** | **Land** | **Buildings excluding dwellings** | **Dwellings** | **Assets under Construction & POA** | **Plant & Machinery** | **Transport Equipment** | **Information Technology** | **Furniture & Fittings** |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Gross Cost at 1 April 2013 | 250,817 | 24,600 | 185,007 | 0 | 50 | 33,371 | 129 | 7,054 | 606 |
| Transfers by Absorption | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions - purchased | 4,723 | 0 | 1,607 | 0 | 117 | 2,339 | 0 | 595 | 65 |
| Additions - leased | 560 | 0 | 0 | 0 | 0 | 560 | 0 | 0 | 0 |
| Additions - donated | 137 | 0 | 0 | 0 | 0 | 131 | 0 | 6 | 0 |
| Impairments charged to the revaluation reserve | (318) | 0 | (318) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 3 | 0 | (9) | 0 | 0 | 6 | 0 |
| Revaluations | (6,350) | 0 | (6,350) | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (2,247) | 0 | (3) | 0 | 0 | (2,208) | 0 | (36) | 0 |
| Gross Cost at 31 March 2014 | 247,322 | 24,600 | 179,946 | 0 | 158 | 34,193 | 129 | 7,625 | 671 |
| Accumulated depreciation at 1 April 2013 | 32,308 | 0 | 4,800 | 0 | 0 | 23,640 | 49 | 3,324 | 495 |
| Transfers by Absorption | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Provided during the year | 8,814 | 0 | 4,871 | 0 | 0 | 2,946 | 17 | 952 | 28 |
| Revaluation surpluses | (9,671) | 0 | (9,671) | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (2,212) | 0 | 0 | 0 | 0 | (2,176) | 0 | (36) | 0 |
| Accumulated depreciation at 31 March 2014 | 29,239 | 0 | 0 | 0 | 0 | 24,410 | 66 | 4,240 | 523 |
| **Net book value** | | | | | | | | | |
| NBV - Owned at 1 April 2013 | 50,684 | 24,600 | 16,682 | 0 | 50 | 5,444 | 80 | 3,726 | 102 |
| NBV - PFI at 1 April 2013 | 167,615 | 0 | 163,520 | 0 | 0 | 4,095 | 0 | 0 | 0 |
| NBV - Donated at 1 April 2013 | 210 | 0 | 5 | 0 | 0 | 192 | 0 | 4 | 9 |
| **NBV total at 1 April 2013** | 218,509 | 24,600 | 180,207 | 0 | 50 | 9,731 | 80 | 3,730 | 111 |
| NBV - Owned at 31 March 2014 | 50,849 | 24,600 | 16,821 | 0 | 158 | 5,689 | 63 | 3,377 | 141 |
| NBV - PFI at 31 March 2014 | 166,957 | 0 | 163,120 | 0 | 0 | 3,837 | 0 | 0 | 0 |
| NBV - Donated at 31 March 2014 | 277 | 0 | 5 | 0 | 0 | 257 | 0 | 8 | 7 |
| **NBV total at 31 March 2014** | 218,083 | 24,600 | 179,946 | 0 | 158 | 9,783 | 63 | 3,385 | 148 |

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any tangible assets.

## 13 Tangible Assets

13.2 2012/13

| | Group | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Gross Cost at 1 April 2012 | 242,436 | 24,600 | 181,702 | 0 | 1,245 | 32,572 | 129 | 1,562 | 626 |
| Transfers by Absorption * | 3,607 | 0 | 0 | 0 | 0 | 0 | 0 | 3,607 | 0 |
| Additions - purchased | 6,060 | 0 | 2,060 | 0 | 50 | 2,015 | 0 | 1,923 | 12 |
| Additions - leased | 460 | 0 | 0 | 0 | 0 | 460 | 0 | 0 | 0 |
| Additions - donated | 108 | 0 | 0 | 0 | 0 | 108 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 1,245 | 0 | (1,245) | 0 | 0 | 0 | 0 |
| Revaluations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (1,854) | 0 | 0 | 0 | 0 | (1,784) | 0 | (38) | (32) |
| Gross Cost at 31 March 2013 | 250,817 | 24,600 | 185,007 | 0 | 50 | 33,371 | 129 | 7,054 | 606 |
| Accumulated depreciation at 1 April 2012 | 23,436 | 0 | 0 | 0 | 0 | 21,966 | 32 | 944 | 494 |
| Transfers by Absorption * | 2,109 | 0 | 0 | 0 | 0 | 0 | 0 | 2,109 | 0 |
| Provided during the year | 8,597 | 0 | 4,800 | 0 | 0 | 3,438 | 17 | 309 | 33 |
| Revaluation surpluses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (1,834) | 0 | 0 | 0 | 0 | (1,764) | 0 | (38) | (32) |
| Accumulated depreciation at 31 March 2013 | 32,308 | 0 | 4,800 | 0 | 0 | 23,640 | 49 | 3,324 | 495 |
| **Net book value** | | | | | | | | | |
| NBV - Owned at 1 April 2012 | 49,758 | 24,600 | 17,010 | 0 | 1,245 | 6,072 | 97 | 613 | 121 |
| NBV - PFI at 1 April 2012 | 169,089 | 0 | 164,687 | 0 | 0 | 4,402 | 0 | 0 | 0 |
| NBV - Donated at 1 April 2012 | 153 | 0 | 5 | 0 | 0 | 132 | 0 | 5 | 11 |
| **NBV total at 1 April 2012** | 219,000 | 24,600 | 181,702 | 0 | 1,245 | 10,606 | 97 | 618 | 132 |
| NBV - Owned at 31 March 2013 | 50,684 | 24,600 | 16,682 | 0 | 50 | 5,444 | 80 | 3,726 | 102 |
| NBV - PFI at 31 March 2013 | 167,615 | 0 | 163,520 | 0 | 0 | 4,095 | 0 | 0 | 0 |
| NBV - Donated at 31 March 2013 | 210 | 0 | 5 | 0 | 0 | 192 | 0 | 4 | 9 |
| **NBV total at 31 March 2013** | 218,509 | 24,600 | 180,207 | 0 | 50 | 9,731 | 80 | 3,730 | 111 |

* The Trust purchased an IT Data Centre from Dudley PCT on 1st January 2013. This involved the purchase of both intangible (£113k) and tangible (£1,498k) assets totalling £1,611k. This transaction has been treated as a 'transfer by absorption' for accounting purposes. The Trust transferred staff by TUPE arrangements from Dudley PCT and also inherited a number of IT contracts for both the provision of IT services to other NHS bodies and maintenance contracts in relation to the infrastructure to provide these services. At the point of transfer the financial position of this service was breakeven. The Trust received an allocation of PDC of £1,611k to purchase the assets. This was therefore treated as a circular flow of funds within the NHS.

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity nor the subsidiary have any tangible assets.

13.3 Financing of Tangible Assets

**Group**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
|---|---|---|---|---|---|---|---|---|---|
| **Net Book Value** | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| At 31 March 2014 | | | | | | | | | |
| Owned | 50,849 | 24,600 | 16,821 | 0 | 158 | 5,689 | 63 | 3,377 | 141 |
| On Statement of Financial Position PFI contracts and other service concession arrangements | 166,957 | 0 | 163,120 | 0 | 0 | 3,837 | 0 | 0 | 0 |
| Donated | 277 | 0 | 5 | 0 | 0 | 257 | 0 | 8 | 7 |
| | 218,083 | 24,600 | 179,946 | 0 | 158 | 9,783 | 63 | 3,385 | 148 |
| At 31 March 2013 | | | | | | | | | |
| Owned | 50,684 | 24,600 | 16,682 | 0 | 50 | 5,444 | 80 | 3,726 | 102 |
| On Statement of Financial Position PFI contracts and other service concession arrangements | 167,615 | 0 | 163,520 | 0 | 0 | 4,095 | 0 | 0 | 0 |
| Donated | 210 | 0 | 5 | 0 | 0 | 192 | 0 | 4 | 9 |
| | 218,509 | 24,600 | 180,207 | 0 | 50 | 9,731 | 80 | 3,730 | 111 |

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any tangible assets.

13.4 Analysis of Tangible Assets

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under Construction & POA | Plant & Machinery | Transport Equipment | Information Technology | Furniture & Fittings |
|---|---|---|---|---|---|---|---|---|---|
| Net Book Value at 31 March 2014 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Commissioner Requested Assets | 195,951 | 24,600 | 171,351 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non Commissioner Requested Assets | 22,132 | 0 | 8,595 | 0 | 158 | 9,783 | 63 | 3,385 | 148 |
| | 218,083 | 24,600 | 179,946 | 0 | 158 | 9,783 | 63 | 3,385 | 148 |
| Net Book Value at 31 March 2013 | | | | | | | | | |
| Commissioner Requested Assets | 196,111 | 24,600 | 171,511 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non Commissioner Requested Assets | 22,398 | 0 | 8,696 | 0 | 50 | 9,731 | 80 | 3,730 | 111 |
| | 218,509 | 24,600 | 180,207 | 0 | 50 | 9,731 | 80 | 3,730 | 111 |

Commissioner Requested assets are land and buildings owned or leased by the Foundation Trust, the disposal of which may affect the Trust's ability to provide these requested goods and services.

13.5 Economic Life of Assets

The estimated useful economic lives of the Group's intangible and tangible assets are as follows with each asset being depreciated over this period, as described in accounting policy notes 1.5 and 1.6

| | Minimum Life Years | Maximum Life Years |
|---|---|---|
| Intangible | | |
| Software Licences | 2 | 10 |
| Tangible | | |
| Land | - | - |
| Buildings excluding dwellings | 5 | 90 |
| Dwellings | 0 | 0 |
| Assets under Construction & POA | 0 | 0 |
| Plant & Machinery | 3 | 15 |
| Transport Equipment | 7 | 7 |
| Information Technology | 5 | 7 |
| Furniture & Fittings | 5 | 10 |

13.6 Impairment Losses

The Trust carried out an impairment review of its non-current assets in March 2014. For land and buildings the Trust received a valuation report from the District Valuer prepared on a Modern Equivalent Asset (MEA) basis. The valuation report was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as the terms are consistent with the requirements of HM Treasury, the National Health Service and Monitor. On application there was no movement in the value of land and a general increase in value of buildings compared to the carrying value at 31st March 2014. In line with IFRS the Trust was able to offset any fall in value of buildings against the relevant revaluation balance held for the applicable assets.

| Impairment of Assets | 31 March 2014 £'000 | 31 March 2013 £'000 |
|---|---|---|
| Changes in market price | 318 | 0 |
| TOTAL IMPAIRMENTS | 318 | 0 |

13.7 Asset Valuations

The Trust received a MEA valuation from the District Valuer in March 2014. The updated valuations of the Trust's land, buildings and dwellings were applied to the Trust financial statements and enable the Trust to disclose an up to date position with regard to asset valuations. No significant assumptions were made as part of the valuation process as minimum capital expenditure had been applied to the land and buildings since the previous full revaluation exercise. If the Trust had not received this updated valuation the carrying values of land, buildings and dwellings would have been £24,800,000; £176,943,000 and £nil respectively.

13.8 Non Current Assets Held For Sale

During the year 2013/14 there were no Non Current Assets held for sale (2012/13 £ nil).

13.9 Capital Commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements were £346,000 (31 March 2013 £168,000). The amount relating to property, plant and equipment is £327,000 (2012/13 £168,000) and intangible assets £19,000 (2012/13 £nil).

## 14 Investments

| | Group | |
|---|---|---|
| | 2013/14 | 2012/13 |
| | £'000 | £'000 |
| Carrying Value at 1 April | 1,146 | 0 |
| Prior period adjustment | 0 | 1,044 |
| Carrying Value at 1 April restated | 1,146 | 1,044 |
| Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income | 29 | 102 |
| Disposals | (48) | 0 |
| Carrying Value at 31 March | 1,127 | 1,146 |

The investments are only held by Dudley NHS Charity.
A separate schedule for the Trust investments has not been produced as the Trust does not have any investments (2012/13 £nil).

## 15 Other Financial Assets

| | Group | |
|---|---|---|
| | 2013/14 | 2012/13 |
| Non Current | £'000 | £'000 |
| NHS Charitable funds: Other financial assets | 0 | 0 |
| Current | | |
| NHS Charitable funds: Other financial assets | 207 | 256 |
| | 207 | 256 |

A separate schedule for the Trust other financial assets has not been produced as the Trust does not have any other financial assets (2012/13 £nil).

## 16 Inventories

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | 31 March 2014 | 31 March 2013 | 31 March 2014 | 31 March 2013 |
| | £'000 | £'000 | £'000 | £'000 |
| Drugs | 1,784 | 1,849 | 1,521 | 1,849 |
| Consumables | 1,315 | 1,159 | 1,315 | 1,159 |
| Energy | 23 | 37 | 23 | 37 |
| Other | 37 | 43 | 37 | 43 |
| TOTAL Inventories | 3,159 | 3,088 | 2,896 | 3,088 |

The Trust expensed £3,088,000 of inventories during the year (2012/13 £2,837,000)

## 17 Trade Receivables and Other Receivables

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | 31 March 2014 | 31 March 2013 | 31 March 2014 | 31 March 2013 |
| **Current** | £'000 | £'000 | £'000 | £'000 |
| NHS Receivables - revenue | 13,563 | 4,897 | 13,563 | 4,897 |
| Other receivables with related parties | 469 | 35 | 469 | 35 |
| Provision for impaired receivables | (811) | (824) | (811) | (824) |
| Prepayments (non PFI) | 1,600 | 1,040 | 1,851 | 1,040 |
| PFI Prepayments | | | | |
| Prepayments - Capital contributions | 0 | 0 | 0 | 0 |
| Prepayments - Lifecycle replacements | 0 | 0 | 0 | 0 |
| Accrued income | 121 | 119 | 174 | 119 |
| Interest Receivable | 2 | 10 | 2 | 10 |
| Corporation tax receivable | 0 | 0 | 0 | 0 |
| PDC dividend receivable | 704 | 19 | 704 | 19 |
| VAT Receivable | 1,121 | 833 | 1,021 | 833 |
| Other receivables | 1,141 | 1,189 | 1,141 | 1,189 |
| NHS Charitable funds Trade and other receivables | 16 | 14 | 0 | 0 |
| **TOTAL CURRENT TRADE AND OTHER RECEIVABLES** | 17,926 | 7,332 | 18,114 | 7,318 |

| | | | | |
|---|---|---|---|---|
| **Non Current** | £'000 | £'000 | £'000 | £'000 |
| Prepayments (non PFI) | 4,474 | 3,396 | 4,474 | 3,396 |
| PFI Prepayments | | | | |
| Prepayments - Capital contributions | 0 | 0 | 0 | 0 |
| Prepayments - Lifecycle replacements | 5,450 | 4,611 | 5,450 | 4,611 |
| Other Receivables | 0 | 1,307 | 0 | 1,307 |
| NHS Charitable funds Trade and other receivables | 0 | 0 | 0 | 0 |
| **TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES** | 9,924 | 9,314 | 9,924 | 9,314 |

Other current and non current receivables include the NHS Injury Scheme (was RTA).

17.2 Provision for impairment of receivables

**Group**

| | 31 March 2014 | 31 March 2013 |
|---|---|---|
| | £'000 | £'000 |
| At 1 April | 824 | 790 |
| Increase in provision | 50 | 129 |
| Amounts utilised | (12) | (37) |
| Unused amounts reversed | (51) | (58) |
| At 31 March | 811 | 824 |

17.3 Analysis of impaired receivables

**Group**

| | 31 March 2014 | | 31 March 2013 | |
|---|---|---|---|---|
| | Trade | Other | Trade | Other |
| Ageing of impaired receivables | £'000 | £'000 | £'000 | £'000 |
| 0 - 30 Days | 0 | 0 | 4 | 0 |
| 30 - 60 Days | 0 | 0 | 0 | 0 |
| 60 - 90 Days | 0 | 0 | 4 | 0 |
| 90 - 180 Days | 2 | 0 | 7 | 0 |
| over 180 Days (over 6 months) | 41 | 768 | 42 | 767 |
| Total | 43 | 768 | 57 | 767 |

A separate schedule for the impairment of receivables have not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any impaired receivables.

17.4 Analysis of non-impaired receivables

**Group**

| | 31 March 2014 | | 31 March 2013 | |
|---|---|---|---|---|
| | Trade | Other | Trade | Other |
| Ageing of non-impaired receivables past their due date | £'000 | £'000 | £'000 | £'000 |
| 0 - 30 Days | 3,685 | 94 | 5,024 | 99 |
| 30 - 60 Days | 1,135 | 117 | 42 | 107 |
| 60 - 90 Days | 85 | 131 | 7 | 132 |
| 90 - 180 Days | 344 | 185 | 5 | 354 |
| over 180 Days (over 6 months) | 88 | 851 | 4 | 792 |
| Total | 5,337 | 1,378 | 5,082 | 1,484 |

A separate schedule for the Trust non-impairment of receivables has not been produced as the NHS Charity non impaired receivables represent just £16,000 (31 March 2013 £14,000) of the value shown by the Group in the 0-30 days category and the subsidiary did not have any receivables outstanding .

| 18 Trade and Other Payables | Group | | Foundation Trust | |
|---|---|---|---|---|
| | 31 March 2014 | 31 March 2013 | 31 March 2014 | 31 March 2013 |
| **Current** | £'000 | £'000 | £'000 | £'000 |
| NHS payables - revenue | 2,434 | 451 | 2,434 | 451 |
| Amounts due to other related parties | 2,369 | 2,101 | 2,369 | 2,101 |
| Trade payables - capital | 1,101 | 609 | 1,101 | 609 |
| Other trade payables | 0 | 0 | 0 | 0 |
| Taxes payable | 3,781 | 3,737 | 3,768 | 3,737 |
| Other payables | 5,832 | 5,542 | 5,704 | 5,542 |
| Accruals | 4,064 | 3,288 | 3,953 | 3,288 |
| PDC dividend payable | 0 | 0 | 0 | 0 |
| NHS Charitable Funds trade and other payables | 85 | 46 | 0 | 0 |
| **TOTAL CURRENT TRADE & OTHER PAYABLES** | 19,666 | 15,774 | 19,329 | 15,728 |

Non-current trade and other payables are nil (31 March 2013 £nil).

Taxes payable consists of employment taxation only (Pay As You Earn and National Insurance contributions), owed to HM Revenue and Customs at the year end, and Corporation Tax payable by the subsidiary Dudley Clinical Services Limited.

| 19 Other Liabilities | Group | | Foundation Trust | |
|---|---|---|---|---|
| | 31 March | 31 March | 31 March | 31 March |
| **Current** | 2014 | 2013 | 2013 | 0 |
| | £'000 | £'000 | £'000 | £'000 |
| Deferred Income | 1,809 | 245 | 1,809 | 245 |
| **TOTAL OTHER CURRENT LIABILITIES** | 1,809 | 245 | 1,809 | 245 |

Non-current liabilities are nil (31 March 2013 £nil).

Where income has been received for a specific activity which is to be delivered in the following financial year, that income is deferred.

**20 Deferred Tax**

Liability for corporation tax only arises from the activity of the commercial subsidiary, the activities of the Trust do not incur corporation tax, see accounting policy note 1.18 for detailed explanation.

The subsidiary did not have any deferred tax in 2014/14 (2012/13 £nil).

## 21 Provision for Liabilities and Charges

| | Group Current | | Group Non Current | |
|---|---|---|---|---|
| | 31 March 2014 | 31 March 2013 | 31 March 2014 | 31 March 2013 |
| | £'000 | £'000 | £'000 | £'000 |
| Other legal claims | 193 | 192 | 0 | 0 |
| Restructuring | 2,604 | 0 | 0 | 0 |
| Other | 148 | 238 | 0 | 0 |
| Total | 2,945 | 430 | 0 | 0 |

| | Total | Other legal claims | Restructuring | Other |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| At 1 April 2013 | 430 | 192 | 0 | 238 |
| Arising during the year | 2,916 | 162 | 2,604 | 150 |
| Utilised during the year - cash | 0 | 0 | 0 | 0 |
| Utilised during the year - accruals | (310) | (72) | 0 | (238) |
| Reversed unused | (91) | (89) | 0 | (2) |
| At 31 March 2014 | 2,945 | 193 | 2,604 | 148 |
| | | | | |
| Expected timing of cashflows: | | | | |
| - not later than one year; | 2945 | 193 | 2,604 | 148 |
| - later than one year and not later than five years; | 0 | 0 | 0 | 0 |
| - later than five years. | 0 | 0 | 0 | 0 |
| TOTAL | 2,945 | 193 | 2,604 | 148 |

A separate schedule for the Trust provision for liabilities and charges has not been produced as neither the NHS Charity or the subsidiary have any provisions.

The restructuring provision of £2.604m relates to a contractual payment the Trust is required to make as a result of voluntary termination of the IT service within the PFI contract. This payment is due to be made in December 2014.

Other Legal Claims include claims under Employers' and Public Liability.

The Carbon Reduction Commitment Scheme (CRC) is a mandatory cap and trade scheme for non-transport CO2 emissions. As the Trust is registered with the CRC scheme, it is required, with effect from 2011/12 to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. This liability is recognised within the Other category of this note.

The NHS Litigation Authority has included in its provisions at 31 March 2014 £69,127,000 (2012/13 £61,254,000) in respect of clinical negligence liabilities for the Trust.

## 22 Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The disclosures provided previously are no longer required.

## 23 Borrowings

| | Group | |
|---|---|---|
| | As at 31 March 2014 | As at 31 March 2013 |
| Current | £'000 | £'000 |
| Obligations under Private Finance Initiative contracts (excl lifecycle) | 5,344 | 4,978 |
| Total Current borrowings | 5,344 | 4,978 |
| | | |
| Non Current | | |
| Obligations under Private Finance Initiative contracts | 142,069 | 146,855 |
| Total Other non Current Liabilities | 142,069 | 146,855 |

A separate schedule for the Trust borrowings has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any borrowings.

## 24 Cash and Cash Equivalents

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | 31 March 2014 | 31 March 2013 | 31 March 2014 | 31 March 2013 |
| | £'000 | £'000 | £'000 | £'000 |
| At 1 April | 34,322 | 36,887 | 32,906 | 36,346 |
| Transfers By Absorption | 0 | (1,611) | 0 | (1,611) |
| Net change in year | (6,501) | (954) | (6,741) | (1,829) |
| At 31 March | 27,821 | 34,322 | 26,165 | 32,906 |
| | | | | |
| Analysed as follows: | | | | |
| Cash at commercial banks and in hand | 247 | 2 | 2 | 2 |
| Cash with the Government Banking Service | 27,574 | 34,320 | 26,163 | 32,904 |
| Other current investments | 0 | 0 | 0 | 0 |
| **Cash and cash equivalents as in Statement of Financial Position** | 27,821 | 34,322 | 26,165 | 32,906 |
| Bank overdraft | 0 | 0 | 0 | 0 |
| **Cash and cash equivalents as in Statement of Cash Flows** | 27,821 | 34,322 | 26,165 | 32,906 |

Other current investments were instant access cash deposits held with UK Bank Institutions.
The net cash impact of the Transfer By Absorption is nil as Public Dividend Capital was drawn from the Department of Health to fund the transfer.

## 25 Events after the reporting period

The Group nor the Trust have any events after the reporting period.

## 26 Contingencies

The Group nor the Trust have any contingent assets or liabilities in 2013/14 ( 2012/13 £nil).

**27 Related Party Transactions**

The Dudley Group NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by Monitor, the Independent regulator for Foundation Trusts. The Trust has taken advantage of the partial exemption provided by IAS 24 'Related Party Disclosures', where the Government of the United Kingdom is considered to have ultimate control over the Trust and all other related party entities in the public sector.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor - part of the NHS in England. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services. The Department of Health is also regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent organisation.

The Trust has had a number of material transactions with other Government Departments and local Government Bodies. These related parties are summarised below by Government Department, with disclosure of the total balances owed and owing as at the reporting date and the total transactions for the reporting year with the Trust.

| | Year ended 31 March 2014 | | | | Year ended 31 March 2013 | | | |
|---|---|---|---|---|---|---|---|---|
| **Group** | Income | Expenditure | Receivable | Payable | Income | Expenditure | Receivable | Payable |
| | £ million | £ million | £ million | £ million | £ million | £ million | £ million | £ million |
| Monitor (Foundation Trusts) | 1.92 | 1.81 | 0.30 | 0.60 | 1.81 | 1.29 | 0.19 | 0.08 |
| Department of Health (NHS) | 306.47 | 12.96 | 13.27 | 3.13 | 291.40 | 13.66 | 4.73 | 0.48 |
| Local Government | 2.85 | 1.25 | 0.43 | 0.00 | 0.63 | 1.40 | 0.00 | 0.00 |
| Central Government | 0.03 | 30.09 | 1.02 | 6.19 | 0.08 | 27.79 | 0.87 | 5.84 |

Key management personnel, namely the Trust Board Directors, are those persons having authority and responsibility for planning, directing and controlling the activities of the Trust. During the year none of the key management personnel have parties related to them that have undertaken any material transactions with The Dudley Group NHS Foundation Trust.
The table below details, on an aggregate basis, key management personnel compensation:

| | 31 March 2014 | 31 March 2013 |
|---|---|---|
| **Compensation** | £ million | £ million |
| Salaries and short-term benefits | 0.90 | 0.80 |
| Post-employment benefits | 0.75 | 0.70 |
| | 1.64 | 1.50 |

The financial statements of the parent (the Trust) are presented together with the consolidated financial statements and any transactions or balances between group entities have been eliminated on consolidation. Dudley Group NHS Charity has a Corporate Trustee who are the Board members of the Trust. The Board members of Dudley Clinical Services Limited include the following Non Executive Directors from the Trust: Richard Miner as Chairman and David Bland as a Director.

Dudley Clinical Services Limited does not have any transactions with any NHS or Government entity except those with its parent, the Trust and HMRC. The Group receivables includes £100,000 owed by the subsidiary (£nil 2012/13) and £16,000 owed by Dudley Group NHS Charity (£14,000 2012/13), and the Group payables includes £128,000 (£nil 2012/13) owed to the subsidiary and £85,000 (£46,000 2012/13) owed to Dudley Group NHS Charity.

**28 Private Finance Initiatives**

28.1 PFI schemes on the Statement of Financial Position

The Dudley PFI project provided for the refurbishment and new building of major inpatient facilities at Russells Hall Hospital, the building of new facilities at Guest Hospital and Corbett Hospital. The Capital value of the scheme was £160.2m. The Project agreement runs for 40 years from May 2001 (except IT, which runs for 15 years from completion). The Dudley PFI is a combination of buildings (including hard Facilities Managed (FM) services) and a significant range of allied and clinical support services.
The standard Unitary Payment changes periodically as a consequence of:

- Inflation ( based on RPI and reviewed annually)
- Deductions for poor performance (Deficiency points and financial penalties for poor performance or non-compliant incidents).
- Variations to the Project Agreement (PA) (agreed under Variations procedure in the PA)
- 50% of market testing or refinancing impact
- Energy tariff adjuster (the difference between actual energy tariff changes and the uplift that comes through RPI)
- Volume adjuster (computed by comparing actual in patient days against that in the schedule, with a tolerance of plus or minus 3%)

The Trust has the rights to use the specified assets for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

The PFI transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual (ARM) issued by Monitor, and therefore the Trust is required to account for the PFI scheme 'onbalance sheet' and this means that the Trust treats the asset as if it were an asset of the Trust and the substance of the contract is that the Trust has a finance lease and payments comprise two elements, an imputed finance lease charge and service charges.

| | As at 31 March 2014 £'000 | As at 31 March 2013 £'000 |
|---|---|---|
| Gross PFI Liabilities | 158,513 | 162,587 |
| of which liabilities are due | | |
| - not later than one year; | 16,444 | 15,732 |
| - later than one year and not later than five years; | 21,376 | 19,912 |
| - later than five years. | 120,693 | 126,943 |
| Finance charges allocated to future periods | (11,100) | (10,754) |
| **Net PFI liabilities** | **147,413** | **151,833** |
| - not later than one year; | 5,344 | 4,978 |
| - later than one year and not later than five years; | 21,376 | 19,912 |
| - later than five years. | 120,693 | 126,943 |

The Trust is committed to make the following payments for on-SoFP PFIs obligations of the service element during the next year in which the commitment expires:

| | 31 March 2014 £'000 | 31 March 2013 £'000 |
|---|---|---|
| Within one year | 21,696 | 21,064 |
| 2nd to 5th years (inclusive) | 86,782 | 84,254 |
| Later than 5 Years | 477,305 | 484,464 |
| **Total** | **585,783** | **589,782** |

| | |
|---|---|
| Total length of the project (years) | 40 |
| Number of years to the end of the project | 27 |

28.2 PFI schemes off the Statement of Financial Position

The Trust does not have any PFI schemes which are deemed to be off-statement of financial position.

**29 Financial Instruments and Related Disclosures**

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Trust has identified are as follows:

29.1 Financial Risk

Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Finance and Performance Committee.

29.2 Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

29.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

29.4 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in note 14 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the end of the period.

29.5 Liquidity Risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability to draw funding from the Trusts £10,000,000 working capital facility minimises such risk. The working capital facility level has been derived by taking into consideration the forecast month end cash balances for the coming two years.

The Trust is therefore not exposed to significant liquidity risk.

29.6 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

29.7 Financial Assets and Liabilities By Category

The following tables show by category the financial assets and financial liabilities at 31 March 2014 and 31 March 2013. The values are shown at fair value which is representative of the carrying value.

| | Group | | | | Foundation Trust | | | |
|---|---|---|---|---|---|---|---|---|
| Financial Assets | As at 31 March 2014 | | As at 31 March 2013 | | As at 31 March 2014 | | As at 31 March 2013 | |
| | Total | Loans and Receivables | Total | Loans and Receivables | Total | Loans and Receivables | Total | Loans and Receivables |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Trade and other receivables excluding non financial | 15,472 | 15,472 | 5,313 | 5,313 | 15,472 | 15,472 | 5,313 | 5,313 |
| Cash and cash equivalents (at bank and in hand) | 26,410 | 26,410 | 32,906 | 32,906 | 26,165 | 26,165 | 32,906 | 32,906 |
| NHS Charitable funds financial assets | 1,626 | 1,626 | 2,832 | 2,832 | 0 | 0 | 0 | 0 |
| | 43,508 | 43,508 | 41,051 | 41,051 | 41,637 | 41,637 | 38,219 | 38,219 |

*Other Financial Assets are fixed term cash investments with UK Bank Institutions

| | Group | | | | Foundation Trust | | | |
|---|---|---|---|---|---|---|---|---|
| Financial Liabilities | As at 31 March 2014 | | As at 31 March 2013 | | As at 31 March 2014 | | As at 31 March 2013 | |
| | Total | Other financial Assets | Total | Other financial Assets | Total | Other financial Assets | Total | Other financial Assets |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Obligations under Private Finance Initiative contracts | 147,413 | 147,413 | 151,833 | 151,833 | 147,413 | 147,413 | 151,833 | 151,833 |
| Trade and other payables excluding non financial | 15,305 | 15,305 | 11,991 | 11,991 | 15,305 | 15,305 | 11,991 | 11,991 |
| Provisions under contract | 2,945 | 2,945 | 430 | 430 | 2,945 | 2,945 | 430 | 430 |
| NHS Charitable Funds financial liabilities | 85 | 85 | 46 | 46 | 0 | 0 | 0 | 0 |
| | 165,748 | 165,748 | 164,300 | 164,300 | 165,663 | 165,663 | 164,254 | 164,254 |

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| 29.8 Maturity of Financial Liabilities | As at 31 March 2014 | As at 31 March 2013 | As at 31 March 2014 | As at 31 March 2013 |
| | £'000 | £'000 | £'000 | £'000 |
| In One Year or Less | 23,679 | 17,445 | 23,594 | 17,399 |
| In more than one year but not more than two years | 5,344 | 4,978 | 5,344 | 4,978 |
| In more than two years but not more than five years | 16,032 | 14,934 | 16,032 | 14,934 |
| In more than five years | 120,693 | 126,943 | 120,693 | 126,943 |
| Total | 165,748 | 164,300 | 165,663 | 164,254 |

**30 Third Party Assets**

The Trust held £5,000 as cash at bank or in hand at 31 March 2014 (31 March 2013 £29,000) which related to monies held by the Trust on behalf of patients. These balances are excluded from cash at bank and in hand figures reported in the accounts.

**31 Losses and Special Payments**

NHS Foundation Trusts are required to record payments and other adjustments that arise as a result of losses and special payments on an accruals basis, excluding provisions for future losses.

| | 2013/14 | | 2012/13 | |
|---|---|---|---|---|
| | Number | Value £000 | Number | Value £000 |
| Loss of Cash | 1 | 0 | 1 | 0 |
| Bad debts and claims abandoned | 78 | 15 | 73 | 51 |
| Stores losses | 1 | 10 | 4 | 36 |
| **Total Losses** | 80 | 25 | 78 | 87 |
| Ex gratia payments | 24 | 51 | 21 | 48 |
| **Total Special Payments** | 24 | 51 | 21 | 48 |
| **Total Losses and Special Payments** | **104** | **76** | **99** | **135** |

There were no clinical negligence, fraud, personal injury, compensation under legal obligations or fruitless payment cases where the net payment for the individual case exceeded £100,000.

**32 Auditors' Liability**

In accordance with the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the liability of the Trust Auditors, Deloitte LLP is restricted to £1,000,000 in respect of liability to pay damages for losses arising as a direct result of breach of contract or negligence in respect of services provided in connection with or arising from their letter of engagement dated 10 February 2014

The Dudley Group NHS
NHS Foundation Trust

# Quality Report 2013/14

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# Contents

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

# Part 1: Chief Executive's statement

I am again delighted to introduce the annual Quality Report and Account, the purpose of which is to give a detailed picture of the quality of care provided by our hospitals and adult community services. This report covers the year from April 2013 to the end of March 2014.

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

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

In this report we have used these three elements to describe the quality of care at the Trust over the year. We have given an overall picture of what the organisation is achieving and where it still needs to improve.

Following on from this introduction, in Part 2 of this document we have outlined our priority quality measures and charted their progress throughout the year. A summary of current and previous priorities can be seen in the table on page eight, more information on each priority can be found on the page numbers listed in the table. This includes progress made to date, as well as our new targets for 2014/15. This part of the report also includes sections required by law on such topics as clinical audit, research and development and data quality.

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

Many of you will know that the Trust was in the spotlight during the year when it was named as one of the 14 chosen to be part of the Sir Bruce Keogh Review. Inclusion was based on having higher than expected mortality indicators for two consecutive years, although the Trust's figure was within the expected range for the HSMR, one of the two key mortality indicators, at the time of the review. Both mortality indicators (SHMI and HSMR) have continued to improve consistently for the Trust and are now within the expected range. It is worth noting that these indicators are not designed or intended to identify 'unnecessary' or 'excess' deaths nor do they measure quality and safety. They are seen to act as a "warning sign" or "smoke-alarm" for potential quality problems, although even this has been disputed recently.

The Keogh investigation looked very broadly and intensely at the quality of care and treatment provided at the Trust. The detailed review considered our performance across five other areas as well as mortality: patient experience, safety, workforce, clinical and operational effectiveness together with leadership and governance. I was pleased that the review team did not find any areas of major concern that warranted further escalation and the Trust was one of only two of the 14 not placed in special

measures. This is testament to the hard work and commitment of all our staff and the pride they take in delivering the best possible care to our patients. As the review has been one of the most far reaching and detailed inspections the Trust has ever experienced, it gives us confidence that we are providing good quality of care whilst recognising the areas where we can do better. Following the review, we established and implemented an action plan for those areas where it was indicated that we could make improvements.

As well as the Keogh Review, we are monitored by a variety of other external organisations and agencies and we are constantly monitoring ourselves on the quality of our care in a variety of ways in order both to assure patients and ourselves of where we are doing well and to learn where we need to change practice and improve our services.

In late March 2014, towards the very end of the year covered by this report, the Trust was visited by the Care Quality Commission as part of its new inspection process and although, at the time of writing, we have not received formal feedback I can assure everyone that we will fully implement any recommendations made. We believe the wide range of measures and checks detailed here indicate that the overall quality of care delivered at The Dudley Group is good and in line with that of other similar Trusts both locally and nationally.

**Our quality priorities**

You will see in the following pages that we have performed quite well with some of our 2013/14 priorities. The successful priorities relate to positive patient experience feedback of our hospital, further substantially reducing serious pressure ulcers in the hospital and community and some improved nutrition and fluid intake care. However, we acknowledge that all of our targets have not been met. For instance, although we had a reduction in Clostridium Difficile cases from last year, we did not meet the ambitiously set target for the year and we had one case of MRSA bacteraemia a few days prior to the end of the year.

With regards to 2014/15, we have retained all of the topics from 2013/14 due to their importance from both a patient and organisational perspective and due to some of the targets not being met. Following the discussion on mortality indicators above and due to a specific recommendation from the Keogh Review we have added this important topic as a further priority.

**Measuring quality**

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

I am especially pleased to report that the Trust is receiving positive feedback from our inpatients, mothers on the maternity unit and patients being seen in the Emergency Department in the national Friends and Family Test (Section 3.2.2). Our nurses continue to improve the quality of care they provide as measured by our detailed monthly Nursing Care Indicator assessments (Section 3.3.4). I am also particularly pleased to report that our midwives won a Royal College of Midwives

Annual Midwifery Award, and we have gained a substantial grant to work with our partners to improve palliative care (Section 3.4.2).

I hope you will find useful this information on the quality priorities we have chosen to focus on, the ways in which we assure ourselves of the quality of care and a selection of the targets, both national and local, we use to form a picture of quality across the Trust.

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

In addition, we summarise this lengthy report in our regular Trust newsletter, Your Trust, and publish quarterly updates on the progress with our quality priorities both in the newsletter and on our website.

I can confirm that, to the best of my knowledge, the information contained in this document is accurate.

**Signed** **Date: 13th of May 2014**

**Paula Clark**
**Chief Executive**

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

## 2.1 Quality improvement priorities

### 2.1.1 Quality priorities summary

The table below gives a summary of the history of our quality priorities and also those we will be working towards in 2014/15.

| Priority | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | Notes |
|---|---|---|---|---|---|---|---|
| **Patient experience**<br>Increase in the number of patients who report positively on their experience on a number of measures. | Achieved | We improved on one measure but had a slight decrease in another | Hospital: Partially achieved<br>Community: Achieved | Hospital: Achieved<br>Community: Partially achieved | Hospital: Partially achieved<br>Community: Not achieved | Priority 1 | See page 10 for more information |
| **Pressure ulcers**<br>Improve systems of reporting and reduce the occurrence of avoidable pressure ulcers. | N/A | N/A | Hospital: Achieved<br>Community: Partially achieved | Hospital: Achieved<br>Community: Achieved | Hospital: Partially achieved<br>Community: Achieved | Priority 2 | New in 2011/12<br>See page 15 for more information |
| **Infection control**<br>Reduce our MRSA rate in line with national and local priorities. | Achieved | Achieved | Achieved | Achieved | Not achieved | Priority 3 | See page 20 for more information |
| Reduce our Clostridium Difficile rate in line with local and national priorities. | | | Not achieved | Achieved | Not achieved | | |
| **Nutrition**<br>Increase the number of patients who have a risk assessment regarding their nutritional status. | N/A | N/A | N/A | Achieved | Partially achieved | Priority 4 | New in 2012/13<br>See page 23 for more information |
| **Hydration**<br>Increase the number of patients who have their fluid balance charts monitored. | N/A | N/A | N/A | Achieved | Achieved | Priority 5 | New in 2012/13<br>See page 23 for more information |
| **Mortality**<br>Improve reviews of hospital deaths. | N/A | N/A | N/A | N/A | N/A | Priority 6 | New in 2014/15<br>See page 28 for more information |
| **Hip operations**<br>Increase the number of patients who undergo surgery for hip fracture within 36 hours from admission (where clinically appropriate to do so). | N/A | Achieved | Achieved | N/A | N/A | N/A | As the target was achieved for two consecutive years this priority was replaced in 2012/13 |
| **Cardiac arrests**<br>Reduce the numbers of cardiac arrests. | Achieved | Achieved | N/A | N/A | N/A | N/A | With a decrease from 32 per month in 2008 to 13 per month by 2011 this no longer remained a challenge |

## 2.1.2 Choosing our priorities for 2014/15

The Quality Account Priorities for 2013/14 covered the following five topics:

**Patient Experience**

**Infection Control**

**Pressure Ulcers**

**Nutrition**

**Hydration**

These topics were agreed by the Board of Directors on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Care Indicators (see Section 3.3.4)) and a national perspective (e.g. reports from national bodies e.g. Age UK, CQC findings etc.). These topics were endorsed by a Listening into Action event on the Quality Report, hosted by the Chief Executive and Director of Nursing, attended by staff, Governors, Foundation Trust members and others from the following organisations Dudley LINK, Dudley Primary Care Trust, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC).

Patient experience is at the core of why the Trust exists. The Trust is committed to reducing infection rates which is central to providing good patient care and is a key commissioner and patient requirement. There are national campaigns of zero tolerance to pressure ulcers and the need to focus on patients' nutrition and hydration.

It has been agreed that the same priorities will be retained in 2014/15 as they are fundamental to patient care and not all targets were achieved in 2013/14. In addition, the recent Keogh Review suggested that the Trust should include mortality indicators as a further priority and this has been agreed by the governors and Board of Directors.

As well as gaining the governors' views on the priority topics, a questionnaire was devised that has been made available both at a Trust open day and on the Trust website. On the website, the questionnaire was made available to all members of the public, and local statutory and voluntary bodies were informed that their views were also welcome using this process. The responses received generally endorsed the decisions made above.

> **To the doctors and consultants – you were superb in your diagnosis and subsequent treatment. I can only thank you all for listening to me and for easing my concerns for my future.**

## 2.1.3 Our priorities

### Priority 1 for 2013/14: Patient experience

| Patient experience | |
|---|---|
| **Hospital** | **Community** |
| a) Maintain an average score of 85 or above throughout the year for patients who report receiving enough assistance to eat their meals.<br><br>b) By the end of the year, at least 80 per cent of patients will report that their call bells are always answered in a reasonable time. | a) Increase the number of patients who use their Single Assessment Process folder/Health and Social Care Passport to monitor their care from 49.4 per cent to 80 per cent by the end of the year.<br><br>b) Increase the number of patients who would know how to raise a concern about their care and treatment if they so wished from 86.8 per cent to 90 per cent by the end of the year. |

### How the Trust measures and records this priority

**Hospital**
This priority has been measured using our real-time survey system. A random sample of inpatients is asked to share their experiences by participating in the survey about their stay before they leave hospital. Responses to the surveys are entered directly into a hand-held computer and downloaded straight into our database to provide timely feedback. During 2013/14, 1440 patients participated in the surveys. All surveys are anonymous and results are shared with individual wards enabling them to take action on patient comments.

**Community**
The community priority has been measured using an annual survey. A paper questionnaire was distributed to community patients who were also provided with a freepost envelope to ensure an anonymous response; 668 responses to the survey were received, with question (a) answered by 261 respondents and (b) answered by 615. The reason for the difference in respondents is that not all patients have a Single Assessment Process folder, which is a useful communication document used by all staff from all services that contribute to the care and management of people with long term conditions.

## Developments that occurred in 2013/14

- The hospital patient experience quality priority was included in the newly developed Quality Outcome Measures Dashboard, a list of key quality indicators, to give lead nurses and matrons timely feedback.
- Three nutritional support workers were appointed on ward A2 which now means there are two wards with such assistance.
- Investigations into the possibility of introducing a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells were undertaken; however, current solutions appear cost prohibitive – we will continue to investigate options.
- A recruitment event was held to increase the number of volunteers trained to provide mealtime assistance – 35 volunteers were recruited and are now undergoing induction.
- Details around the welcoming of family members to assist their relatives at mealtime, if they wish to do so, were included in our Welcome to the Ward leaflets.
- Internal reporting processes strengthened where a patient reports not receiving enough assistance to eat.
- A pilot is underway on our surgical wards for a 30 second response time to answering call bells, including information posters displayed to advise patients of what can be expected.
- The final version of the new Health and Social Care Passport to improve information sharing between the patient, carers and health and social care professionals has been agreed and signed off by all stakeholders and printing quotes are being obtained. An information leaflet will accompany the launch of this new document which will replace the Single Assessment Process Folder.
- The annual survey of community services was extended to include a question on reasons for patients choosing not to use the document to monitor their care.

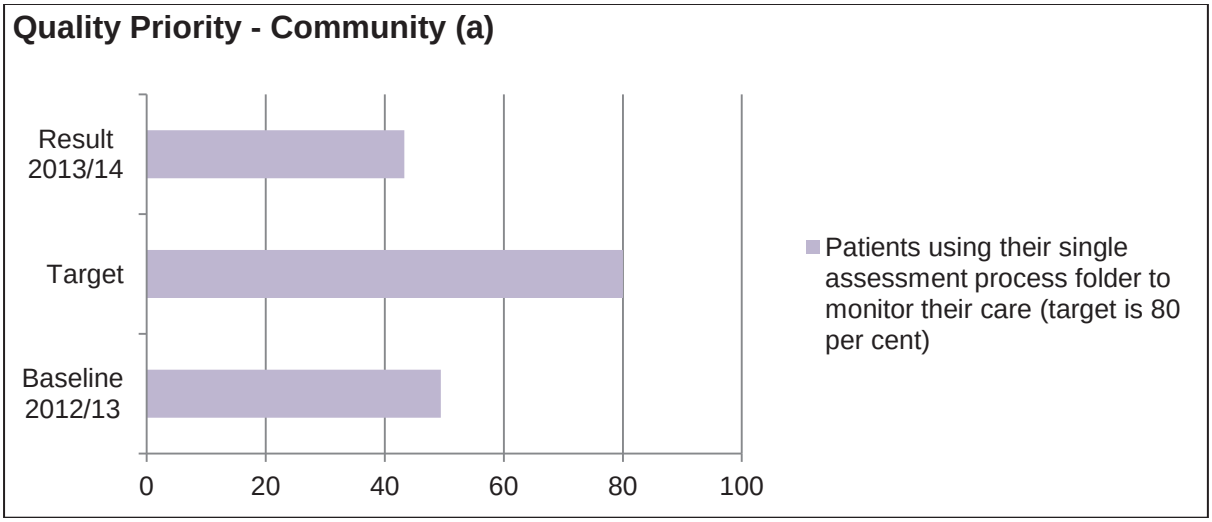
## Current status: Hospital

| Quality priority hospital (a) | Q1 | Q2 | Q3 | Q4 | 2013/14 |
|---|---|---|---|---|---|
| Maintain an average score of 85 or above throughout the year for patients who report receiving enough assistance to eat their meals | 77.3 | 77.6 | 81.2 | 91.7 | **81.8** |
| Number of patients who felt that they sometimes or never get the help that they needed | 3 (out of 326 surveyed) | 9 (out of 429 surveyed) | 3 (out of 359 surveyed) | 2 (out of 326 surveyed) | **17 (out of 1440 surveyed)** |
| **Quality priority hospital (b)** | **Q1** | **Q2** | **Q3** | **Q4** | **2013/14** |
| By the end of the year at least 80 per cent of patients will report that their call bells are always answered in a reasonable time | 89.2 | 89.1 | 89.4 | 86.5 | **88.6** |

It can be seen that although there has been a recent improvement in the figures, the Trust has not met the target relating to patients' perceptions of receiving enough assistance to eat their meals (target 85 with actual figure of 81.8).

With regards to the call bell target, this has been achieved for the year as a whole.

## Current status: Community

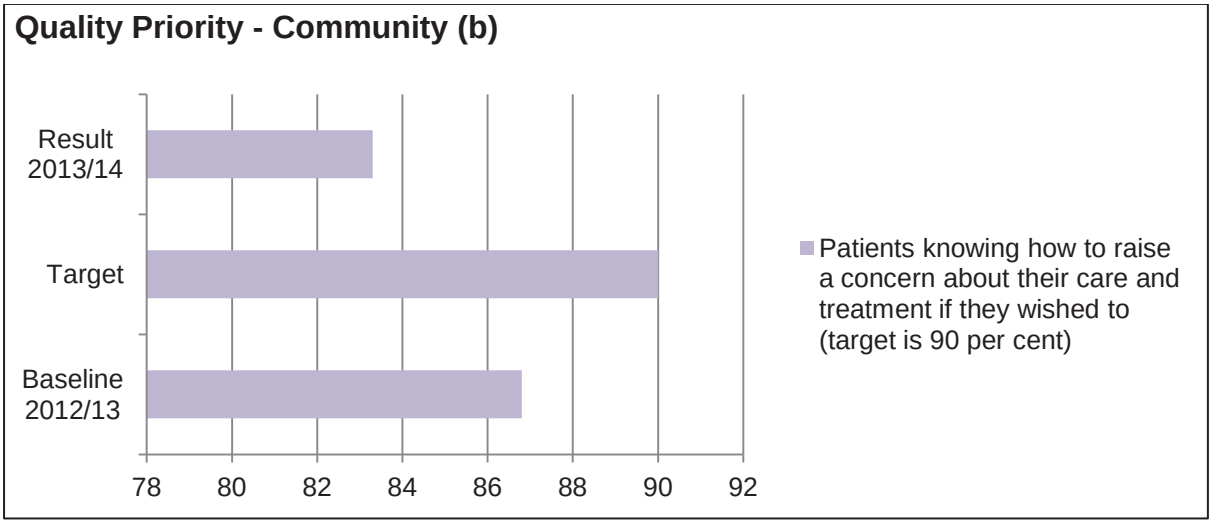



It can be seen on the chart that the Trust did not meet this target in 2013/14.
Of the patients with a Single Assessment Process folder, 88.7 per cent reported that they understood its purpose, but only 43.3 per cent use it to monitor their own care.
In the 2013/14 community survey the Trust asked patients with a Single Assessment Process who did not use it to monitor their own care the reason for this to help understand why improvements were not being made against this target.

The reasons patients stated were:

- They did not feel any need to do this
- They did not know they could
- That the Trust staff do this and staff explain to them what is going on
- That they have physical reasons why they cannot do this e.g. cannot see well enough

For this reason this priority will not be carried forward to 2014/15 as it does not appear to be an important priority for patients.




Of those asked, 83.3 per cent of patients stated that they would know how to raise a concern about their care and treatment if they wished to do so, against a target of 90, and a slight dip in score was seen against the previous year. It is important this priority does not drop further so it will be retained in the 2014/15 priority schedule.

## New priority 1 for 2014/15

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

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

**Rationale for inclusion**
The hospital (a) target has seen lower than required scores during the year and we are looking for a more consistent approach to this important aspect of patient care.

Hospital (b) is an important patient experience measure for patients and, therefore, sees a more challenging target set for 2014/15.

The community priorities were chosen following the results of the 2013/14 patient surveys which indicated these areas need improvement.

**Developments planned for 2014/15**
Actions being undertaken to achieve the Trust target include:

- Continue to recruit volunteer mealtime assistants
- Newly recruited volunteer mealtime assistants to be trained and in place on the wards where needed
- Targeted patient experience surveys to be undertaken with patients requiring mealtime assistance to ensure patients are getting the help they need
- Call bell data included on the new ward huddle board (prominent boards on each ward that include important safety and patient experience information for patients, relatives and staff) to maintain the focus on this important issue and to let staff and patients know how their ward is performing
- Review and further develop the pilot carried out on surgical wards in 2013/14 and roll out to all wards
- Develop postcard-style information to give to patients finishing their treatment advising who to contact if they are worried and how to raise a concern
- Utilise the Single Point of Access (SPA) telephone number for patients to use
- Refresh posters in clinic settings advising patients how to raise concerns
- Review appointment and discharge letters to ensure patients receive information on who to contact if they are worried after treatment and how to raise a concern

**Board sponsor:** Denise McMahon, Director of Nursing
**Operational lead:** Mandy Green, Deputy Head of Communications and Patient Experience

## Priority 2 for 2013/14: Pressure ulcers

| Pressure ulcers | |
|---|---|
| **Hospital** | **Community** |
| a) Reduce avoidable stage 4 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50 per cent in 2013/14.<br><br>b) Reduce avoidable stage 3 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25 per cent in 2013/14. | Reduce avoidable stage 3 and 4 acquired pressure ulcers that occur on the district nurse caseload so that the number for 2012/13 has been reduced by 25 per cent in 2013/14. |

### How we measure and record this priority

Pressure ulcers, also called pressure sores and bed sores, are staged one to four with four being the most serious. When a patient is identified as having a pressure ulcer, the details are entered into the computer incident reporting system and are reviewed by the Tissue Viability team prior to reporting externally.

If pressure damage is noted within 72 hours of admission, this is not considered to have developed in hospital. This time frame is agreed regionally as it is recognised that pressure damage can occur but not be visible immediately.

### Developments that occurred in 2013/14

In April 2013 the Trust changed the tool used to stage the depth of pressure ulcers. The new tool was adapted from the agreed national tool. To publicise the tool, several education sessions took place across the Trust and the Tissue Viability team visited all parts of the hospital with a specially decorated bed. During this tour, the team gave out information about the tool and took the opportunity to raise awareness about all key methods of preventing pressure ulcers.

The pressure ulcer prevention campaign launched in 2012 known as the ‘50 Day Dash’ continued. Some wards have now gone far beyond the initial aim of having 50 pressure ulcer free days, achieving more than 500 days free from avoidable stage 2,3 and 4 pressure ulcers. The relevant wards were recently rewarded for all their hard work with a visit from the chief executive who was full of praise for the staff. Information on the campaign remains visible on the Trust intranet

Certain patients need high specification plug-in alternating air mattresses. This specialised type of equipment is not required on every bed so the Trust ensured that, when needed, the equipment was available as soon as possible. Appreciating that patients were not on this equipment immediately on admission led to the evaluation of a new type of mattress, known as the hybrid mattress, that could be available on every bed. Following work to evaluate several different options, new static air mattresses, which have air cells inside them and are suitable for patients who are at high risk of developing pressure ulcers, have now been introduced and are in-situ on

all inpatient beds (excluding maternity and paediatrics). When plug-in mattresses are required they can be issued within an acceptable time frame because overall demand for this type of equipment has reduced significantly.

Standardised pressure ulcer prevention and management documents are now being used across the hospital and community. The prevention document includes a SKIN (Surface Keep moving Incontinence Nutrition) bundle, which carers complete to ensure every aspect of pressure ulcer prevention is addressed at each patient care episode. Further improvements have been made in the way in which the documents are monitored.

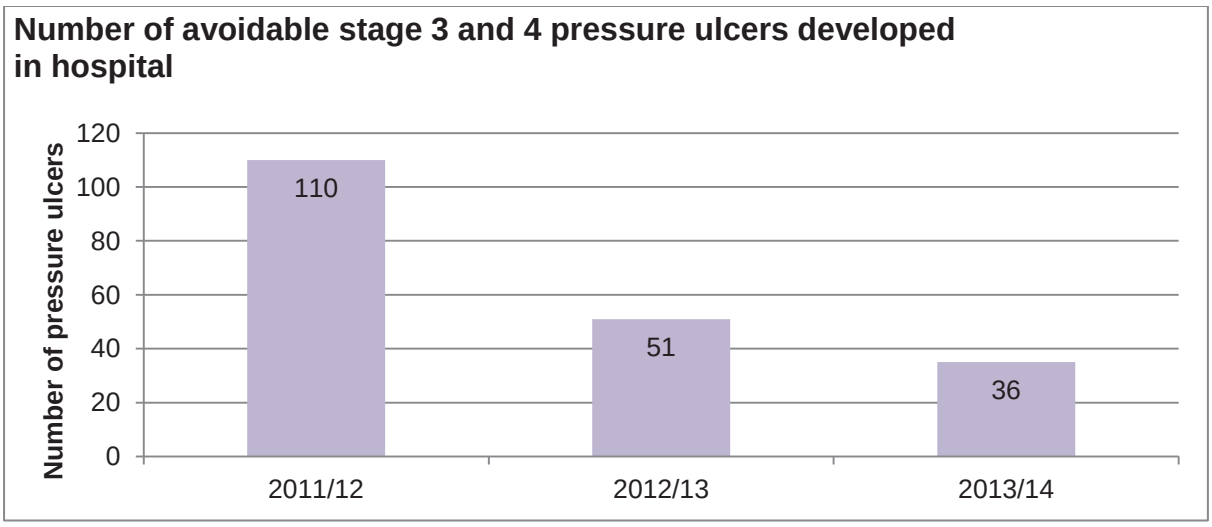
The Trust has recognised the importance of continually updating community carers in pressure ulcer prevention and completion of the SKIN bundle documents. This includes carers in the home and residential home settings. SKIN bundle sessions continue for this group of staff across the year on a rolling programme and all sessions are well attended. The Trust has supported the continued hospital link nurse sessions in which nurses off all wards are kept updated every two weeks.

Recently the Trust has employed two new nurses to support community nurses through development of guidance and education to continue to improve pressure ulcer prevention.

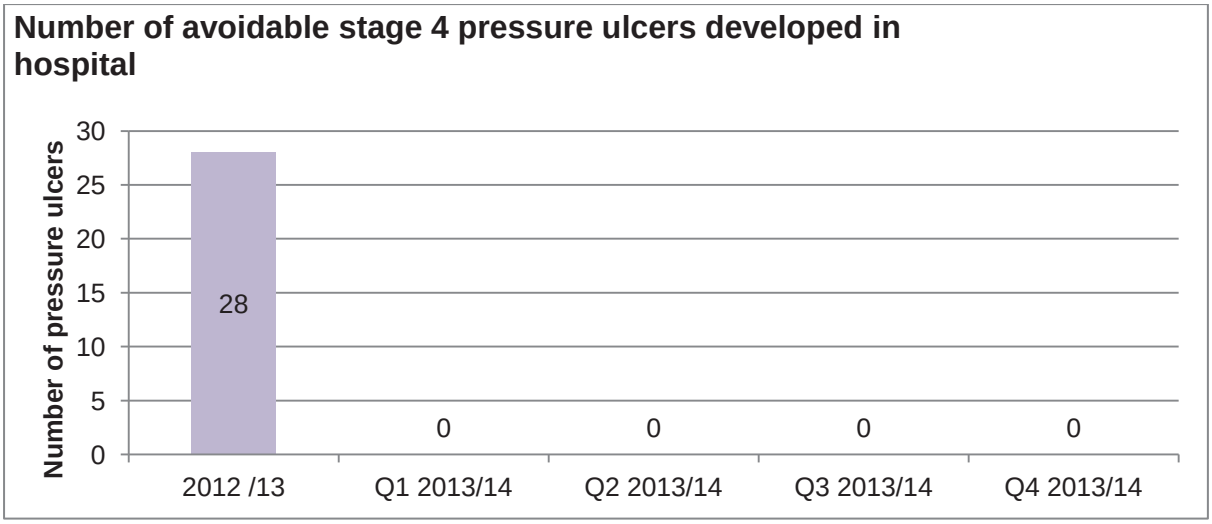
An innovative video campaign was launched during the Christmas period. This was a fun video reminding staff of the ways to reduce the risk of pressure ulcers. The video is available on the Trust intranet for staff to see.

## Current status: Hospital

The graph below shows the total number of avoidable stage 3 and 4 pressure ulcers that developed in the hospital from 2011/12 to the present. It gives an indication of the dramatic fall in numbers due to the hard work of all staff involved. While there were 51 stage 3 and 4 ulcers in 2012/13 these have been reduced to 36 this year.



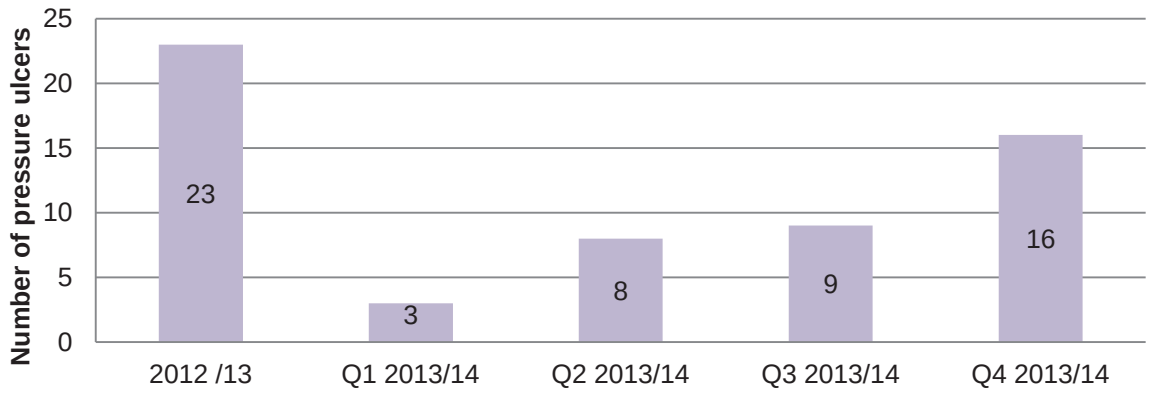

Specifically for avoidable stage 4 hospital acquired pressure ulcers, the target set was that the number for 2012/13 would be reduced by 50 per cent in 2013/14. In 2012/13 there were 28 stage 4 ulcers. This year there have been none of these at all and so the target has been achieved.




**I can only sing the praises of the department as nothing was too much trouble and would like to say a big thank you for their dedication and care.**

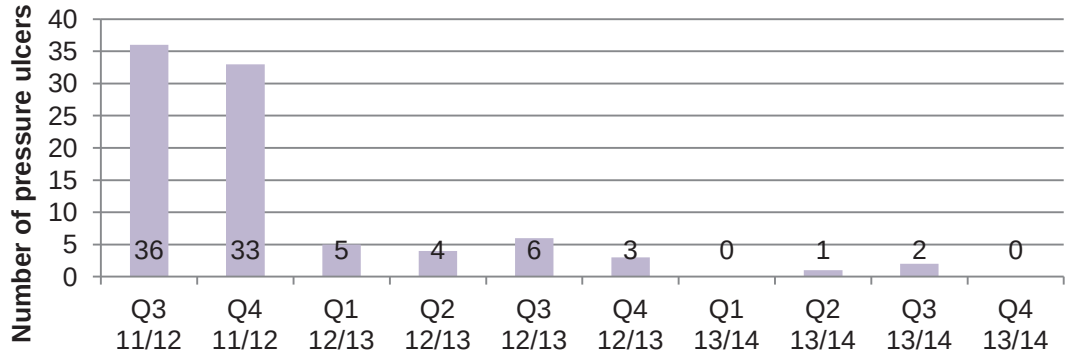
With regards to avoidable stage 3 hospital acquired pressure ulcers, the target set was that the number for 2012/13 would be reduced by 25 per cent in 2013/14. In 2012/13 there were 23 stage 3 ulcers and so to hit the target the Trust should have had fewer than 16. It can be seen that there have been 36 and so this target has unfortunately not been met. This non-achievement should be seen in context of the introduction of a new staging tool and the overall yearly reduction of stage 3 and 4 ulcers from 51 to 36. It is likely that the numbers of stage 3 ulcers have risen as some of these would previously have developed into stage 4.

**Number of avoidable stage 3 pressures ulcers developed in hospital**




## Current status: Community

**Total number of avoidable stage 3 and 4 pressure ulcers developed on the district nursing caseload**




It can be seen that the district nurse caseload target that avoidable stage 3 and 4 acquired pressure ulcers in 2013/14 would be reduced by 25 per cent from the 2012/13 number has been achieved. In 2012/13 there were 18 ulcers in total and so a reduction of 25 per cent would be to have 13. There have been three in total for the whole year and so the actual reduction has been more than 80 per cent.

## New priority 2 for 2014/15

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

**Rationale for inclusion**

- Pressure ulcers are difficult to treat and slow to heal, and prevention is therefore a priority.
- Although the Trust has continued to reduce the overall numbers in 2013/14, it realises there is still much to do and moving to a zero tolerance of pressure ulcers in hospital should be the aim.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

**Developments planned for 2014/15**

Actions being undertaken to achieve the Trust target include:

- Continue to support hospital staff in the effective use of new mattresses
- Utilise the equipment coordinator to monitor current practice in all wards. This will include checking that SKIN bundles are completed effectively and ensuring patients are all nursed on the appropriate equipment
- Develop and embed the use of a new equipment selection flow chart for the community service supported by education sessions
- Continue weekly meetings with the pressure ulcer group to review any stage 3 or 4 ulcers that may develop while the patient is under the care of the Trust
- The Tissue Viability team will continue to work with private care agencies and organise education sessions and updates as required
- The team will support nursing homes with regular link nurse meetings
- Following the success of a first newsletter sent out to nursing homes, the team intend to send a regular newsletter to update nursing home staff and practice nurses
- Education sessions to continue for all staff with practical sessions
- Play a role in working with national groups to agree standard definitions for wounds that are diabetic foot ulcers or related to circulation problems compared to pressure ulcers

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

## Priority 3 for 2013/14: Infection control

| Infection control | |
|---|---|
| Reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. | |
| **MRSA** | **Clostridium difficile** |
| Have no post 48 hour cases of MRSA bacteraemia (blood stream infections). | Have no more than 38 post 48 hour cases of Clostridium difficile. |

### How we measure and record this priority

MRSA bacteraemia and C. diff numbers are divided into pre and post 48 hours cases. Only the post 48 hours cases are attributed to the Trust, meaning the patient acquired it in hospital. Pre 48 hours cases mean the patient was already developing the infection before they were admitted to hospital. As part of the local health economy the Trust has to record both pre and post 48 hours cases.

When our pathology laboratory has a positive result, the information is fed into the MESS (Mandatory Enhanced Surveillance System) national database. From here the data for all trusts is collated and sent to the Public Health England for publication.

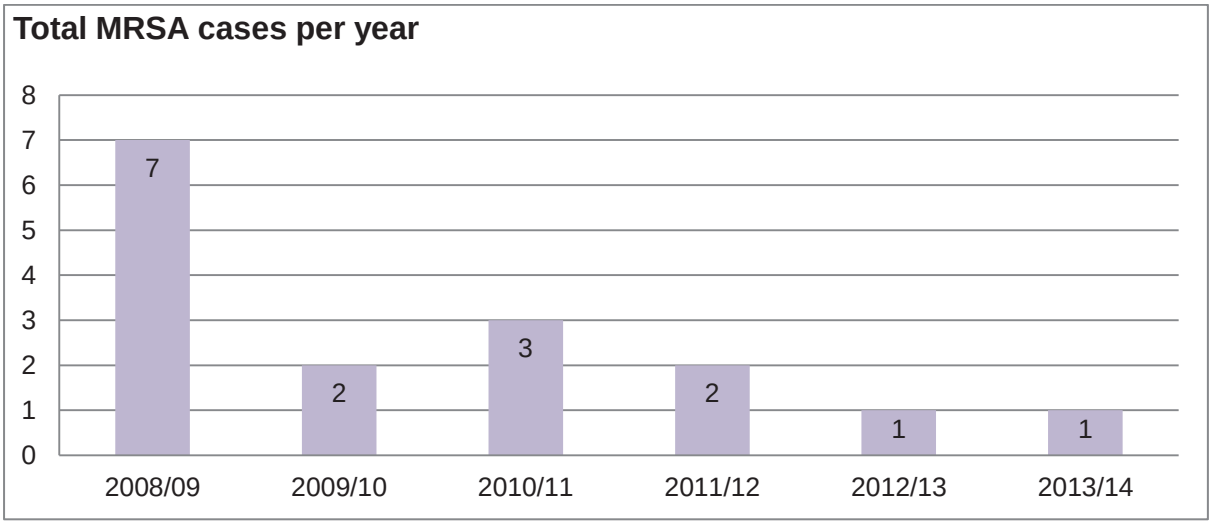
### Developments that occurred in 2013/14

- Further education programmes have been developed and there has been improved attendance of staff at the relevant sessions.
- Effective antimicrobial prescribing has been promoted.
- The hydrogen peroxide vapour (HPV) 'fogging' service that contributes to the prevention of cross infection has been rolled out.
- The C. diff care pathway has been revised in line with national guidance to include the use of fidaxomicin (Dificlir), which is associated with lower rates of relapse.
- An Infection Control Nurse has been assigned to the investigation and follow up of patients with C. diff.
- The Trust has participated in primary care educational programme for GPs to improve prescribing of antimicrobials and awareness of C. diff.

**"The ward I was in was kept scrupulously clean by the hard working cleaning staff every day."**

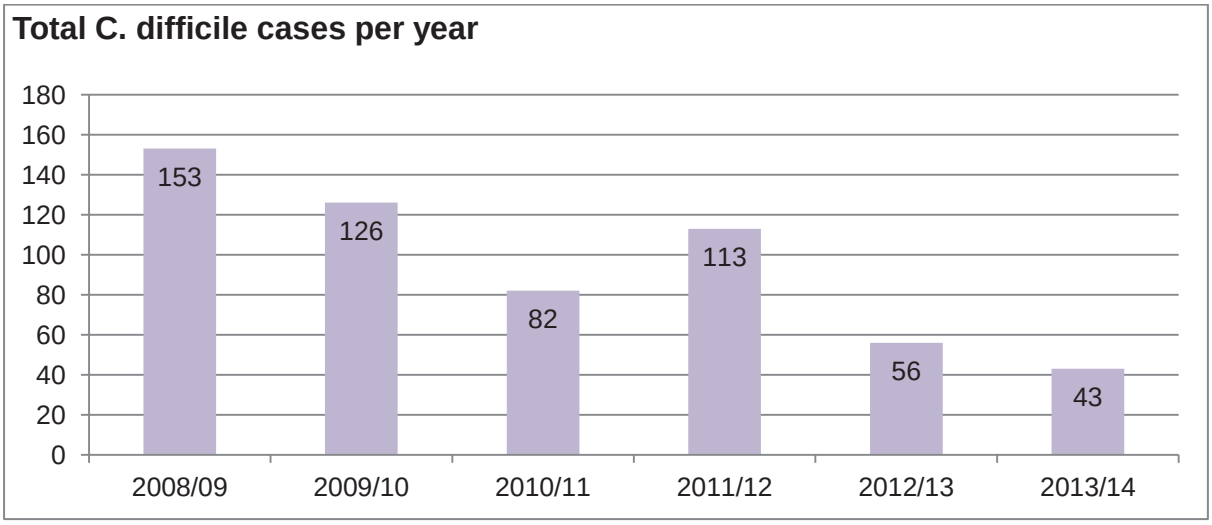
## Current status: MRSA

We continue our good work to maintain a low level of MRSA bacteraemia; however, we did not achieve the target of having no cases. The graph below shows the continued reduction of MRSA bacteraemia cases (post 48 hour, i.e. patients who acquired it whilst in hospital) from a total of seven in 2008/9 to the one case this year.




## Current status: C. difficile

With regards to C. diff, the target set by the government in 2012/13 was no more than 77 and the Trust achieved this with just 56 in the year. When the Trust was set the target of 38 for this year, it was accepted that this would be challenging and this has proved to be the case. The Trust has had 43 cases in the year and so the target has not been met even though it is the Trust's best performance for six years.



## New priority 3 for 2014/15

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

**Rationale for inclusion**

- The drive to reduce healthcare associated infections, which includes MRSA bacteraemia and C. diff, continues to get more and more challenging.
- The reduction of infection remains a key priority across the NHS.
- The Trust is extremely conscious of its non acheivement of the targets in 2013/14.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

**Developments planned for 2014/15**

Actions planned to achieve the above aims include:

- Working with our hydrogen peroxide vapour (HPV) 'fogging' contractor to agree a rolling programme of decontamination services to assist in the prevention of cross infection
- Providing further training around specimen collection and utilising the specimen checklist relating to C. diff
- Develop further education programmes and competencies that can be utilised across the Trust for Infection Control
- Working with community nursing teams to enhance their knowledge around specimen retrieval, infection prevention and control and data collection.
- Developing an agreement with the principal commissioner (Dudley CCG) on local actions, including an algorithm to differentaite between avoidable and unavoidable cases, based on NHS England's publication: C. diff infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation
- Publish the numbers of avoidable and unavoidable C. diff cases on the Trust website

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

**"The staff on the ward were caring and helpful, the ward was spotlessly clean and nothing was too much trouble for the staff."**

## Priorities 4 and 5 for 2013/14: Nutrition and hydration

| Nutrition |
| --- |
| a) Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90 per cent of patients will have the weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2014).<br><br>b) Increase the number of patients having a food recording chart and a fluid balance chart in place if the Malnutrition Universal Screening Tool (MUST) score is 1 or above. Through the year on average at least 90 per cent of patients will have the weekly risk assessment completed and this will rise to at least 93 per cent by the end of the year (March 2014). |

| Hydration |
| --- |
| Increase the number of patients who have their fluid balance charts fully completed. Through the year on average at least 90 per cent of patients will have their charts fully completed and this will rise to at least 93 per cent by the end of the year (March 2014). |

### How we measure and record these priorities

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

The Malnutrition Universal Screening Tool (MUST) has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. The tool has been in use at the Trust for a number of years. The NCI monitoring also includes checking the recording of fluid input and output of patients. The completion rates of each ward are fed back to the matrons and ward managers for action where necessary.

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

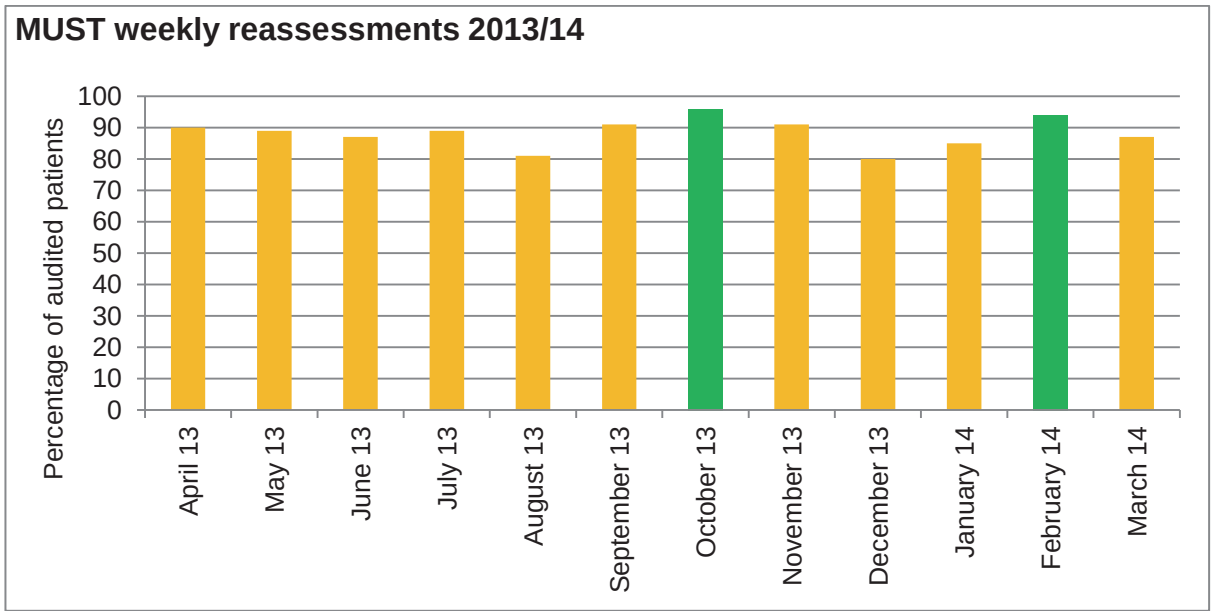
### Developments that occurred in 2013/14

- An escalation process has been developed for tracking areas of concern from the mealtime audits
- An electronic based learning package has been identified and we are awaiting verification of compatibility with current Trust IT systems
- Free standing notices at the entrance of each ward area to denote Protected Mealtime Service is occurring have been introduced

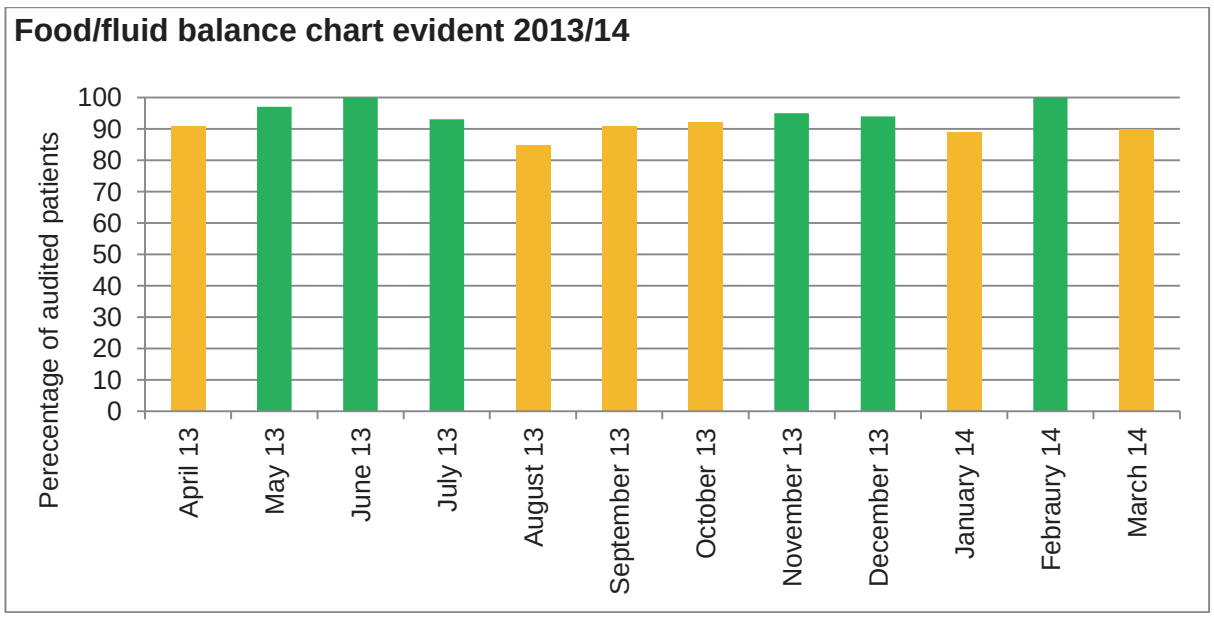
- New national descriptors for speech language therapy in relation to food consistency grading have been rolled out
- Participated in International Nutrition and Hydration week when the importance of a good diet was publicised in a variety of ways across the Trust

## Current status: Nutrition

Results for the weekly reassessments of the MUST scores show that although 93 per cent or over was achieved in October and February, unfortunately the average of 90 per cent throughout the year was just missed, with the Trust achieving an average of 89 per cent. In March the figure attained was 87 per cent and so the 93 per cent end of year target was not met.

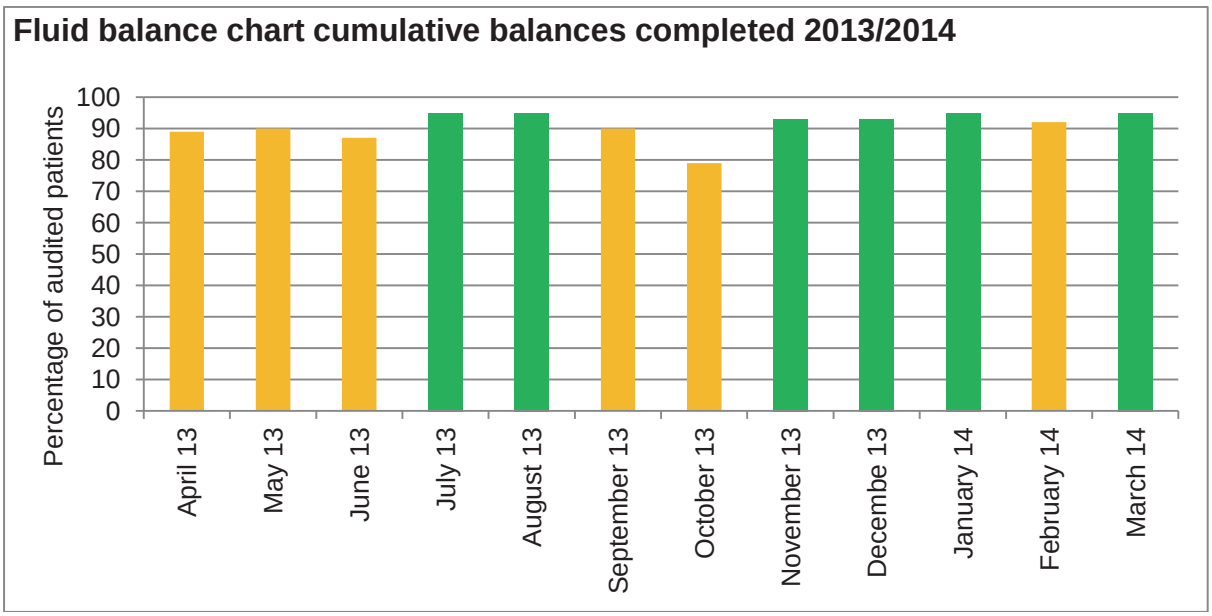



Results for patients identified at risk having both a fluid balance and food monitoring chart in place show that 93 per cent or over was achieved in six of the months and the average of 90 per cent throughout the year has been met (average was 93 per cent). In March 2014 the figure attained was 90 per cent and so the 93 per cent end of year target was not met.



## Current status: Hydration

Results for patients having their fluid balance charts completed show that 93 per cent or over was achieved in six of the months and the average of 90 per cent throughout the year has been met (average was 91 per cent). In March the figure attained was 95 per cent and so the 93 per cent end of year target was also met.




## New priorities 4 and 5 for 2013/14

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

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

**Rationale for inclusion**

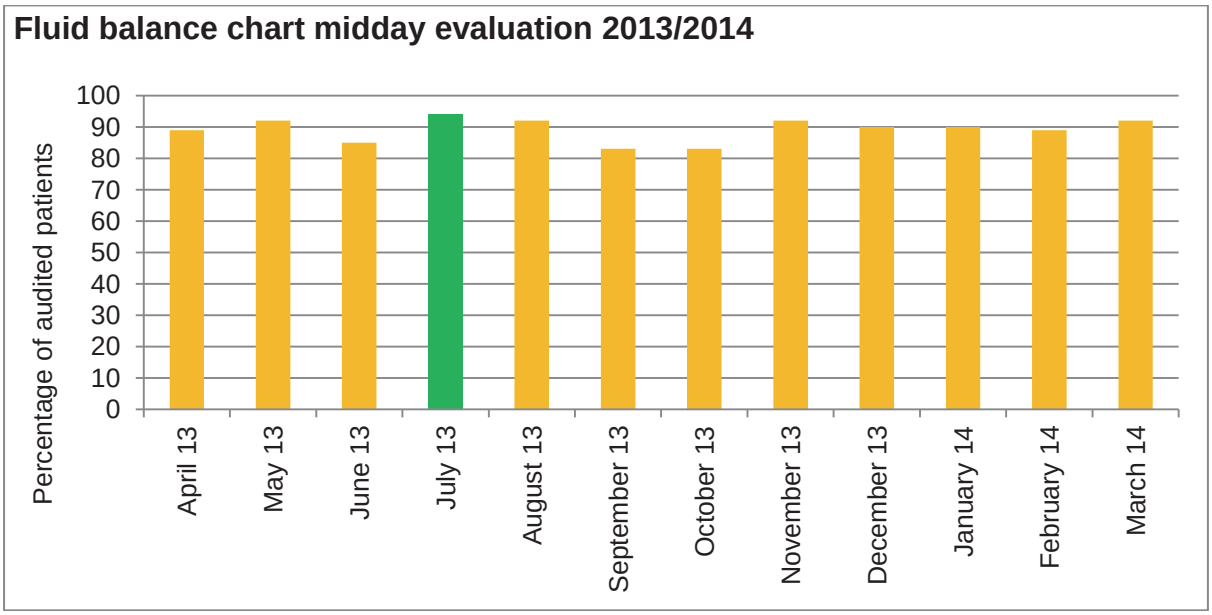
- Not all of our targets on these topics were met last year.
- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The consequences of poor nutrition and hydration are well documented and include increased risk of infection, poor skin integrity and delayed wound healing, decreased muscle strength, depression and, sadly, premature death. Put simply poor nutrition and hydration causes harm.
- A number of national reports have questioned the state of practice on these topics across hospitals generally.

As 2013/14 figures show, with regards to undertaking the weekly re-assessments of the MUST we did not achieve the 90 per cent average target (actual figure 89 per cent) or the end of year target of 93 per cent (actual figure 87 per cent). Consequently we are retaining this target for 2014/15. Due to adding in a sixth priority topic this year (Mortality – see section below), and as we achieved an average of 93 per cent in our second nutrition target, we shall just have one nutrition target in 2014/15.

With regards to hydration, we achieved both elements of that target, with nurses ensuring they completed patients' fluid balances at the end of the day. It is important that nurses not only monitor and total the fluid balance at the end of the day but also monitor input and output continually. In order to further improve care, we have decided that the balance should also be calculated and documented at midday. These lunch time evaluations are vital in ensuring that any hydration issues are identified early so interventions and active management can be implemented to halt any deterioration of the patient.

**I am sure that the high standard and excellent choice of food provided by the catering staff at Russells Hall Hospital was a major contributor in aiding my recovery.**

In 2013/14, the average monthly completion of these midday fluid balances was 89 per cent (see below). The new hydration target for 2014/15 is that this should average 93 per cent.




**Developments planned for 2014/15**

- The present process of monthly mealtime audits will be reviewed to develop a more robust system of ensuring appropriate action is taken dependant on the audit results.
- A more automated system of ensuring that patients and staff are forewarned about mealtimes rather than relying on the use of the hand bells will be introduced.
- An electronic learning package will be implemented.
- A formalised strategy will be developed to ensure that nutrition and hydration are priority issues.
- All current menus will be reviewed to ensure greater choice for patients.
- All nutrition based policies will be reviewed and amended to ensure they reflect up-to-date practice at the Trust.

**Board Sponsor:** Denise McMahon, Director of Nursing
**Operational Leads:** Dr S. Cooper, Consultant Gastroenterologist; Sheree Randall, Matron; Karen Broadhouse, Quality Project Lead

**The care I received from every person who I came into contact with was excellent and made me feel important, well informed and cared for at all times.**

## New priority 6 for 2014/15: Mortality

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

**How we will measure and record this priority**

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

**Rationale for inclusion**

- Feedback from the Keogh Review in May 2013 indicated that the Trust should consider including Mortality as a Quality Priority .
- The Keogh Report highlighted the importance of detailed and systematic case note review as the way forward in learning from hospital deaths and, therefore, the Trust needs to ensure that this is undertaken regularly in all specialties.
- A high Summary Hospital-level Mortality Indicator (SHMI) is a trigger for hospitals to investigate and understand where performance may be falling short in specific areas.

**Current status**

At present, the Trust has an average of 70.6 per cent of in-hospital deaths undergoing specialist multi-disciplinary review within 12 weeks. The details by speciality are below:

**Meeting 85% target** **At or above Trust average** **Below Trust average**

| Specialty | % audited within 12 weeks |
| --- | --- |
| Cardiology | 80.6 |
| Gastroenterology | 65.1 |
| General medicine | 64.5 |
| Medical assessment | 82 |
| Orthogeriatrics | 100 |
| Rehabilitation | 70.6 |
| Respiratory | 95.5 |
| Stroke medicine | 85.9 |
| Diabetes | 88.9 |
| Endocrinology | 100 |
| Renal | 32.1 |
| Rheumatology | 100 |

| Specialty | % audited within 12 weeks |
| --- | --- |
| Clinical oncology | 63.6 |
| Haematology | 50 |
| Medical oncology | 33.3 |
| Care of the elderly | 79.3 |
| ENT | 66.7 |
| General surgery | 62.8 |
| Urology | 30 |
| Vascular surgery | 47.4 |
| T&O rehabilitation | 100 |
| Trauma and orthopaedics | 96.3 |
| Neonates | 100 |
| Gynaecology | 100 |

**Developments planned for 2014/15**

- Directorate mortality and action plans will be reviewed quarterly.
- Monthly mortality meeting will be held by the Medical Director, Information staff and Dudley CCG staff to review:
    - Mortality Indices,
    - Mortality Tracking System Performance
    - Review action plans
    - Provide exception reports where necessary to board.

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

## 2.2 Statements of assurance from the Board of Directors

### 2.2.1 Review of services

During 2013/14 The Dudley Group NHS Foundation Trust provided and/or sub-contracted 59 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2013/14 represents 99.1 per cent of the total income generated from the provision of relevant health services by The Dudley Group NHS Foundation Trust for 2013/14.

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

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

- Nursing Care Indicators – monthly audits of key nursing interventions and their documentation. The results are published, monitored and reported to Board of Directors monthly by the director of nursing (see section 3.3.4).
- Ongoing patient surveys that give a 'feel' for our patients' experiences in real time so that we can quickly identify any problems and correct them (see section 3.2.2).
- Every other month, senior medical staff attend the Board of Directors meeting to provide a report and presentation on performance and quality issues within their speciality areas.
- Every other month, a matron attends the Board of Directors meeting to provide a report and presentation on nursing and quality issues across the whole Trust.
- The Trust has an electronic dashboard of indicators for directors, senior managers and clinicians for monitoring performance. The dashboard is essentially an on-line centre of vital information for staff.
- The Trust works with its local commissioners scrutinising the Trust's quality of care at joint monthly Clinical Quality Review Meetings.
- External assessments, which included the following key ones this year:
    - The Keogh Review occurred in May 2013. Following the review, the Trust was one of two of the 14 hospitals reviewed not to be placed in special measures. A publically available action plan was implemented following the visit (see http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx).
    - Following an unannounced visit on site, in July 2013 the Care Quality Commission (CQC) declared that the Trust was compliant with the regulated activity of medicines management. As part of its new regime of inspections, the CQC visited the Trust in March 2014 and a formal report is expected in June 2014.

- In February 2013, Dudley Clinical Commissioning Group undertook a visit into the Trust's frail elderly services. The Trust received the final report in May 2014 and is drawing up an action plan based on the report.
- The Clinical Pathology Accreditation (UK) Ltd, which is the authority which approves laboratories, visited the following departments: Microbiology (July 2013) and Immunology (July 2013). Both maintained accredited status.
- In May 2013, NHS Quality Control North West visited the Trust's Aseptic Pharmacy Unit and the conclusion was that the unit continues to operate to a very high standard, utilising a very comprehensive and well documented quality system.
- The West Midlands Quality Review Service (WMQRS) visited the Trust on two occasions. In January 2014 the service reviewed the Care of Critically Ill & Critically Injured Children, and in February 2014 it undertook a formative review of certain elements of the maternity service. The outcome of both reviews found no major issues of note and a number of improvements are in the process of being implemented.
- With regards to education and training, the West Midlands Deanery undertakes a variety of checks on the education of doctors at the Trust. Following previous visits to the paediatric speciality in 2012, the Trust had a follow up visit led by the Postgraduate Dean in April 2013, the result of which was that the programme was approved. A further check in November 2013 had a similar positive outcome and so the next inspection for paediatrics is now due in three years time. In June 2013, an Anaesthetic Department visit had a similar favourable outcome with the programme approved. In February 2014, the Trust had a monitoring visit on its Medical Undergraduate Teaching Academy. The feedback from the visit highlights evidence of good practice and enthusiastic feedback of medical students who gain experience at the Trust.
- In March 2014 the Nursing and Midwifery Council (NMC), which oversees the education of nurses and midwives, undertook a review of the University of Wolverhampton, which the student nurses at the Trust attend. No concerns specific to the Trust were raised.

**"The care support workers and staff were kind, friendly and helpful and made my recovery a very pleasant experience."**

## 2.2.2 Participation in national clinical audits and confidential enquiries

During 2013/14, 32 national clinical audits and five national confidential enquiries covered relevant health services that the Trust provides. During that period the Trust participated in 100 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

### Table 1

**National clinical audits that the Trust was eligible to participate in, actually participated in during 2013/14 and the percentage of the number of registered cases submitted by the terms of the audit**

| Name of Audit | Type of Care | Participation | Submitted % |
|---|---|---|---|
| ICNARC Case Mix Programme Database | Acute Care | Yes | 100% |
| Emergency Use of Oxygen | Acute Care | Yes | 100% |
| National Audit of Seizures in Hospitals | Acute Care | Yes | 100% |
| National Emergency Laparotomy Audit | Acute Care | Yes | Ends 2015 |
| National Joint Registry | Acute Care | Yes | 97% |
| Paracetamol Overdose (care provided in Emergency Departments) | Acute Care | Yes | 100% |
| Severe Sepsis & Septic Shock | Acute Care | Yes | 100% |
| TARN Severe Trauma Audit | Acute Care | Yes | 81.4% |
| National Comparative Audit of Blood Transfusion: Audit of the Use of Anti-D | Blood & Transplant | Yes | 100% |
| National Comparative Audit of Blood Transfusion: Audit of Patient Information & Consent | | Yes | 96% |
| National Bowel Cancer Audit Project | Cancer | Yes | 100% |
| Data for Head and Neck Oncology | Cancer | Yes | 100% |
| National Lung Cancer Audit | Cancer | Yes | 100% |
| National Oesophago-gastric Cancer Audit | Cancer | Yes | 100% |
| MINAP Acute Coronary Syndrome/Acute Myocardial Infarction Audit | Heart | Yes | 100% |

| Name of Audit | Type of Care | Participation | Submitted % |
|---|---|---|---|
| Cardiac Rhythm Management | Heart | Yes | 100% |
| National Cardiac Arrest Audit | Heart | Yes | 100% |
| National Heart Failure Audit | Heart | Yes | 86% to Feb 14 |
| National Vascular Registry | Heart | Yes | 96-100% |
| National Diabetes Inpatient Audit | Long-term Conditions | Yes | 100% |
| National Pregnancy in Diabetes Audit | | Yes | Ends 30 Aug 2014 |
| National Paediatric Diabetes Audit | Long-term Conditions | Yes | 100% |
| Inflammatory Bowel Disease Audit | Long-term Conditions | Yes | 100% |
| National Chronic Obstructive Pulmonary Disease Audit programme | Long-term Conditions | Yes | Ends May 2014 |
| Renal Replacement Therapy (Renal Registry) | Long-term Conditions | Yes | 100% |
| Rheumatoid and Early Inflammatory Arthritis | Long-term Conditions | Yes | Began Feb 2014 |
| Falls and Fragility Fractures Audit Programme | Older People | Yes | 100% |
| Sentinel Stroke National Audit Programme | Older People | Yes | 100% |
| Elective Surgery (National PROMs Programme) | Other | Yes | 96% |
| Epilepsy 12 Audit (Childhood Epilepsy) | Women & Children's Health | Yes | Ends Oct 2014 |
| Maternal, Newborn and Infant Clinical Outcome Review Programme | Women & Children's Health | Yes | 100% |
| Moderate and severe asthma in children CEM audit | Women & Children's Health | Yes | 100% |
| National Neonatal Audit Programme | Women & Children's Health | Yes | 100% |
| Paediatric Asthma Audit | Women & Children's Health | Yes | 100% |

## Table 2

**National confidential enquiries that the Trust was eligible to participate in, actually participated in during 2013/14 and the percentage of the number of registered cases required by the terms of the enquiry**

| Name of Audit | Type of Care | Participation | Submitted % |
|---|---|---|---|
| Alcohol Related Liver Disease | NCEPOD | Yes | 100% |
| Subarachnoid Haemorrhage | NCEPOD | Yes | 100% |
| Tracheostomy Care | NCEPOD | Yes | 100% |
| Lower Limb Amputations | NCEPOD | Yes | 100% |
| Gastrointestinal Haemorrhage | NCEPOD | Yes | In progress |

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

## Table 3

**Additional National Clinical Audits that the Trust participated in during 2013/14**

| Name of Audit | Type of Care | Participation | Submitted % |
|---|---|---|---|
| National British Society for Rheumatology Audit on the Management of Gout | Rheumatology | Yes | 100% |
| National Bowel Cancer Mortality Outlier Review | General Surgery | Yes | 98% |
| National Audit Project (NAP5) Accidental Awareness during General Anaesthesia (AAGA) | Anaesthetics | Yes | 100% |
| National Obstetric Anaesthetic Database (NOAD) | Anaesthetics | Yes | 100% |
| NICE-BAD National Audit on Psoriasis | Dermatology | Yes | 100% |
| National Care of the Dying Audit Hospitals (NCDAH) Round 4 | Palliative Medicine | Yes | 100% |
| National Prostate Cancer Audit | Urology | Yes | Organisational data submitted |

**“Any nurse or doctor that I saw introduced themselves and shook my hand. I was made to feel very comfortable and any questions I had were answered clearly.”**

## The reports of the following 21 national clinical audits were reviewed in 2013/14:

National Lung Cancer Audit
UK Inflammatory Bowel Disease Audit
Paediatric Pneumonia Audit
Adult Community Acquired Pneumonia
Review of Asthma Deaths
National Hip Fracture Database
National Comparative Audit: Blood sample collecting and labelling
National Colorectal Cancer Audit
National Neonatal Audit Programme
Adult Asthma
Emergency Use of Oxygen
National Diabetes Inpatient Audit
National Joint Registry
Renal Colic Audit
National Audit for Dementia
Paediatric Asthma Audit
Adult Bronchiectasis
Non-Invasive Ventilation – Adults
Sentinel Stroke National Audit Programme
National Comparative Audit: Use of blood in adult medical patients
Feverish Children Audit

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

**Dementia**
Trust pathway/strategy to be formalised. Planned implementation of the Dementia Champions Project and training commenced in March 2014.

**Gastroenterology**
Appointed a named inflammatory bowel disease (IBD) consultant and regular monthly IBD meetings are undertaken. Set up a transition clinic for IBD with the paediatric team. Planned action is for arrangements to be made for general practitioners to meet with the IBD team.

**Neonates**
National guidance for retinopathy screening as an inpatient to be used, admission form for retinopathy to be revised to document date and time seen/signed, and neonatal unit staff to input and check accuracy of all data entry onto the computer database.

**Paediatrics**
An asthma leaflet has been introduced for parents and a special sheet generated to ensure proper documented discharge planning for every patient. Increased awareness for paediatric nurse colleagues to check and document inhaler and spacer technique, and for relevant medical staff to request chest X-rays only where needed and prescribe antibiotics only where necessary. Further education for junior

doctors on feverish children introduced onto teaching programme and guidelines to be established for investigations. A further proposed action is to develop an advice leaflet for parents.

**Respiratory Medicine**
Inhaler technique to be checked with all adult asthma patients prior to discharge. All patients to be prescribed oral steroids within four hours and smoking cessation to be discussed with all patients. All bronchiectasis patients to have blood tests for aspergillus and immunoglobulins and all patients to have yearly sputum culture and to be referred for active cycle breathing techniques (ACBT). A successful pilot carried out on respiratory ward of oxygen prescription in drug charts. The new drug chart now has a dedicated space for oxygen prescribing. All patients have a treatment plan in place if Non-Invasive Ventilation (NIV) fails.

**Diabetes**
Several key initiatives have improved our performance. There has been a significant improvement in examination and management of foot problems, and we are now a leading example of good practice in this area having a featured case study on NHS England. Improvement in the number of patients seen by the diabetes team in the first 24 hours, and in how aware the staff are about diabetes.

**Orthopaedics**
Actions are to continue good practices for robust pre-operative checks and patient selection and to ensure that mechanisms are in place for identifying and using tried and tested prostheses with a good track record.

**Haematology**
It is planned to develop a Trust-wide policy for written consent for blood transfusion, to audit local practice around transfusion and treatment for anaemia, and to include advice for clinicians regarding underweight adult dosing in blood transfusion training sessions and in the transfusion policy. In addition, a zero tolerance awareness campaign to be repeated in the Trust. Other actions planned to include the implementation of e-phlebotomy, to introduce the ‘two-sample’ approach and the blood bank request form to be re-designed to reflect acceptance criteria.

## Local clinical audit

The reports of 92 completed local clinical audits were reviewed in 2013/14 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

**Haematology**
Ward/department resource folder developed to improve staff knowledge of thromboprophylaxis and anticoagulation.

**Pharmacy**
Screensavers introduced onto hospital intranet and email/text messages sent to junior doctors as reminders of timely completion of prescriptions for take home medications.

**Surgery**
Improving communication channels in the decision-making for calling second emergency theatre team. Flow chart displayed within relevant clinical areas.

**Anaesthetics/Critical Care**
Re-audit showed improved critical care nurses' knowledge relating to airway management following the introduction of an educational programme. Education session introduced for anaesthesia trainees and consultants on how to perform low flow anaesthesia safely and effectively. Electronic patient record on ITU updated to encourage compliance with antimicrobial guidelines.

**Clinical Biochemistry**
Patients considered for bariatric surgery are now given information on the need for lifelong follow up and vitamin supplementation, and are asked to sign to confirm they agree to this. Clinic patients who do not attend are contacted to find out why and are offered support to encourage them to attend.

**Neurology**
For Parkinson's patients, *Get It On Time* medication campaign launched. Screensaver uploaded onto the Trust intranet. Posters displayed on notice boards and information packs disseminated to all areas.

**Emergency Department**
Repeat attendees are identified and patient alerts or individual management plans allocated as necessary. Case notes of all patients who do not wait to be seen are reviewed by a consultant.

**Infection Control**
Increased publicity of timely notification of suspected bacterial meningitis or meningococcal septicaemia to Public Health.

**Maternity**
Visual aids on Postpartum Haemorrhage (PPH) displayed on labour wards and obstetric theatres. Current guidance on pregnancy of unknown location reviewed as findings suggested that repeat βHCG (beta subunit of human chorionic gonadotropin) did not show any benefit to the clinical diagnosis. Conservative management is an acceptable alternative.

**Neonates**
A new proforma has been introduced which documents neonatal abstinence observations including the hepatitis status and the referral to social services. Babies are now referred to social services as soon as a diagnosis is identified.

**Orthopaedics**
All major post-operative cases are reviewed on day one following the operation, and all handover is now done electronically. Introduction of a kidney protection care bundle and AKI (Acute Kidney Injury) management guidelines have been added to junior doctor induction packs.

**Urology**
Quick and easy access clinic introduced in urology with 92 per cent of patients discharged the same day and inpatient admission avoided.

## 2.2.3 Research and development

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2013/14 that were recruited during that period to participate in research approved by a Research Ethics Committee was 2284. Of these, 262 were recruited to commercial studies. While overall recruitment reduced by three per cent compared to 2012/13 (2591), accrual to commercial studies, generally acknowledged as being more complex, increased to 11.4 per cent (7.1 per cent in 2012/13), representing a growth in commercial income.

The Trust has always been strong in research activity centred in the cancer, cardiology and musculoskeletal clinical disciplines. This has not only continued but increased further during this financial year, recruiting to both NHS National Institute for Health Research (NIHR) adopted studies and commercial clinical trials.

Dermatology and endocrinology are relatively new to clinical research in Dudley, but both had great successes and will become large research centres over the course of the next financial year. The Research and Development Department continues to monitor and support progress to enable the specialties to reach their full research potential. Trust publications for the calendar year 2013, including conference posters, stand at 107.

NIHR portfolio adopted research activity can also be found within acute medicine, gastroenterology, HIV medicine, maternity, neurology, stroke, urology, breast and vascular surgery. There are plans to increase activity in all of these and other specialties.

The Trust hosts three research fellows and several PhD students, funded predominantly by Arthritis Research UK and Birmingham & Black Country Comprehensive Local Research Network (BBC CLRN).

The Trust ran publicity events at two sites on International Clinical Trials Day, 20th May 2013, with the assistance of staff from BBC CLRN. The ‘OK to ask’ campaign continues to be publicised within the Trust via posters, slots on the Health Hub in Russells Hall Hospital and stalls at Trust member open days.

Staff in orthopaedics and diabetes have worked together to produce a Trust-wide system that generates its own individually tailored patient information sheets for diabetic patients who are undergoing elective orthopaedic surgery. This is an excellent example of collaborative multi-disciplinary working that resolves a long recognised clinical issue.

The Myeloma XI trial, providing treatment pathways for patients with multiple myeloma, and the TEAMM study, seeking to establish the best use of antibiotics in myeloma patients who are at high risk from septic death, demonstrate selection of research studies that will benefit current and future patients.

Participation in the ROSE study, an observational study of rivaroxaban running parallel to our clinical practice, is an example of best practice when introducing a new therapy. The haematology specialty network, which comprises all trusts offering this service within BBC CLRN, was recently awarded most improved specialty by the NIHR. This was largely attributed to the significant number of participants recruited here at The Dudley Group.

## 2.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of the Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body it entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at:

*http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf*

CQUIN is a quality increment that applies over and above the standard contract. The sum is variable based on 2.5 per cent of our activity outturn and conditional on achieving quality improvement and innovation goals. The estimated value in 2013/14 was £6.1m as part of our contracts with clinical commissioning groups for acute and community services, and with Specialised Services commissioners. We have not yet agreed the final settlement figure for 2013/14 as some targets are still contingent upon outstanding information. However, for the purpose of the year end accounts, we have assumed 81% per cent achievement of both Dudley CCG and Specialised Services schemes. This would equate to approx £4.9m. In 2012/13 the payment was £5.4m.

There is one CQUIN scheme per contract, made up of several goals. Goals for the Friends & Family Test, venous-thromboembolism, dementia and NHS Safety Thermometer (Pressure Ulcers) are nationally determined, and the remainder is locally agreed. We have rated last year's CQUINs on a red/amber/green basis dependent on achievement to date. At the time of reporting, we are expecting to fall short of fully meeting the goals for Friends and Family (part 2: increased response rate), Pressure Ulcers, Reduction in Fractures as a result of Falls, Letters returned to the referring Clinician and Senior Clinician Review. In all cases, the goals have been at least partially achieved. We have actions in place to ensure the quality of care in these areas is improved.

**Acute and community 2013/14**

| Goal No. | CQUIN targets and topics | Quality domains and RAG rating |
|---|---|---|
| 1 | Friends and Family Test (3 parts) | **Patient experience** |
| 2 | NHS Safety Thermometer – Pressure Ulcers | **Patient experience**<br>**Safety**<br>**Effectiveness** |
| 3 | Dementia screening, risk assessment and referral for specialist services (3 parts) | **Safety**<br>**Effectiveness**<br>**Patient experience** |
| 4 | VTE risk assessment (2 parts) | **Safety** |
| 5 | Safe and timely discharge | **Effectiveness** |

| Goal No. | CQUIN targets and topics | Quality domains and RAG rating |
|---|---|---|
| 6 | Patient safety culture | **Safety**<br>**Effectiveness** |
| 7 | Patient experience for learning disability patients | **Patient experience** |
| 8 | Reduction in fractures as a result of falls | **Safety**<br>**Effectiveness** |
| 9 | Letters returning to the referring clinician | **Effectiveness** |
| 10 | Choose and Book | **Effectiveness** |
| 11 | Senior clinician review | **Effectiveness** |

### Specialised services 2013/14

| Goal No. | CQUIN targets and topics | Quality domains and RAG rating |
|---|---|---|
| 1 | Friends and Family Test (3 parts) | **Patient experience** |
| 2 | NHS Safety Thermometer – Pressure Ulcers | **Patient experience**<br>**Safety**<br>**Effectiveness** |
| 3 | Dementia screening, risk assessment and referral for specialist services (3 parts) | **Safety**<br>**Effectiveness**<br>**Patient experience** |
| 4 | VTE risk assessment (2 parts) | **Safety** |
| 5 | Quality dashboards | **Safety**<br>**Effectiveness**<br>**Innovation** |
| 6 | Renal dialysis – Renal patient view | **Effectiveness**<br>**Innovation**<br>**Patient experience** |
| 7 | HIV – registration and communication with GPs | **Safety**<br>**Effectiveness** |
| 8 | Neonatal Intensive Care – Improved access to breast milk | **Safety**<br>**Effectiveness** |
| 9 | Neonatal Intensive Care – Simple discharge pathway | **Effectiveness** |
| 10 | Neonatal Intensive Care – Retinopathy of prematurity | **Safety**<br>**Effectiveness** |

## CQUIN report 2014/15

In 2014/15 the amount the Trust will be able to earn is 2.5 per cent on top of the actual outturn value. The estimated value of this is approximately £6.4m. The nationally mandated CQUIN goals for the Friends & Family Test, dementia screening and the NHS Safety Thermometer will continue.

### Acute and community

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

### Specialised services

| Goal No. | CQUIN targets and topics | Quality domains |
|---|---|---|
| 1 | Friends and Family Test (4 parts) | Patient Experience |
| 2 | NHS Safety Thermometer – Pressure Ulcers | Patient Experience<br>Safety<br>Effectiveness |
| 3 | Dementia and Delirium (3 parts) | Safety<br>Effectiveness<br>Patient Experience |
| 4 | Quality Dashboards | Safety<br>Effectiveness<br>Innovation |
| 5 | Renal Dialysis – Shared Haemodialysis Care | Patient Experience<br>Effectiveness |
| 6 | Neonatal Intensive Care – Total Parenteral Nutrition | Safety<br>Effectiveness |

## 2.2.5 Care Quality Commission (CQC) registration and reviews

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

Following an unannounced visit on site, in July 2013 the Care Quality Commission (CQC) declared the Trust compliant with the regulated activity of medicines management.

The Care Quality Commission has not taken enforcement action against the Trust during 2013/14.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust awaits the results of the CQC inspection undertaken in late March 2014.

## 2.2.6 Quality of data

The Trust submitted records during 2013/14 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

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

| | The Dudley Group | National average |
|---|---|---|
| **Admitted patient care** | 99.7% | 99.1% |
| **Outpatient care** | 99.9% | 99.3% |
| **Accident and Emergency care** | 99.2% | 95.8% |

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

| | The Dudley Group | National average |
|---|---|---|
| **Admitted patient care** | 100% | 99.9% |
| **Outpatient care** | 100% | 99.9% |
| **Accident and Emergency care** | 100% | 99.1% |

*All above figures are for April 2013 to February 2014*

The Trust's Information Governance Assessment Report overall score for 2013/14 was 79 per cent and was graded 'Satisfactory'.

The Trust was subjected to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

**Accident and Emergency**

| | The Dudley Group | National average |
|---|---|---|
| **Investigations** | 10.6% | 24.8% |
| **Treatments** | 23.6% | 33% |

**Paediatric Emergency**

| | The Dudley Group | National average |
|---|---|---|
| **Primary diagnosis** | 10% | 11.2% |
| **Secondary diagnosis** | 7.4% | 15.3% |
| **Primary procedure** | 0% | 11.8% |
| **Secondary procedure** | 0% | 16% |

*In the above tables the lower the figure the better the result.*

These results should not be extrapolated further than the Accident and Emergency and Paediatric Emergency samples audited.

During 2013/14 there were eight data protection incidents logged on the Information Commissioner's incident reporting site. Actions taken from these incidents included:

- Fax audit being undertaken to reduce the number of faxes being used across the Trust
- Systems put in place for staff to ensure the Electronic Staff Record has up to date address information
- Importance of data security and confidentiality reinforced for community staff
- Mandatory training enforced
- Managers reminded monthly via mandatory training reports of their staff training compliance

## 2.2.7 Core set of mandatory indicators

This is the second year that all trusts have been mandated to insert this section which includes a stipulated number of measures. The tables include the two most recent sets of nationally published comparative data as well as, where available, more up-to-date Trust figures. It should be appreciated that some of the 'Highest' and 'Lowest' performing trusts may not be directly comparable to an acute general hospital e.g. specialist eye or orthopaedic hospitals that have very specific patient groups and which generally do not include emergency patients or those with multiple long-term conditions.

| Mortality | | | |
|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period: October 2012 – September 2013** | **Previous reporting period: July 2012 – June 2013** | **Statements** |
| **Summary Hospital-level Mortality Indictor (SHMI) value and banding** | **Value**<br>Trust 1.11<br>National average 1<br>Highest 1.18<br>Lowest 0.63<br>**Banding**<br>Trust 2<br>National average 2<br>Highest 1<br>Lowest 3 | **Value**<br>Trust 1.13<br>National average 1<br>Highest 1.16<br>Lowest 0.63<br>**Banding**<br>Trust 1<br>National average 2<br>Highest 1<br>Lowest 3 | The Trust considers that this data is as described for the following reasons:<br>• The Trust is pleased to note that the latest SHMI value is within the expected range<br>The Trust has taken the following action to improve this value and so the quality of its services by:<br>• Continuing to improve reviews of all mortality (see new Quality Priority). There is evidence that the Trust's SHMI is reducing |
| **Percentage of patient deaths with palliative care coded at either diagnosis or specialty level (Context indicator)** | Trust 25.3%<br>National average 21.2%<br>Highest 44.9%<br>Lowest 2.7% | Trust 23.74%<br>National Average 16.51%<br>Highest 42.6%<br>Lowest 3% | The Trust considers that this data is as described for the following reasons:<br>• There is a very robust system in place to check accuracy of palliative care coding<br>The Trust has taken the following actions to improve these percentages, and so the quality of its services by:<br>• Ensuring this percentage will always be accurate and reflect actual palliative care. |

| Patient Reported Outcome Measures (PROMS) | | | | | |
|---|---|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period: 2012/13 Provisional** | | **Previous reporting period: 2011/12 finalised** | | **Statements** |
| **Groin Hernia Surgery** | Trust | 0.08 | Trust | 0.05 | The Trust considers that this data is as described for the following reasons:<br>• using feedback data (from HSCIC) we are very pleased with the outcomes that patient report. Patients who said that their problems are better now when compared to before their operation (Groin Hernia: 95%, Hip replacement: 94%, Knee replacement: 87%, Varicose veins: 94%)<br>The Trust has taken the following actions to improve these scores, and so the quality of its services by:<br>• ensuring the Trust regularly monitors and audits the pre and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures. |
| | National average | 0.09 | National average | 0.09 | |
| | Highest | 0.16 | Highest | 0.14 | |
| | Lowest | 0.02 | Lowest | 0.00 | |
| **Varicose Vein Surgery** | Trust | 0.05 | Trust | 0.12 | |
| | National average | 0.09 | National average | 0.10 | |
| | Highest | 0.18 | Highest | 0.17 | |
| | Lowest | 0.02 | Lowest | 0.05 | |
| **Hip Replacement Surgery** | Trust | 0.44 | Trust | 0.40 | |
| | National average | 0.44 | National average | 0.42 | |
| | Highest | 0.54 | Highest | 0.50 | |
| | Lowest | 0.32 | Lowest | 0.31 | |
| **Knee Replacement Surgery** | Trust | 0.32 | Trust | 0.32 | |
| | National average | 0.32 | National average | 0.30 | |
| | Highest | 0.35 | Highest | 0.39 | |
| | Lowest | 0.16 | Lowest | 0.18 | |

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

| Readmissions | | | | | |
|---|---|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period: 2011/12** | | **Previous reporting period: 2010/11** | | **Statements** |
| **% readmitted within 28 days**<br>**Aged 0-15** | Trust | 9.09 | Trust | 9.34 | The Trust considers that this data is as described for the following reasons:<br>• since the national published figures (see across) are historical, we have looked at our latest locally available (pre-published) data. This indicates recent improvements (Aged 16 and over: 2012/13 10.2%, 2013/14 9.9%) (Age 0-15: 2012/13 10.3%, 2013/14 9.7%)<br><br>The Trust intends to take the following actions to reduce this percentage, and so the quality of its services by:<br>• consultant review of all medical referrals in Emergency department<br>• extended consultant cover in assessment areas of the Trust<br>• CCG investment into community nursing teams to avoid admissions and readmissions<br>• better information and support around discharge via the discharge facilitator service |
| | National average | 10.15 | National average | 10.15 | |
| | Highest | NA* | Highest | NA* | |
| | Lowest | NA* | Lowest | NA* | |
| **% readmitted within 28 days**<br>**Aged 16 and over** | Trust | 11.62 | Trust | 11.55 | |
| | National average | 11.45 | National average | 11.42 | |
| | Highest | NA* | Highest | NA* | |
| | Lowest | NA* | Lowest | NA* | |

**comparative figures not available*

| Responsiveness to inpatients' personal needs | | | | | |
|---|---|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period: 2012/13** | | **Previous reporting period: 2011/12** | | **Statements** |
| **Average score from a selection of questions from the National Inpatient Survey measuring patient experience**<br>**(Score out of 100)** | Trust | 64.9 | Trust | 63.8 | The Trust considers that this data is as described for the following reasons:<br>• the Trust notes that it is only slightly lower than the national average and is making year on year improvements, with the 2013/14 (pre-published) figure being 66.6<br><br>The Trust intends to take/has taken the following actions to improve this score, and so the quality of its services by:<br>• ensuring the Trust continues to ask these questions as part of the real-time surveys, but it will look to restructure its real-time surveys to enable results to be attributed to and acted upon at ward level. |
| | National average | 68.1 | National average | 67.4 | |
| | Highest | 84.4 | Highest | 85.0 | |
| | Lowest | 57.4 | Lowest | 56.5 | |

| Staff views | | | | | |
|---|---|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period: 2013** *(published Feb 2014)* | | **Previous reporting period: 2012** | | **Statements** |
| **Percentage of staff who would recommend the Trust to friends or family needing care** | Trust | 66% | Trust | 61% | The Trust considers that this data is as described for the following reasons:<br>the Trust is pleased to see an increase in the number of staff who would recommend the Trust as a place to receive treatment<br>The Trust intends to take/has taken the following actions to improve this percentage/ and score, and so the quality of its services by:<br>• multi-disciplinary groups focusing on action planning for improvements.<br>• communicating with and supporting managers to understand their data broken down by directorate and area and take actions where necessary.<br>The Trust involves and communicates with staff though adopting the Listening in Action programmes. This has covered a wide range of topics and new areas are being agreed for 2014/15. |
| | National average | 64% | National average | 60% | |
| | Highest | 89% | Highest | 86% | |
| | Lowest | 40% | Lowest | 35% | |

| Venous Thromboembolism (VTE) | | | | | |
|---|---|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period: Q3 Oct - Dec 2013** | | **Previous reporting period: Q2 Jul - Sep 2013** | | **Statements** |
| **Percentage of admitted patients risk-assessed for Venous Thromboembolism** | Trust | 94.4% | Trust | 95.07% | The Trust considers that this data is as described for the following reasons:<br>• the Trust is pleased to note that it is similar to the national average in undertaking these risk assessment, with the 2013/14 (pre-published) figure being 95.2%.<br>The Trust intends to take the following actions to improve this percentage, and so the quality of its services by:<br>• continuing the educational sessions with each junior doctor intake<br>• continuing with a variety of promotional activities to staff and patients<br>• implementing the use of technology to assist in the recording of the risk assessments |
| | National average | 95.8% | National average | 95.69% | |
| | Highest | 100% | Highest | 100% | |
| | Lowest | 77.7% | Lowest | 81.7% | |

| Infection control | | | | | |
|---|---|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period: 2012/13** | | **Previous reporting period: 2011/12** | | **Statements** |
| **Rate of Clostridium difficile per 100,000 bed days amongst patients aged 2 or over** | Trust | 23.9 | Trust | 44.8 | The Trust considers that this data is as described for the following reasons:<br>• the Trust acknowledges it needs to improve its rate and has done so in 2013/14 having had 43 cases compared to 56 the previous year (see section 2.1.3), making the most recent (pre-published) rate 18.2<br><br>The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services by:<br>• having an ongoing process to learn from individual cases to reduce the risk of further incidents<br>• releasing a smartphone app so that all medical staff can have the correct antimicrobial guidelines available immediately on their mobile telephones<br>• having intensive HPV (hydrogen peroxide vapour) cleaning to supplement traditional cleaning methods<br>• revising treatment methods to include new drugs and having an associated video e-learning package for this |
| | National average | 17.3 | National average | 21.8 | |
| | Highest | 30.6 | Highest | 51.6 | |
| | Lowest | 0 | Lowest | 0 | |

| Clinical incidents | | | | | |
|---|---|---|---|---|---|
| **Topic and detailed indicators** | **Immediate reporting period Apr 2013 – Sept 2013** | | **Previous reporting period: Oct 2012 – March 2013** | | **Statements** |
| **Rate of patient safety incidents**<br>**(incidents reported per 100 admissions)**<br>**(Comparison is to 46 medium acute Trusts)** | Trust | 9.02 | Trust | 8.8 | The Trust considers that this data is as described for the following reasons:<br>• as organisations that report more incidents usually have a better and more effective safety culture, the Trust is pleased to note it has higher than average reporting rates and continues to encourage staff to report all levels of incidents including near misses with the 2013/14 (pre-published) rate being 9.34 and percentage of severe harm or death being 0.3%).<br><br>The Trust has taken the following actions to improve this rate, and so the quality of its services by:<br>• continual raising of awareness of what constitutes as an incident and how to report and continual improvement of quality investigations and learning using improved report templates. |
| | Average | 7.23 | Average | 7.6 | |
| | Highest | 14.49 | Highest | 16.7 | |
| | Lowest | 3.54 | Lowest | 1.68 | |
| **Percentage of patient safety incidents resulting in severe harm or death** | Trust | 0.3% | Trust | 0.3% | |
| | National average | 0.7% | National average | 0.63% | |

# Part 3: Other quality information

## 3.1 Introduction

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

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

To compare ourselves against other trusts, we use CHKS Ltd, which is a leading UK provider of comparative healthcare information, as a business intelligence monitoring tool.

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

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

**Patient Safety**
Are patients safe in our hands?

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

The fourth section includes general quality measures which have remained the same for 2011/12 as the Board of Directors and our stakeholders believe these take into consideration both national and local targets which will be important to patients and give a further perspective of the Trust's quality of care.

> **The ward ran like clockwork, with all the staff cooperating in the care of the patients. The nurses were exceptional and nothing was too much trouble.**

# Patient Experience

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

### 3.2.1 Introduction

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

### 3.2.2 Trust-wide initiatives

We gather feedback via, for example:

- The Friends and Family Test
- Real-time surveys (face-to-face surveys)
- NHS Choices/Patient Opinion (online)
- National surveys
- Comment cards
- Complaints, concerns and compliments
- Patient Safety Leadership Walkrounds
- Targeted surveys – e.g. food

Below are examples of some of the numbers of feedback we have received this year (2013/14) and more detailed information about some of the methods. These methods alone show more than 20,000 opportunities for us to listen to our patients' views.

| Method | Number |
|---|---|
| Friends and Family Test – Inpatient | 7391 |
| Friends and Family Test – Emergency Department | 8100 |
| Friends and Family Test – Maternity | 1559 |
| NHS Choices/Patient Opinion | 229 |
| Community Services surveys | 668 |

| Method | Number |
|---|---|
| Real-time – inpatient | 1440 |
| Real-time – EAU | 42 |
| Outpatient surveys | 708 |
| Surveys of carers of people with dementia | 145 |
| Discharge surveys | 303 |

## a) Friends and Family Test (FFT)

The Friends and Family Test aims to provide a simple headline metric to drive continuous improvements. It makes sure that staff providing the service and the Board of Directors receives regular feedback from patients on how the services are being received, what is working well and where improvements are needed.

All inpatient and Emergency Department providers in the UK were required to participate in the Friends and Family Test from 1st April 2013 (inpatients started in April 2012 in Dudley) with maternity services starting in October 2013. Results are published on NHS Choices as: normal, better or worse than others. Friends and Family Test scores are also updated in our wards/departments each month for patients to see.

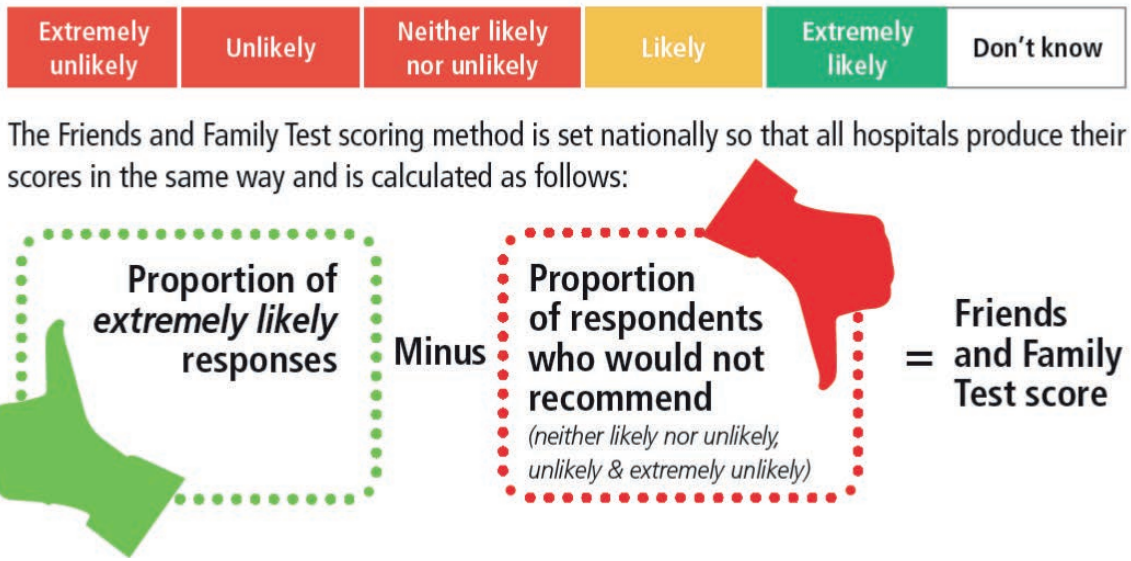
- The Test asks a simple question "How likely are you to recommend (ED/Hospital/Maternity service) to friends and family if they needed similar care or treatment?"
- This is followed up with a question asking "Was there anything that could be improved?"

For inpatients the question is asked at discharge via a confidential postcard. ED patients who are not admitted are either given a postcard or a token (to post into collection boxes).

For maternity the question is asked a number of times during the woman's progression through her pregnancy, birth and postnatal care. The survey is given at the following times:

| | |
|---|---|
| 1 | 36 week antenatal appointment |
| 2 and 3 | At discharge following birth (birth and postnatal ward) |
| 4 | At discharge from community postnatal service |

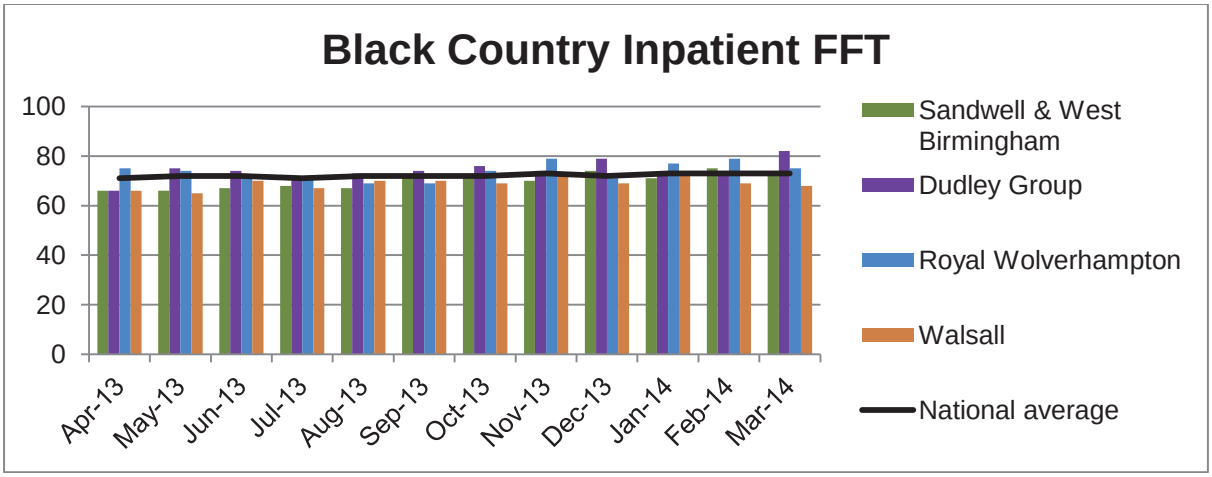
There is a requirement to achieve a 20 per cent response rate for inpatients and ED and 15 per cent for maternity.

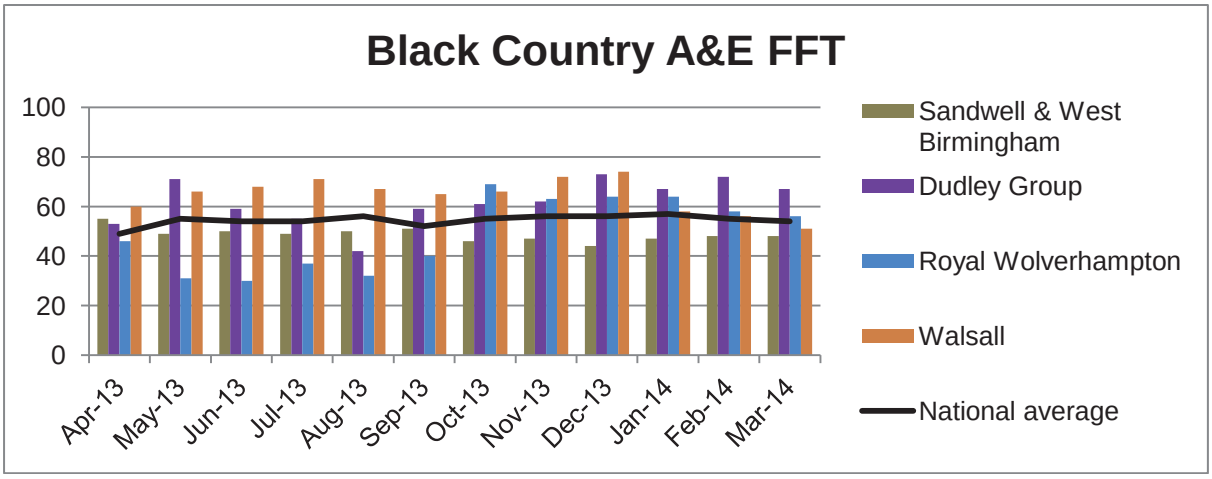


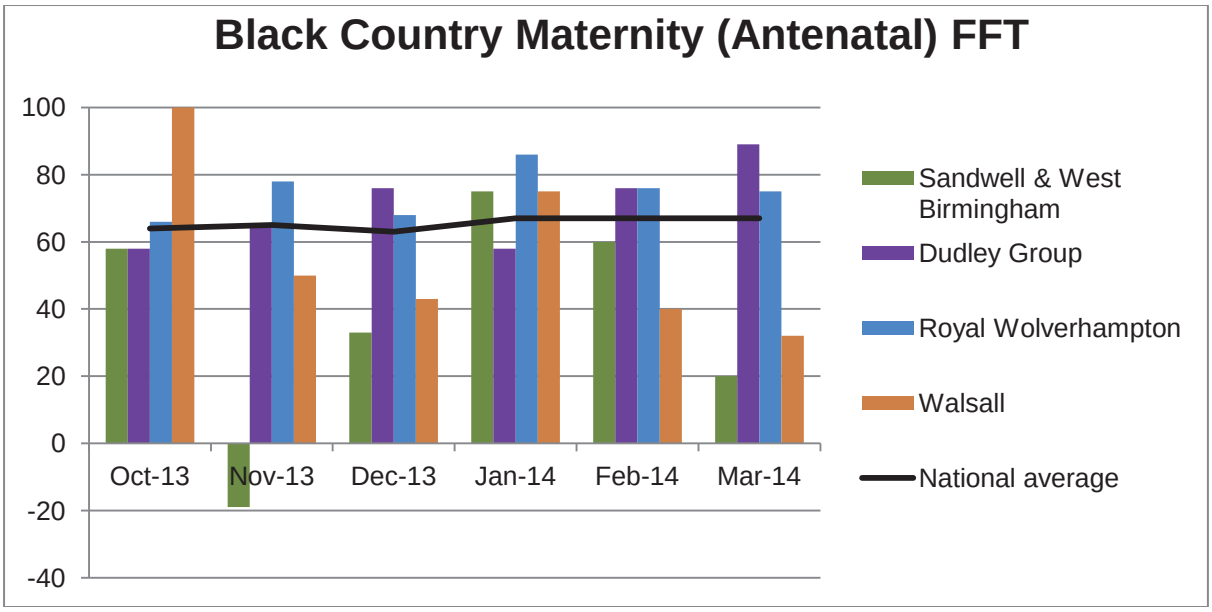

*Likely* and *don't know* answers are not included in the score. Scores can range from -100 to +100

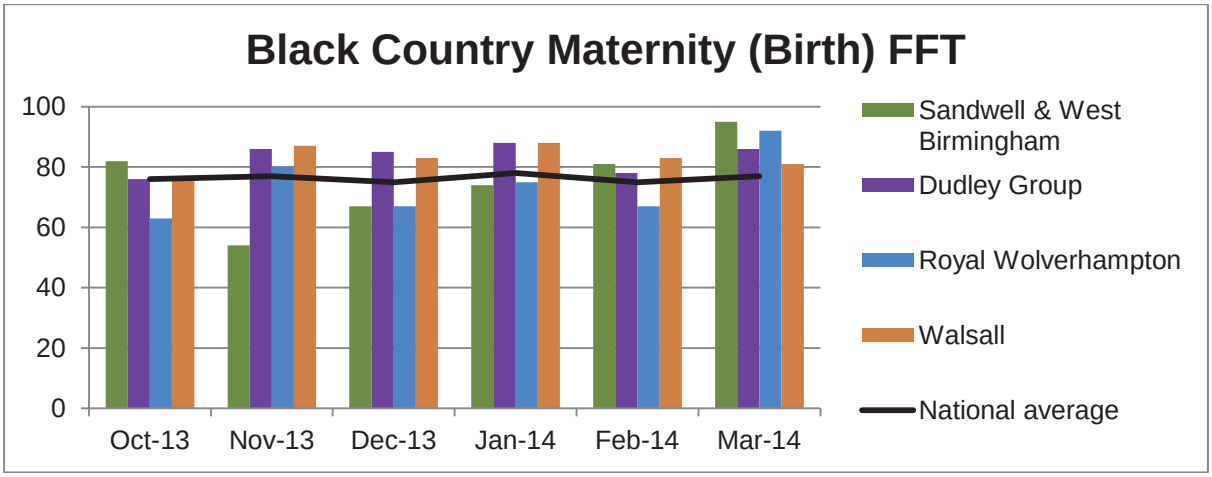
The charts below show our scores for 2013/14 which indicate, for the majority of months, the Trust was above the national average and a high scorer in the Black Country region.

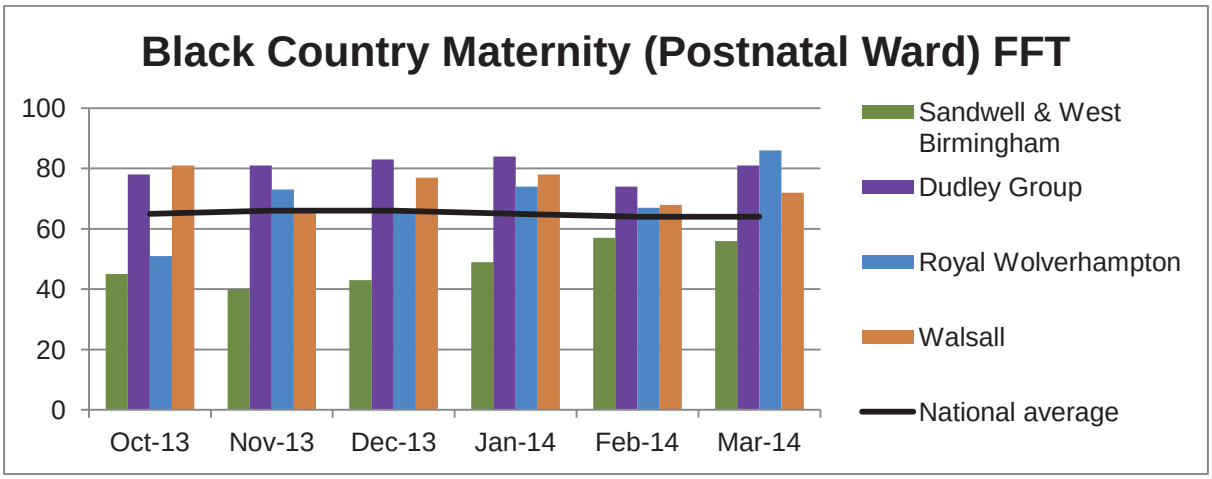
In 2014/15 we are expecting to see the Friends and Family Test rolled out to staff, outpatients, community and day case.

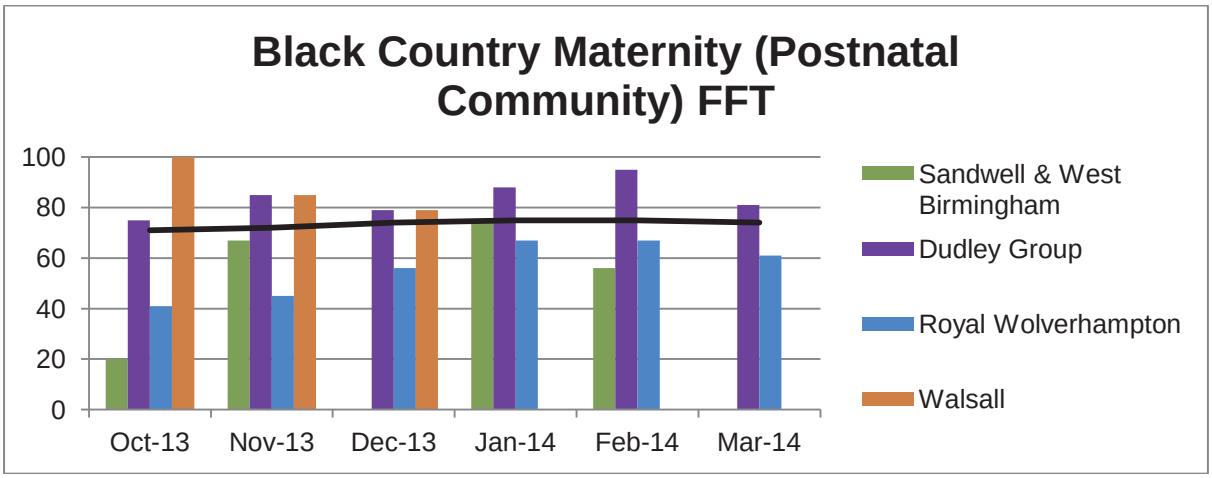





*In December and March Sandwell had fewer than the required responses and so data was not published.*

*From January to March, Walsall did not report any data.*

## b) Real-time surveys

During 2013/14, 1,440 patients participated in our real-time surveys. This number has decreased compared to last year as more resource has been directed towards implementation and running of the Friends and Family Test and targeted surveys on inpatient meals to help inform our menu review. The real-time surveys work well alongside the Friends and Family Test and these are reported in a combined report to wards and specialties allowing them to use important feedback from patients in a timely manner. This allows us to react quickly to any issues and to use patient views in our service improvement planning.

## c) Patient stories

We have continued using patient stories during 2013/14 to enable the patient voice to be heard at the highest level. Stories have been heard at Board meetings and used for service development planning and training purposes.

> **Excellent care and treatment from arrival through to discharge with friendly re-assuring nurses before, wonderful, skilful surgery, followed by delightful aftercare, including tea and toast.**

## 3.2.3 National survey results

In 2013/14 the results of three national patient surveys were published: inpatients, cancer and maternity.

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

| Survey | Sample month | Trust response rate | National average response rate |
|---|---|---|---|
| Inpatient survey (published April 2014) | July 2013 | 50% | 49% |
| Cancer survey (published August 2013) | September to November 2012 | 66% | 64% |
| Maternity survey (published December 2013) | February 2013 | 37% | 46% |

### What the results of the surveys told us

**Inpatient Survey**
The survey told us that we are 'About the Same' as other trusts in all 10 sections of the survey: the Emergency Department, waiting list and planned admissions, waiting to get to a bed on a ward, the hospital and ward, doctors, nurses, care and treatment, operations and procedures, leaving hospital and overall views and experiences.

Areas where improvements could be made:

- Inpatient meals

**Cancer services**
Compared to last year, the results of 20 questions showed an improvement and 11 showed no change; however, 27 had deteriorated.

Things we are good at:

- Enabling patients to take part in cancer research

Areas where improvements could be made:

- Provision of information on getting financial help
- Patients being given the name of the clinical nurse specialist in charge of their care
- Patients being given a choice of treatments and being more involved in decision making

**Maternity**
In the three survey sections we scored 'about the same' as other trusts in two sections (labour and birth and staff) and 'better' than other trusts in care in hospital after the birth.

Things we are good at:

- Partner or companion able to be involved as much as they wanted
- Women being spoken to in a way they could understand

Areas where improvements could be made:

- Staff introducing themselves

**Below are some examples of actions taken as a result of patient feedback:**

| Inpatients | |
|---|---|
| **You Said** | **We Did / Doing** |
| The food needs to improve. | Complete menu review underway.<br>Change of bread to Hovis.<br>Change in some meat products.<br>Sandwich trial undertaken – new fillings.<br>Patient taste sessions being set up to test proposed new menu. |
| It is too noisy at night. | Proposal to change to soft close bins being scoped.<br>Some staff on individual wards have been reminded to be quiet.<br>Campaign being drawn up regarding quiet night times.<br>Switch off times for TVs agreed and put onto night time site coordinator's schedules. |
| Extra drinks needed. | Drinks rounds increased on wards where this was requested.<br>Volunteers visit wards to help refill water jugs. |
| It would be good to have a hot meal on the discharge lounge before you go home. | Hot meals introduced to the discharge lounge. |
| The cups are too small for a good cup of tea/coffee. | Cups replaced with mugs. |
| Can sometimes take a while to answer call bells if staff are busy. | Surgical wards are trialling a new call bell answering process. |

| Emergency Department | |
|---|---|
| **You Said** | **We Did / Doing** |
| Relatives' room was tired and shabby. | Room redecorated and new furniture purchased. |
| Need more staff. | More funding acquired for nurses. Staffing reviewed daily by lead nurse. |
| The waiting room is very uncomfortable. | Seating has been moved around to try and improve the waiting area and patient flow. Quotes for new seating requested from charitable funds. Bariatric seating being sourced. Vending machines checked daily to check stock and availability. |
| Waiting time too long when you have a clinic appointment. | Receptionists instructed to advise patients of waiting time when they book in. Any delays over 15 minutes to be reported to the nurse in charge. |
| Extra wheelchairs needed. | This was a Trust-wide issue and so 60 additional wheelchairs procured. |

| Maternity | |
|---|---|
| **You Said** | **We Did / Doing** |
| Clearer signs needed so that the correct room can be recognised. | A new poster will be designed for the entrance of the department. |
| Waiting times in the clinic can be long, without any explanation. | Lead midwife/clinic coordinator to regularly update women on the waiting times. Information board to be kept updated. |
| Food could be better. | Maternity unit included on food survey to help inform menu review. |
| Fathers to be able to stay overnight, comfortable seating needed. | Partners are able to stay overnight if women are in single room. We are purchasing more guest beds for this purpose. |

| Cancer | |
|---|---|
| **You Said** | **We Did / Doing** |
| More information was needed around getting financial help | We are working with the Dudley Citizens Advice Bureau who, in partnership with Macmillan Cancer Support, help patients in identifying and assisting them to claim benefits they are entitled to. |
| More information about treatments and options were needed | We are reviewing and improving our information. We have also purchased some information stands to improve the availability of cancer information. |
| Can I bring a friend or relative to my appointment? | We have included information in our letters to patients advising that they can bring a friend or relative to their appointment. |

## 3.2.4 Examples of specific patient experience initiatives

### a) Sensory room on the Children's Ward

The new sensory room features a cushioned floor and is filled with specialist toys and equipment. It can be used by children on the ward and their families under the supervision of one of the ward's play specialists. It has been funded entirely by donations from the local community following an appeal organised by play specialists Linda Taylor, Ruth Russell, Julie Dale and Mary Williams.

The room is an invaluable addition to the hospital's provision for patients with additional learning needs. Linda Taylor has indicated that we have always catered very well for most of our children but realised that we had very little that was specifically targeted towards our patients with more complex play needs. Even though it was our patients with additional needs that we initially had in mind for the room, it will be incredibly beneficial to all the children. It is ideal for sensory development but also gives all children a lovely place to relax or just spend some time quietly under supervision.

The Cbeebies *Waybuloo characters Yojojo and De Li joined patients and staff on the Children's Ward to mark the grand opening of the brand new sensory room.*

## b) Community volunteers (in partnership with Dudley College)

During 2013/14, patients at Russells Hall Hospital have been able to take advantage of the skills of Dudley College students who visit the hospital to offer free hair and beauty treatments. Since September the students have visited different wards each week helping lots of patients to feel better and look good.

The students, who are all training for a career in the hair and beauty industry, offer complimentary treatments making a huge difference to people who are in hospital and away from family and loved ones. Through their visits to the hospital students gain confidence and build on their communication skills as well as obtaining assessment opportunities when appropriate. It gives a win-win feel-good factor to everyone involved.

## c) Schwartz Centre Rounds

The Trust has started a series of events called Schwartz Centre Rounds. These were originally pioneered in America, but have been championed in England by the Kings Fund and are now overseen by the Point of Care Foundation, both of which pioneer innovation in healthcare.

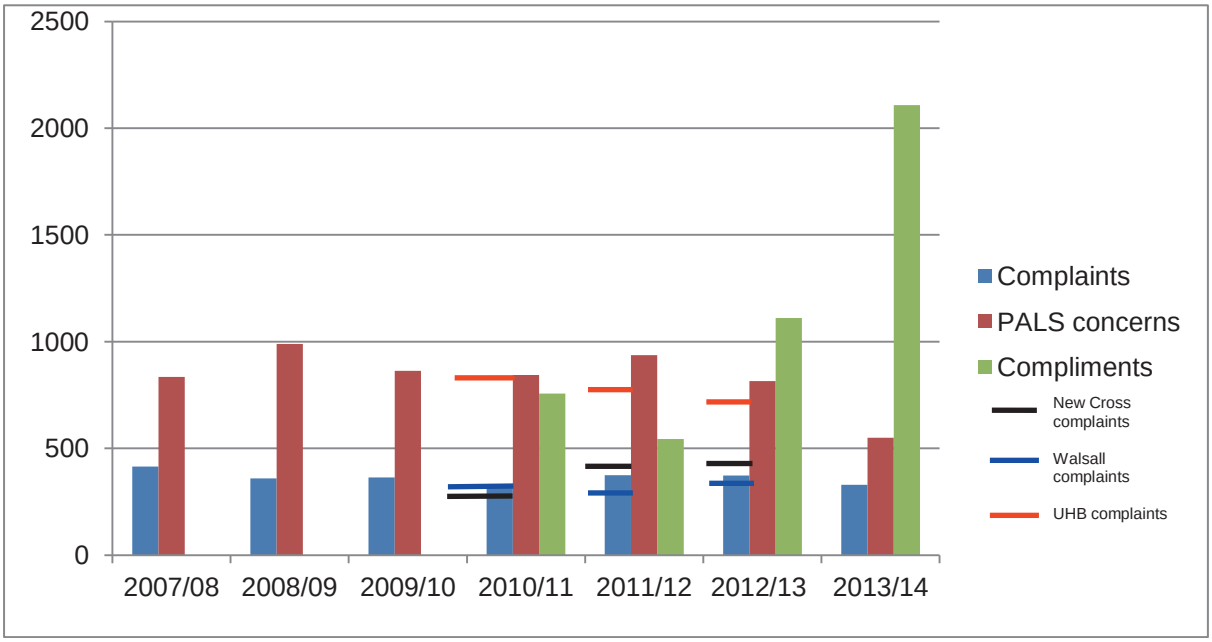
These meetings offer an emotionally safe space for staff to explore the human impact of caring. During a Schwartz Centre Round, a patient case study is presented by a team of clinicians who describe the care and treatment provided to the patient with particular reference to the human impact it had on the patient and staff. This leads into a facilitated open discussion for others to offer their own reflections.
The experience of staff who have taken part mirrors what the Kings Fund identified in a national evaluation, that:

- Individual participants report benefits for themselves,
- Participants report benefits for their day-to-day care of patients,
- Rounds are seen as a source of support in providing day-to-day patient care,
- Participants report that team work is strengthened,
- There have been small but significant changes in the hospital culture.

## 3.2.5 Complaints, concerns and compliments

This summary contains three sets of tables showing a) the total number of complaints, concerns raised with the Patient Advice and Liaison Service (PALS) and compliments received during the year, compared to both previous years and where possible compared with local trusts b) the types of complaints and concerns this year c) the percentage of complaints compared to the total number of patients visiting the Trust and a further section d) some examples of changes in practice made from complaints and concerns.

### a) Total numbers of complaints (with local trust benchmarks), PALS concerns and compliments

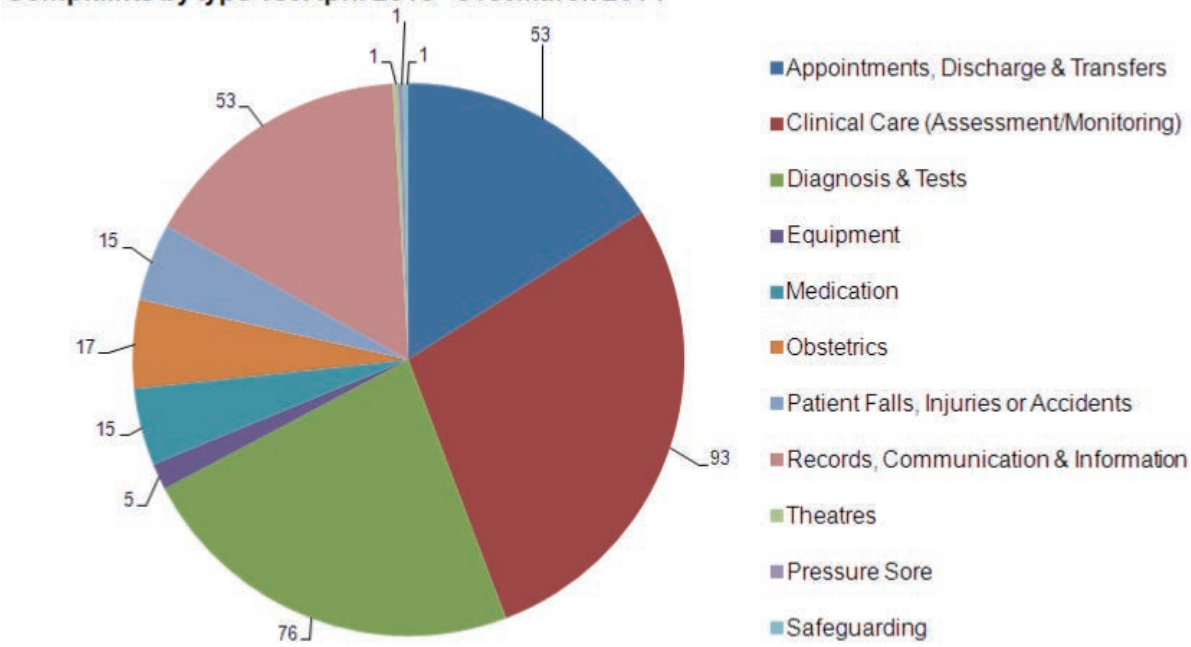



It can be seen that the number of concerns and complaints has reduced from last year. The Trust has introduced an improved system of recording the compliments received and so this will account for some of the increase this year.

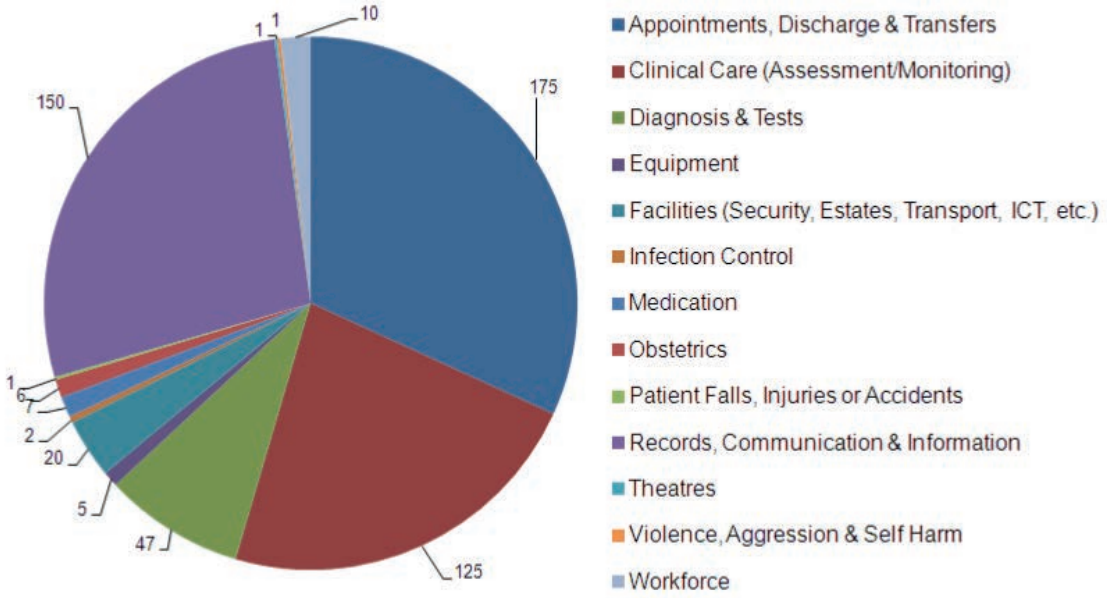
**At all times I felt that we were being actively listened to, treated with respect and given appropriate information and choices.**

## b) Types of complaints and concerns throughout the year

**Complaints by type 1st April 2013 - 31st March 2014**




**Concerns by type 1st April 2013 - 31st March 2014**



## c) Percentage of complaints against activity

| Activity | Total for 2012/13 | Total Q1 ending 30/6/13 | Total Q2 ending 30/9/13 | Total Q3 ending 31/12/13 | Total Q4 ending 31/3/14 | Total for 2013/14 |
|---|---|---|---|---|---|---|
| **Total patient activity** | 735,247 | 185,113 | 181,539 | 186,084 | 181,503 | **734,239** |
| **Complaints against activity** | **0.05%** | **0.05%** | **0.04%** | **0.04%** | **0.04%** | **0.04%** |

## d) Examples of changes in practice from complaints and concerns from departments across the Trust

| Summary of complaint | Actions Taken |
|---|---|
| **Trust-wide**<br>General | The chief executive invited previous and ongoing complainants to Listening into Action meetings, held in December 2013 and March 2014, to listen to their experiences. Following feedback received during the first meeting, an immediate change was to offer new complainants a meeting to discuss their concerns prior to the commencement of an investigation. |
| **Ambulatory Medicine**<br>Complainant was dissatisfied with 'insensitive' correspondence | Department will formally invite patients to research projects at the time they attend clinic; furthermore, letters have been amended to take into account comments regarding 'insensitivity'. |
| **Community Pharmacy**<br>Patient was concerned that her own supply of drugs for her allergy was used in Emergency Department (ED) | Patient was supplied with adequate replacement on discharge. However, following discussion between consultants and pharmacy it was agreed to increase current 'fixed order' level to ensure more than double the previous level is held in stock. Also, additional drugs were added to ED stock list to ensure a supply is always in the cupboard ready for use. |
| **Diagnostics**<br>Whilst patient was being X-rayed following a hip operation, patient got out of wheelchair and fell sustaining bruising. | Staff now emphasise the need for patients to remain seated until asked or given assistance to move or mobilise to reduce a reoccurrence of this incident. |
| **Emergency Department**<br>Patient discharged from department (ED) with a cannula still in situ. | The individual caring for the patient was an agency nurse. This incident was taken into account when a decision was made not to use this nurse again and staff agency was informed. |
| **Emergency Department**<br>Patient attended Emergency Department (ED) with symptoms of DVT but not all appropriate tests completed. | Doctors will educate colleagues about the importance of considering the possibility of DVT even in younger patients with minimum risk factors. |

| Summary of complaint | Actions Taken |
|---|---|
| **Specialty Medicine**<br>Due to religious beliefs patient unhappy to be seen by male technician. This led to a wait of two hours to be seen by a female technician. | Information leaflets will be revised and a new 'alert' placed on local booking system so that when department informed that a patient always requires staff of a specific gender it is recorded on the system. |
| **Specialty Medicine**<br>Relatives concerned about care and communication in ward. | Apology offered for the lack of empathy from staff. Palliative care team will work with ward staff to provide further training on end of life care. Communication between staff and relatives was discussed during a ward meeting. |
| **Surgery & Anaesthetics**<br>Patient should be monitored every six months but had waited longer (eye clinic). | New clinics have been set up to help alleviate the situation. (patient sent 'soon' appointment). |
| **Surgery & Anaesthetics**<br>Patient concerned he was on Surgical Admission Unit for too long and not kept informed or offered food | Laminated signs erected in the bays and side rooms to explain to patients why they are kept 'nil by mouth' but advising them to ask nursing staff if they are unsure. Theatre 'team briefs' will also enable staff to offer appropriate refreshments if long delays expected. |
| **Surgery & Anaesthetics**<br>Relative concerned about long wait for patient in admissions area when attended as day case. Also unhappy with general pre-operative arrangements. | Family met by the deputy matron on the day and she offered her apologies. Advised that a new 'team brief' was introduced in theatres to discuss lists and need to keep patients better informed of any delays. |
| **Trauma, Orthopaedics & Plastics**<br>Daughter concerned about poor communication on ward. Patient was due appointment at another Trust but this was cancelled as ambulance was not booked. | Lead nurse advised ward staff that they must inform the ward clerk at all times when they need to arrange transport. |
| **Women & Children (Maternity & Gynaecology)**<br>Delay in treatment in maternity resulted in baby being born in an inappropriate place. Also communication issues raised. | Explanation provided regarding urgency of treatment, staff did as much as they could to assist afterwards. Staff will be reminded of the importance of effective communication and appropriate behaviour in stressful situations. |

## 3.2.6 Patient-Led Assessments of the Care Environment (PLACE)

In May 2013, 17 patient assessors joined hospital staff to undertake an assessment of the quality of our non-clinical services and buildings. These reviews are called Patient-Led Assessments of the Care Environment (PLACE). This is a new assessment that replaces the previous annual PEAT (Patient Environment Action Team) system.

The assessments are patient-led to ensure that the patient voice is given the highest priority. Assessors visited different parts of the hospital (inpatient wards, outpatient clinics etc.) and scored Russells Hall Hospital against 150 standards covering:

- Cleanliness
- The condition of the buildings and fixtures (inside and out)
- The quality and availability of food and drinks
- How well the environment protects people's privacy and dignity

We were delighted that we scored higher than the national average in three of the four above topics.

| | Cleanliness | Food | Privacy, dignity and wellbeing | Condition, appearance and maintenance |
|---|---|---|---|---|
| **Russells Hall Hospital** | 97.87% | 78.36% | 90.92% | 90.46% |
| **National Average** | 95.75% | 85.41% | 88.90% | 88.78% |

We scored slightly lower than the national average for food and hydration (78.36 per cent against the national average of 85.41 per cent) and this is something we are already committed to improving. We have already held some tasting sessions with public and patients and plan to hold more to help us make our decision about what elements of food provision we need to improve. We are also analysing patient feedback on a weekly basis and making improvements and menu changes on the basis of their comments.

Examples of the comments made by patient assessors on the day:

*"Sometimes these things are just about 'ticking boxes' but this has been much more than that – everyone has taken it really seriously and I feel like we've done what we came to do properly."*

*"The day gave me an insight into things from a different perspective. I was looking at things from a completely different angle, and looking out for things I wouldn't normally notice. I'd say interesting and informative sums up the whole day for me."*

*"I think we all found exactly what we were expecting to find: a hospital that cares and really does consider its patients and their relatives."*

## 3.2.7 Single-sex accommodation

We are compliant with the government's requirement to eliminate mixed-sex accommodation. Sharing with members of the opposite sex only occurs when clinically necessary (for example where patients need specialist equipment such as in the Critical Care Unit), or when patients actively choose to share (for instance in the Renal Dialysis Unit). During the year, the Trust reported six breaches of same-sex accommodation due to a small number of recovering patients on the Intensive Care Unit waiting for beds on general wards.

As part of our real-time survey programme, patient perception is also measured by asking patients whether they shared a room or bay with members of the opposite sex when they were admitted to hospital. Of the 1309 patients who responded to this question, the number whose perception was that they shared a room/bay with members of the opposite sex was 36 (3 per cent). This excludes emergency areas.

## 3.2.8 Patient experience measures

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

The above data is from national inpatient surveys conducted for CQC. Scores were initially expressed as percentages but from 2011 scores are reported out of 10 (Previously this table was compiled from raw data scores).

**"The doctor who treated me was thorough and professional and treated me with respect and dignity."**

# Patient Safety

## 3.3 Are patients safe in our hands?

### 3.3.1 Introduction

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

### 3.3.2 Patient Safety Leadership Walkrounds

These Patient Safety Leadership Walkrounds consist of directors hearing first hand the safety concerns of frontline staff and governors listening to patients and any concerns they may have.

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

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

- A dedicated acute confusion team is now in place on a ward to ensure the allocation of specialist skilled nursing staff to provide additional support to patients with dementia or an episode of acute confusion. There has been an observed reduction in number of falls on the unit since its introduction.
- Relocation of the drug preparation/treatment room nearer to the inpatient area has improved response times for patient medication including analgesia.
- Addition of five pieces of vital signs monitoring equipment provided for a ward which has enhanced the safety and quality of care for patients.
- Patients waiting in the discharge lounge were previously not given the option of hot meals. A choice of a hot meal is now available.
- Ward previously had no equipment to accommodate overnight stays of patients' relatives/carers. Four reclining chairs are now available on the ward for relatives to stay overnight, if required.
- Additional weighing scales that have a stable base and a facility to hold on to for balance were acquired for a department to improve patient safety.
- A six-month trial of the relocation of the delivery suite has been successful and has now become permanent.
- Visiting hours for the Neonatal Unit were extended.

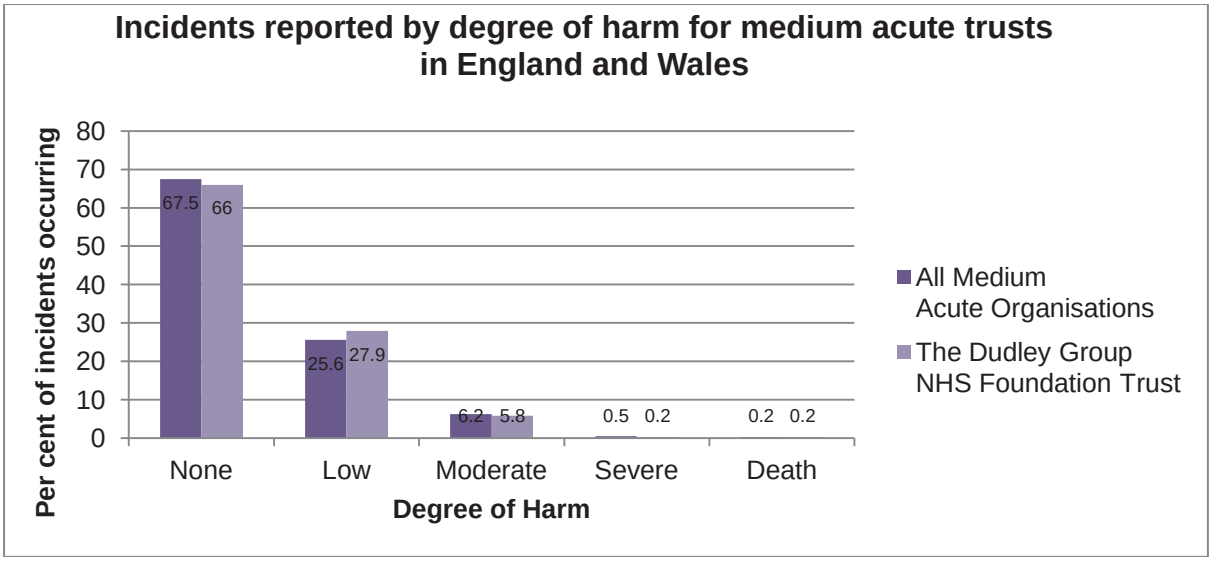
## 3.3.3 Incident management

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

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

The latest national comparative figures available are for the period 1st April 2013 to 30th September 2013. Organisations are compared against others of similar size. The Trust is the seventh highest reporter of all incidents in its class of medium size acute trusts.

With regards to the impact of the reported incidents, it can be seen from the graph below, for the same period stated above, that the Trust is similar to other medium sized trusts. Nationally across all medium sized acute trusts, 67.5 per cent of incidents are reported as no harm (the Trust 66 per cent) and 0.7 per cent as severe harm or death (Trust 0.3 per cent).




During the period beginning April 2013 to the end of March 2014, the Trust has had one Never Event (a special class of serious incident that are generally preventable) which resulted in no patient harm. It had 147 serious incidents, all of which underwent an internal investigation and, when relevant, action plans were initiated and changes made to practice (Serious incidents are a nationally agreed set of incidents which may not necessarily have resulted from error but need investigating to check the circumstances of their occurrence).

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

- Bespoke falls assessment developed to meet the needs of renal dialysis patients
- Dedicated urology ward
- Purchase of additional bed/chair alarms to help prevent patient falls
- Formalised guideline around the frequency of patient vital signs recording

- Introduction of a medicines link nurse practitioner to improve education for all staff
- Trust-wide radiology handover form introduced to ensure sign off from named nurse before patient leaves the ward
- All handwritten X-ray requests to be in block capitals
- Red/Amber/Green criteria introduced for Ophthalmology follow up patients to allocate appointments according to clinical urgency
- All patients now weighed on admission to the Emergency Assessment Unit to ensure accuracy of medication dosages
- Patient discharge checklist proforma implemented
- Use of name stamps for doctors and nurses to clearly identify prescribers on medication sheets
- Standard operating procedure implemented for community staff in regard to safe storage of Trust equipment at the end of working shift or whilst off duty
- Introduction of a new oxygen therapy prescription form
- Review of throat pack flow chart and policy within theatres

## 3.3.4 Nursing Care Indicators

Every month 10 nursing records and the supportive documentation are checked at random in all general inpatient areas and specialist departments at the hospital, and in every nursing team in the community (approximately 430 records are audited per month). The purpose is to ensure nursing staff are undertaking risk assessments, performing activities that patients require and are accurately documenting what has taken place.

The themes looked at are patient observations, pain management, manual handling, tissue viability, medications, documentation, privacy and dignity (community only), nutrition, infection control, Think Glucose, bowels and fluid balance. As can be seen in the table below, the Trust now assesses 12 criteria in hospital and eight in the community. Within community services, there are currently four variations of the audit tool and in hospital there are six in order to capture the practice for specialist areas.

**Community results**
The table below shows the end-of-year results for each of the criteria assessed by the community teams. During 2013, a review has been undertaken and the questions within each of the individual criteria have been amended slightly. Community results are very stable with little fluctuation month on month.

| Criterion | Patient Observations | Pain | Manual Handling | Tissue Viability | Medications | Documentation | Privacy and Dignity | Nutrition |
|---|---|---|---|---|---|---|---|---|
| 2011 | 97% | 98% | 94% | 95% | 99% | 98% | 99% | 97% |
| 2012 | 97% | 98% | 97% | 97% | 99% | 98% | 99% | 97% |
| 2013 | 97% | 99% | 97% | 99% | 98% | 98% | 99% | 98% |
| Difference 2012 - 13 | = | ↑1% | = | ↑2% | ↓1% | = | = | ↑1% |

**Inpatient results**
During 2013, a slight amendment has been made to the audit questions with the inclusion of the resuscitation trolley checks to the patient observation criterion. Results continue to show improvements with the largest in the fluid balance theme with an increase of 14 per cent on previously reported results. Improvements can be seen in 10 out of the 11 criteria that are assessed.

| Criterion | Patient Observations | Pain | Manual Handling | Tissue Viability | Medications | Documentation | Nutrition | Infection Control | Think Glucose | Bowels | Fluid Balances |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2010 | 77% | 70% | 71% | 86% | 92% | | 68% | 95% | | | |
| 2011 | 83% | 80% | 79% | 93% | 94% | 88% | 77% | 97% | 53% | 78% | |
| 2012 | 86% | 88% | 85% | 95% | 94% | 88% | 82% | 91% | 79% | 81% | 77% |
| 2013 | 92% | 95% | 91% | 95% | 97% | 90% | 89% | 94% | 90% | 87% | 91% |
| Difference 2012-13 | ↑6% | ↑7% | ↑6% | = | ↑3% | ↑2% | ↑7% | ↑3% | ↑11% | ↑6% | ↑14% |

## 3.3.5 Harm Free Care and NHS Safety Thermometer

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

Each month, on a set day, an assessment is undertaken which has covered on average 650 inpatients (with exceptions being day case patients, those attending for renal dialysis and well babies) and 620 patients being cared for in the community. The assessment consists of interviews with the patients, accessing the patient's bedside nursing documentation and, when required, examining the main health record.

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

We aim to reduce these rates to zero percent. Some examples of actions being taken as a result of the assessments are shown below:

- Introduction of a new formal escalation process for less than average results
- Implementation of intentional rounding throughout the Trust (a process of each patient being seen by a member of staff at set times which is documented) as a patient safety measure to improve patient to nurse contact and reduce the prevalence of falls
- Implementation of a systematic process of documenting the care of patients with a urinary catheter bundle to monitor the correct use of indwelling urinary catheters

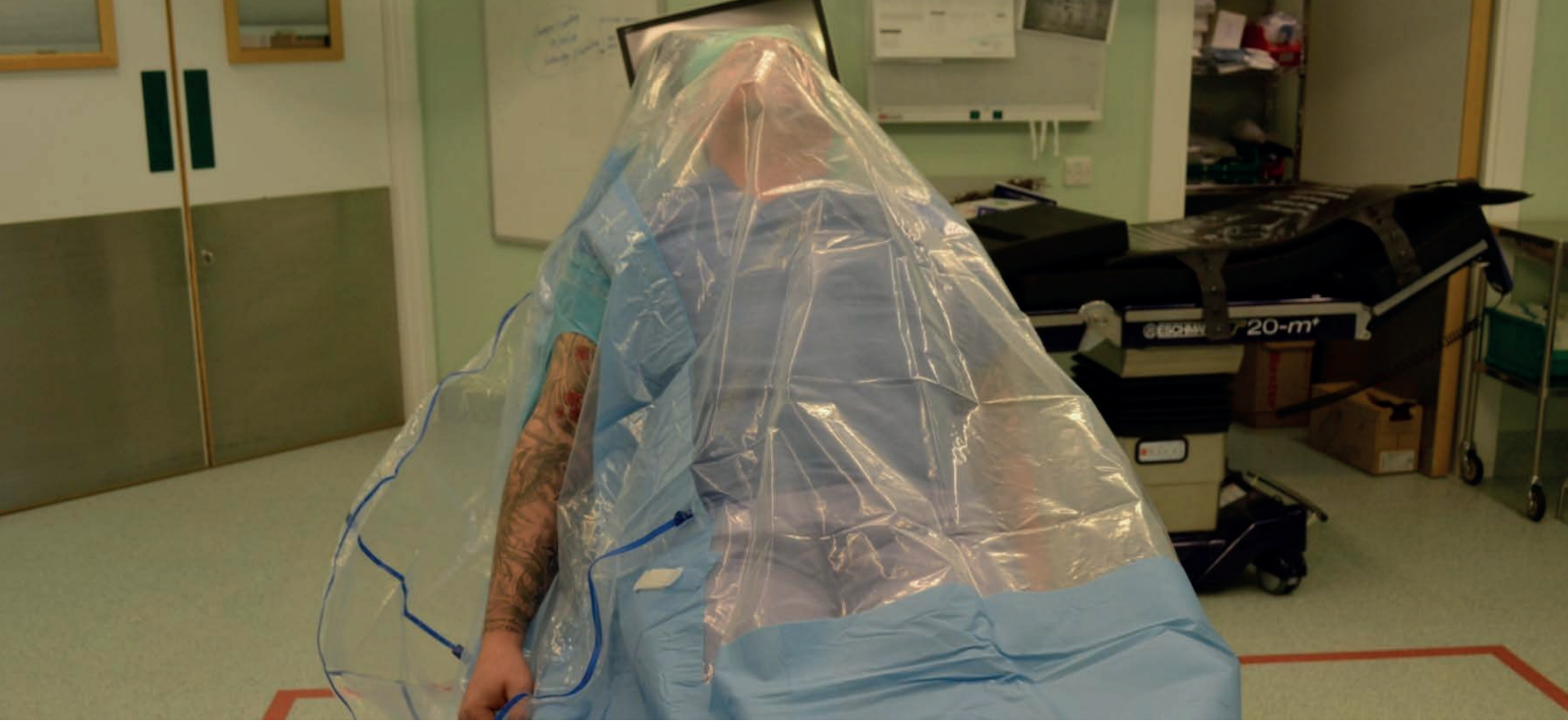
## 3.3.6 Examples of specific patient safety initiatives

### a) Hypo boxes in wards and departments

All wards and other clinical areas now have a hypo box containing all that is needed for the prompt and appropriate treatment of hypoglycaemic episodes experienced by patients. Hypoglycaemia should be treated as a medical emergency because a patient could become unconscious. The standardised hypo boxes will enable staff to quickly treat the diabetic emergency.

As well as selection of glucose products, the hypo boxes contain a patient record book to record patient details and treatment. The boxes are kept in an easily accessible and standard place on every ward and contain a variety of glucose products to be given immediately a patient is having a hypoglycaemic episode. A laminated copy of the clinical guidelines reminds staff how to treat such events.

> **We received nothing but absolute care, consideration and smiling faces, helpful beyond duty.**



## c) Beach chair shoulder drape with patient safety window

A new innovative product designed by Dr Nahla Farid, Consultant Anaesthetist at the Trust, is now being manufactured and is available for trusts across the country. For shoulder operations, the patient needs to be in a sitting position and, in the past, all of the patient has been covered by normal opaque drapes except for the affected shoulder and arm. This made it difficult for the theatre team and, in particular, the anaesthetist to continually observe the position of the head and neck of the patient. A change in position of the head and neck could potentially introduce a risk to patients in terms of physical injury. The new drape allows a complete view of the patient's position so substantially reducing the risk of non-recognition of any movement. The drape is less expensive than the existing drapes and is now being used successfully in the Trust.

## b) Electronic referral to the eye department for rapid consultation and management

The department, together with a number of general practitioners, is piloting a new system whereby all urgent referrals are made electronically using a template which is easy to complete and which contains all the information required to make an assessment on priority. The previous telephone and fax referral system had a number of problems such as telephone messages being time consuming with the referring doctor often needing to wait to find the appropriate member of staff to accept the call. The content of telephone conversations cannot be audited while faxes are generally hand-written and the print on arrival can be illegible. They may not contain all the necessary information to make an informed decision on urgency, and they are subject to potential practical issues such as problems with ink and paper. These issues can result in delays in treatment and a less-than-quality service.

With the new system, all urgent referrals are made by email using a form which is easy to complete and which contains all the information required to make an assessment on priority. The incoming email results in a senior member of staff with an alarm device being notified immediately so the patient with an urgent eye problem can be assessed immediately, and treated more efficiently and effectively in the right place at the right time. It is planned to extend the system to all general practitioners (GPs) in Dudley.

## 3.3.7 Patient safety measures

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

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

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

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

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

# Clinical effectiveness

## 3.4 Do patients receive a good standard of clinical care?

### 3.4.1 Introduction

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

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

#### a) The Mom2Mom breastfeeding support project gained a Royal College of Midwives Annual Midwifery Awards

The project, which encourages support from family members, was announced as the winner of the JOHNSON'S® Baby Award for Evidence into Practice**.** The Mom2Mom support project's main aim is to encourage Dudley's new mums to choose breastfeeding with the support of their own mothers.

Project lead Lucy Johnson said, "We were finding that so many of our mums-to-be were worried about the idea of breastfeeding and were considering using formula milk instead. The idea of experienced mothers passing on their knowledge to new mums isn't a new one, but we found that lots of new grandparents were apprehensive about offering advice in case they suggested the wrong thing. We introduced Mom2Mom workshops to teach grandparents-to-be how to best support their daughters once they give birth and to keep them up to date with current best practice."

#### b) Improving palliative care

The Trust is thrilled to be one of the few trusts taking part in the Specialist Care at Home pilot to improve palliative care for our patients. In collaboration with Dudley CCG and Mary Stevens Hospice, we have been awarded £250,000 from Macmillan Cancer Support for an innovative pilot to improve palliative care for patients in a home setting. By working with our partners we can make a real difference to improving end of life care for our patients. In addition, the Trust has signed up for Phase 2 of the transforming end of life care in acute hospitals, which is part of the national end of life care programme. Again, we are working collaboratively with our partners in primary care, hospice and social care to ensure we all improve the quality of patient, family and carer experience, general decision making, planning and communication, education and training for our workforce across all settings.

## 3.4.3 Examples of innovation

### a) Action Health

A pioneering exercise programme called Action Health has started this year at Russells Hall Hospital in conjunction with the cardiac rehabilitation charity Action Heart and Macmillan Cancer Support, which provided a grant of £35,000 for the service to Professor Carmichael. Action Heart, with its specialist gym, commenced in 1978 and now looks after more than 700 patients at any one time. The 12-week programme provides tailored individual advice for patients and helps them incorporate physical activity into their lives. Research has shown that being active during and after treatment can help recovery and the long-term health of cancer patients.

Catherine Bytheway, one of the first patients to take part said, “It was a good opportunity to do something really positive after a not so positive situation – I got to take control of myself again. I would recommend it to anyone being treated for cancer. I felt so much more motivated compared to when I tried exercising on my own.”

Another patient has said, “Having learnt of the benefits of being active after having cancer, I decided to take up the offer of 12 weeks’ free gym membership. I am now on my seventh week. I don’t find it easy to make the effort but the feeling of achievement, well-being and knowing that I am improving my chances for a healthier life, more than compensates for the work it takes.”

### b) Flexible endoscopic therapy for Zenker’s diverticulum

Gastroenterology consultant Dr Sauid Ishaq has launched a treatment to cure a rare illness which has transformed the life of 75-year-old Roy Bradley. At the hospital, six patients have so far benefited from the treatment which relieves a condition that makes it hard to swallow.

Dr Ishaq, said, “We are very excited because we are the only centre in the country to offer this procedure, which is called flexible endoscopic therapy for Zenker’s diverticulum.”

The procedure, which lasts 20 to 30 minutes under a short-acting sedative, provides an answer for patients who would not be well enough for surgery under general anaesthetic. It involves using an argon beam to melt the wall of a pouch, vaporising surrounding tissue so that food can go straight down the gullet.

Mr Bradley said, “I was having a heck of a job swallowing food and it caused me a lot of problems and embarrassment. I’ve got coronary heart disease, which meant there would be danger if I had an anaesthetic for surgery. Now I don’t have any embarrassing moments and I’m enjoying what seems like a new lease of life.”

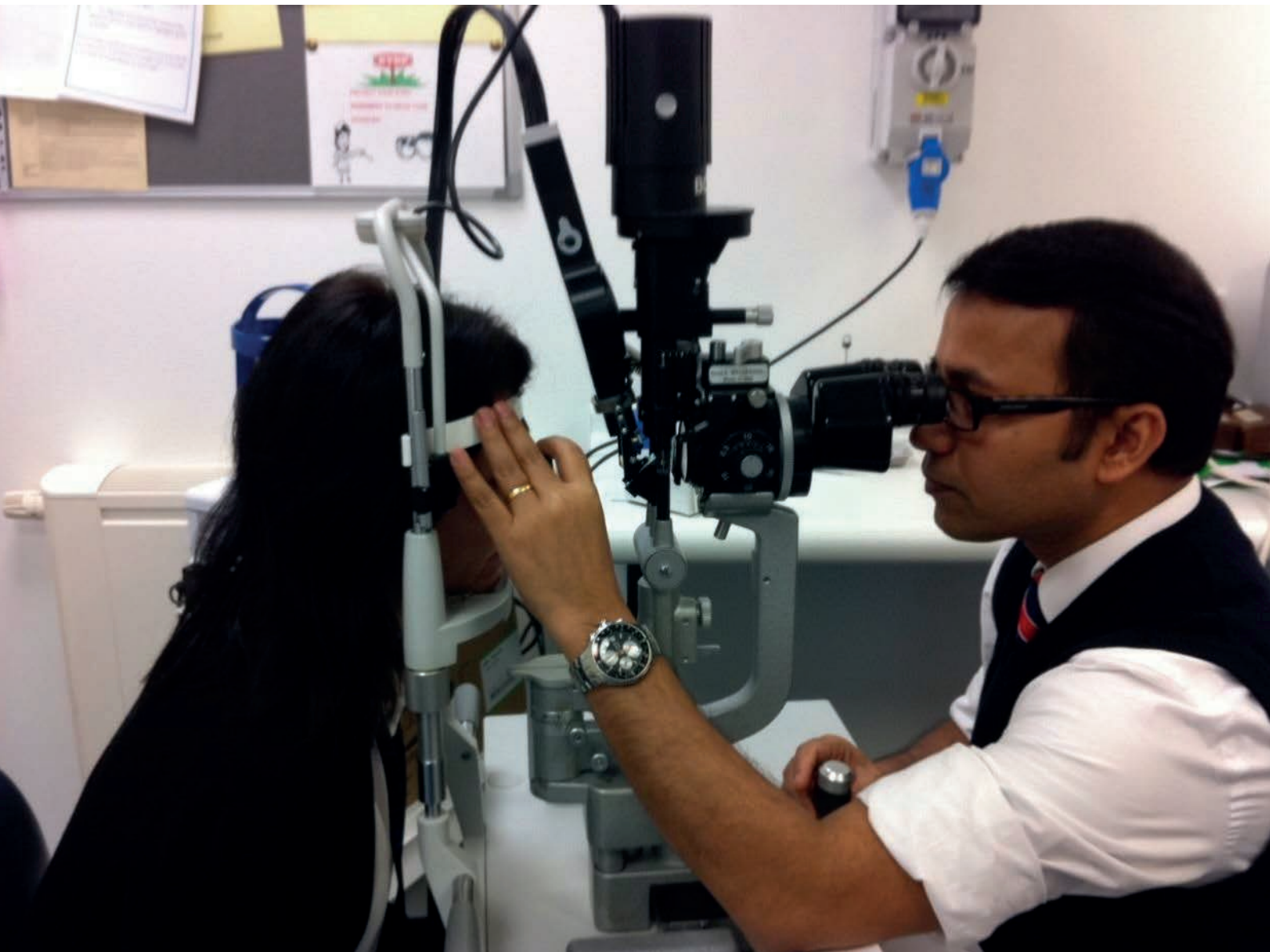
> **I cannot speak too highly of the treatment I received. The surgeon inspired the greatest confidence in me despite the obvious risks.**

## c) Innovative glaucoma treatments

Consultant Ophthalmologist, and the glaucoma lead at the Trust, Mr Akash Raj has started to build a world-class glaucoma service. Since February 2014, 20 patients with glaucoma have benefitted from Micropulse Laser Trabeculoplasty, a new procedure only available at four sites across the country, including Russells Hall Hospital (and the only centre in the entire Midlands area). This allows glaucoma patients who either cannot tolerate eye drops or who have an allergy to them, or want independence from eye drops, to be effectively treated and either delaying or reducing the need for eye surgery.

In addition, in September 2013, Mr Raj began using iStents glaucoma tubes as an alternative to conventional surgery, with this technique being performed at only a handful of other centres in the UK. This procedure is less invasive and has fewer complications than surgery and is the smallest human implant available in the world.

Mr Raj has initiated a Glaucoma Support Group for the Dudley and the Black Country to help and support glaucoma patients in the region with providing all round information on glaucoma and involving them in the better glaucoma care movement. He has also started the Dudley Eye (Glaucoma) Charity appeal to help maintain and continually improve the world-class glaucoma service that Russells Hall Hospital can now provide.



## 3.4.4 Examples of specific clinical effectiveness initiatives

### a) Cardiac Rehabilitation and Prevention Programme

This year the Department of Health published the national Cardiovascular Diseases Outcomes Strategy in which the local collaborative programme between the Trust and Action Heart was praised as ‘cutting edge’.

The programme has an open policy with respect to eligibility, accepting patients from across the cardiac diagnostic range, resulting in the team accommodating patients with pre-existing conditions/co-morbidities such as stroke, diabetes, transient ischaemic attack (mini stroke), chronic kidney disease, peripheral artery disease and rheumatoid arthritis. This collaboration means, for example, that there is a clear process with the mini stroke service, providing a 12-week exercise and lifestyle programme for this group of patients who had previously received little structured support. In addition, Action Heart and the Trust support a borough-wide exercise referral scheme for patients at high risk of developing cardiovascular disease, receiving referrals from all of Dudley’s general practitioners and hospital consultants.

### b) Ambulatory Emergency Care (AEC)

AEC is a new approach to delivering safe, effective and efficient care for a significant proportion of our emergency adult patients. This new service means patients are seen, treated and allowed to go home on the same day, so avoiding an overnight admission to hospital. Working this way offers better patient experience and also ensures that those patients who do need admission are also treated more effectively with better access to beds.

A pilot began in November 2013 and initially saw more than 1000 patients. A total of 66 per cent of these patients were seen, treated and discharged the same day. The patients are seen quickly by a senior doctor who devises a plan of care and requests same day diagnostic tests, specialist referrals and follow-up appointments, if necessary. This enables the patient to return home and remain ambulant whilst in receipt of our care. Both patients’ and staff experience of receiving and delivering care in this way has been extremely positive. The team continues to monitor this and action any recommendations made through patient and staff feedback.

## 3.4.5 Clinical effectiveness measures

| | Actual 2007/08 | Actual 2008/09 | Actual 2009/10 | Actual 2010/11 | Actual 2011/12 | Actual 2012/13 | Actual 2013/14 |
|---|---|---|---|---|---|---|---|
| Trust readmission rate for surgery<br>Vs<br>Peer group West Midlands SHA<br>Source: CHKS Insight | 4.6%<br>Vs<br>4.1% | 3.9%<br>Vs<br>4.3% | 4.1%<br>Vs<br>4.2% | 4.4%<br>Vs<br>4.7% | 5.6%<br>Vs<br>5.0% | 6.1%<br>Vs<br>6.8% | 6.9%^*<br>Vs<br>5.9 |
| Number of cardiac arrests<br>Source: Logged switchboard calls | 397 | 250 | 170 | 145 | 119 | 126 | 158 |
| Elective admissions where the planned procedure was not carried out (not patient decision)<br>Vs<br>Peer group West Midlands area<br>Source: CHKS insight | N/A | 2.0%<br>Vs<br>1.6% | 1.4%<br>Vs<br>1.6% | 1.4%<br>Vs<br>1.3% | 0.67%<br>Vs<br>1.1% | 0.68%<br>Vs<br>1.2% | 0.7%^<br>Vs<br>0.87% |

*^April 2013 to January 2014 for Trust/April 2013 to December 2013 for Peer*

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

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

| National targets and regulatory requirements | Trust 2009/10 | Trust 2010/11 | Trust 2011/12 | Trust 2012/13 | Target 2013/14 | National 2013/4 | Trust 2013/14 | Target Achieved/ Not Achieved |
|---|---|---|---|---|---|---|---|---|
| **1. Access** | | | | | | | | |
| Maximum time of 18 weeks from point of referral to treatment (admitted patients) | 95.8% | 97.03% | 95.7% | 96.1% | **90%** | **91.4%*** | **93.95%** | ☺ |
| Maximum time of 18 weeks from point of referral to treatment (non-admitted patients) | 99.1% | 99.2% | 99.2% | 99.5% | **95%** | **96.9%*** | **99.18%** | ☺ |
| Maximum time of 18 weeks from point of referral to treatment (incomplete pathways) | N/A | N/A | N/A | 98.1% | **92%** | **94.1%*** | **96.74%** | ☺ |
| A&E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival | 98.1% | 98.8% | 97.27% | 95.4% | **95%** | **95.7%** | **93.74%** | ☹ |
| A maximum wait of 62 days from urgent referral to treatment of all cancers | 86.5% | 87% | 88% | 88.7% | **85%** | **86.5%^** | **89%** | ☺ |
| All cancers: 62 day wait for first treatment from consultant screening service | N/A | 99.6% | 96.6% | 99.4% | **90%** | **94.9%^** | **99.6%** | ☺ |
| All cancers: 31 day wait for second or subsequent treatment: surgery | N/A | 99.6% | 99.6% | 99.2% | **94%** | **97.4%^** | **100%** | ☺ |
| All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments | N/A | 100% | 100% | 100% | **98%** | **99.7%^** | **100%** | ☺ |
| A maximum wait of 31 days from diagnosis to start of treatment for all cancers | 99.3% | 99.8% | 99.7% | 99.5% | **96%** | **98.4%^** | **99.9%** | ☺ |
| Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment | 98% | 96.8% | 97.2% | 96.2% | **93%** | **95.4%^** | **97.5%** | ☺ |
| Two week maximum wait for symptomatic breast patients | 69% | 98.2% | 99% | 98.1% | **93%** | **95.1%^** | **98.2%** | ☺ |
| **2. Outcomes** | | | | | | | | |
| Certification against compliance with requirements regarding access to healthcare for people with a learning disability | N/A | N/A | Compliant | Compliant | Compliant | - | Compliant | ☺ |
| Data Completeness for community services: Referral to treatment information | N/A | N/A | N/A | 97.3% | **50%** | **+** | **98.4%#** | ☺ |
| Data Completeness for community services: Referral information | N/A | N/A | N/A | 65.6% | **50%** | **+** | **64.6%#** | ☺ |
| Data Completeness for community services: Treatment activity information | N/A | N/A | N/A | 99.1% | **50%** | **+** | **100%#** | ☺ |

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

☺ = Achieved target
☹ = Not achieved target
# Latest monthly figure for March 2014

* applies only from April 2013 to February 2014 as full year figures are not currently available
^applies only from April 2013 to December 2013 as full year figures are not currently available

## 3.6 Glossary of terms

| | |
|---|---|
| **AAA** | Abdominal Aortic Aneurysm |
| **A&E** | Accident and Emergency (also known as ED) |
| **ADC** | Action for Disabled People and Carers |
| **BAD** | British Association of Dermatologists |
| **Bed Days** | Unit used to calculate the availability and use of beds over time |
| **BBC CRLN** | Birmingham and Black Country Comprehensive Local Research Network |
| **BHF** | British Heart Foundation |
| **CCG** | Clinical Commissioning Group |
| **C. difficile** | Clostridium difficile (C. diff) |
| **CNS** | Clinical Nurse Specialist |
| **CQC** | Care Quality Commission |
| **COPD LES** | Chronic Obstructive Pulmonary Disease Local Enhance Services |
| **CHKS Ltd** | A national company that works with Trusts and provides healthcare intelligence and quality improvement services |
| **CQUIN** | Commissioning for Quality and Innovation payment framework |
| **CEM** | College of Emergency Medicine |
| **DVD** | Optical disc storage format |
| **DVT** | Deep Vein Thrombosis |
| **EAU** | Emergency Assessment Unit |
| **ENT** | Ear, Nose and Throat |
| **ED** | Emergency Department (also known as A&E) |
| **FCE** | Full Consultant Episode (measure of a stay in hospital) |
| **Foundation Trust** | Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities |
| **GP** | General Practitioner |
| **HASC** | Health and Adult Social Care Scrutiny Committee |
| **HAT** | Healthcare Acquired Thrombosis |
| **HED** | Healthcare Evaluation Data |
| **HES** | Hospital Episode Statistics |
| **HQIP** | Healthcare Quality Improvement Partnership |
| **HSCIC** | Health and Social Care Information Centre |
| **HSMR** | Hospital Standardised Mortality Ratio |
| **HTA** | Human Tissue Authority |
| **IBD** | Irritable Bowel Disease |
| **ICNARC** | Intensive Care National Audit & Research Centre |
| **LINK** | Local Involvement Network |
| **MBC** | Metropolitan Borough Council |

| | |
|---|---|
| **MINAP** | Myocardial Ischaemia National Audit Project |
| **Monitor** | Independent regulator of NHS Foundation Trusts |
| **MRSA** | Meticillin-resistant *Staphylococcus aureus* |
| **MESS** | Mandatory Enhanced Surveillance System |
| **MUST** | Malnutrition Universal Screening Tool |
| **NCEPOD** | National Confidential Enquiry into Patient Outcome and Death |
| **NCI** | Nursing Care Indicator |
| **NICE** | National Institute for Health and Care Excellence |
| **NIHR** | NHS National Institute for Health Research |
| **NHS** | National Health Service |
| **NNAP** | National Neonatal Audit Programme |
| **NOF** | Neck of Femur |
| **NPSA** | National Patient Safety Agency |
| **NIV** | Non Invasive Ventilation |
| **NVQ** | National Vocational Qualification |
| **OSC** | Overview and Scrutiny Committee |
| **PALS** | Patient Advice and Liaison Service |
| **PEAT** | Patient Environment Action Teams |
| **PFI** | Private Finance Initiative |
| **PROMs** | Patient Reported Outcome Measures |
| **RAG** | Red/Amber/Green |
| **ROSE** | Rivaroxaban Observational Safety Evaluation |
| **SHMI** | Summary Hospital-level Mortality Indicator |
| ***SKIN*** | Surface, Keep Moving, Incontinence and Nutrition |
| **SUS** | Secondary Uses Service |
| **SLT** | Speech and Language Therapy |
| **TARN** | Trauma Audit and Research Network |
| **TEAMM** | Tackling Early Morbidity and Mortality in Myeloma |
| **VTE** | Venous Thromboembolism |

# Annex

## Comment from Dudley MBC Overview and Scrutiny Committee (received 24/04/2014)

The committee welcomes the opportunity to respond to this consultation as the responsible body for local authority health scrutiny.

Members had occasion to assess delivery against leading priorities identified in the previous Quality Account consultation in February 2014.

Inconsistent compliance regards fluid balance charting remains a concern for the committee. Members will explore this and other key issues underlined across the improvement priorities through follow-up committee's Dignity in Care Review action plan in 2014/15.

The committee acknowledges the view that the existing topics are still key care issues of importance to patients and the public and so should remain priorities going into 2014/15. Consistent baseline reporting will enable local scrutineers to better identify with rates of improvement across themes. In addition, members would support proposals to consider mortality as a future priority particularly in the light of recent Keogh Review experiences.

On urgent care, The Dudley Group NHS Foundation Trust has demonstrated strong partnership working with the CCG enabling a comprehensive, robust and inclusive clinical and patient-led approach to the design of the service. Activity assumptions based on the opening of the Urgent Care Centre being built into the CCG's contract with The Dudley Group NHS Foundation Trust for 2014 until 2016 was particularly welcomed.

Members look forward to The Dudley Group NHS Foundation Trust input on the service model for the triage/streaming element of the urgent care centre and the proposed premises solution as the service specification and procurement framework takes shape in 2014/15.

## Comment from the Dudley Health and Wellbeing Board (received 28/04/2014)

Health and Wellbeing Boards came into force in April 2013 as part of the Health and Social Care Act 2012. As system leader for the health and care sector, the Board needs to be confident that quality assurance processes are in place and robust across the system. Dudley's Health and Wellbeing Board welcomes the opportunity to comment on The Dudley Group NHS Foundation Trust's annual quality account and is encouraged that Dudley's Clinical Commissioning Group as lead commissioner, the Health Scrutiny Committee and Healthwatch Dudley will also be commenting.

Some Board members had the opportunity to comment during a recent CQC Inspection of the Trust and welcomed the opportunity to participate and make known their views through that process.

The Board is encouraged by the improvements in patient experience supported by the Friends and Family Test and notes some of the innovative work in this area. However, there is still further work to do to embed. The Health Scrutiny Committee will be focusing on hospital patient experience during 2014 and the Board hopes that the Trust will commit to implement any recommendations.

It is heartening to see that levels of infection, specifically for MRSA and Clostridium difficile (C. diff) show a reducing trend; however, the Trust remains above the national average for C. diff and should endeavour to maintain or reduce further on 2013/14 levels, and take a holistic approach to infection control.

The Board notes the significant amount of work undergone to improve hospital mortality as a result of the Keogh Review and supports the Trust's decision to continue mortality reduction as a priority for 2014/15.

The Board acknowledges the improvements that have been made during 2013/14 and that the report demonstrates that the Trust is committed to continuous improvement of quality across the broad spectrum of patient experience, clinical effectiveness and safety. The Board hopes that the Trust will continue to work with partners to make further quality improvements during 2014/15.

## Comment from the Dudley Clinical Commissioning Group (received 29/04/2014)

The CCG note this report outlines the continued focus on the delivery of high quality care by the Trust.

The CCG has previously stated its commitment to reducing avoidable mortality and is pleased to note the Trust's continued focus on this key area. In 2013 the Trust was one of 14 hospitals nationally where concerns were raised regarding the mortality indicators over the preceding two year period and subsequently a review was undertaken, led by the NHS England Medical Director, Sir Bruce Keogh. The CCG participated in this review which resulted in a wide range of recommendations for improvement including improving aspects of the patient experience and increased investment in front-line staff. The Trust actively participated in the review, was very receptive to the need for improvement, and has subsequently made significant progress during the year in implementing the recommendations made.

The Trust is to be commended for having consistently received positive feedback from patients through the national *"Friends and Family Test"* however, there are other areas the CCG would like to see more rapid improvement such reducing the number of patients with hospital acquired pressure ulcers and continued improvements in reducing *C difficile* and MRSA infections.

The Trust did not meet the national A&E waiting time target to admit or discharge 95 per cent of attenders within four hours. Historically, the Trust has been very successful in meeting this target so it is regrettable that this was not achieved in 2013/14. However, Dudley CCG has recently carried out a major public consultation on the redesign of urgent care across the borough with the support of both the Trust and Dudley Health and Wellbeing Board. This will result in the establishment of a new Urgent Care Centre at Russells Hall Hospital by the end of this financial year, which will enable the Trust to provide significant advancements in service and better co-ordinated care with the rest of the local health and social care system in Dudley. In the meantime, we are reinvesting resources non-recurrently into the hospital to assist in resolving their performance.

Finally, the CCG will work with the Trust in ensuring that evidence of on-going progress is made throughout the year. This is vital for the interests of the patient population of Dudley and will also continue to hold the Trust to account constructively and assertedly for its future performance.

Paul Maubach
Chief Accountable Officer

## Comment from the Trust's Council of Governors (received 22/04/2014)

The Trust's Quality Account is presented against a background of continuing change and financial pressures in the NHS. The 2012 Health and Social Care Act came into force on 1st April 2013 heralding a major re-organisation of the NHS in England, and strict 4 per cent annual efficiency gains continue to be required of all trusts. At the same time, the age profile of the population, and hence the healthcare needs, increase proportionately. Both factors are having, and will continue to have, a significant effect on services and how they are delivered. It is also against this background that actions to satisfy the findings of the Francis Reports which required a rigorous focus on patient care and safety have been implemented.

Governors fully support the Chief Executive's Statement in Section 1 of this report and note, in particular, comments on the Keogh Review rationale and outcomes in which the Trust mortality rates were found to be within the expected range.

Governors have been kept fully up to date with actions following that review. We are pleased to note the increased focus on patient experience and safety which has had many strands including, for example, a revised complaints process, and re-organisation of the complaints and PALS provision in consultation with stakeholders.

Governors now take part in Patient Safety Leadership Walkrounds with directors and will be members of a new Patient Experience Group which reports to the Board. Governors note the successful involvement of the Trust in many clinical audits and research trials.

Governors meet many patients, members of the public and community groups each year and gain feedback about the quality of services and patient experience. Governors find that users' views of clinical treatment and the care provided by our nurses, doctors and other staff is very positive, reflecting the improved Friends and Family Test scores achieved by the Trust. On occasion, there are less positive views about communication, food and parking.

Pressure on services has increased further in 2013/14 particularly in the Emergency Department. In common with many trusts, failure to consistently meet the four hour target has been of concern for some time. Measures are in place to improve this situation and governors have strongly supported the proposed relocation of the walk-in centre and primary care out-of-hours service at the Dudley Borough Walk-in Centre to form an Urgent Care Centre at Russells Hall Hospital during 2014/15. This should result in a more appropriate service for all patients and a reduction in waiting and treatment times.

The process used to ratify the Trust's choice of Quality Priorities gives a wide range of patients, members, governors, staff and other interest groups the opportunity to be involved and influence choices. While detail is given in section 2 of this report, of the 2013/14 priorities governors are pleased to note the success in reducing the number to zero of avoidable stage 4 pressure ulcers developed in the hospital. The failure to achieve the avoidable stage 3 pressure ulcer target in the hospital is disappointing.

In addition, governors are pleased to see that the community target for the reduction in avoidable pressure ulcers has been met. Governors also note that one of the two hospital patient experience targets was achieved and neither of the two community patient experience targets were met. Further focus will be required to achieve the new patient experience targets in 2014/15. Governors note the further work undertaken on the new Health and Social Care Passport and look forward to implementation during 2014/15. With regard to infection control, governors recognise that the C. diff target set by the Department of Health was extremely challenging. It was not achieved, though some assurance can be taken that there were fewer cases than in 2012/13. The Council of Governors has agreed the continuation of all 2013/14 Quality Priorities into 2014/15 together with mortality as a new priority as recommended by the Keogh Review.

Governors recognise their increased responsibilities following the introduction of the 2012 Health and Social Care Act, the outcomes of the Francis enquiries and the Trust's Keogh Review. The Council of Governors has carried out its own development review and in consultation with the Board of Directors has put in place a future role for governors in which their increased needs for information and assurance can be met in order to hold the Board of Directors to account through its non-executive directors.

In common with other acute trusts, the Trust operates under increasing pressure. The increasingly complex demands of an ageing population and efficiency gains have to be met while protecting the quality of services and care and safety of patients. That staff, especially in stressful and pressured situations on the front line, demonstrate such high levels of care and commitment is to be commended. On behalf of patients, carers and the public, governors wish to place on record their recognition and appreciation of the commitment and excellent work done by staff at all levels in the organisation.

## Comment from Healthwatch Dudley (received 24/04/2014)

Healthwatch Dudley recognises the good work undertaken within the Dudley Group, which is highlighted in the performance measures and patient views in the annual Quality Report and Account for 2013/14.

In the relatively short time it has been in existence, Healthwatch Dudley has been able to capture many views from local people about their experience of Dudley Group NHS Foundation Trust services. Healthwatch Dudley representatives are pleased to have been invited to meetings and events following the Keogh Review and Care Quality Commission inspection.

The team has been reassured by actions already taken to improve patient outcomes and experiences and an invitation has been accepted to become a member of the newly-established Patient Experience Group. The team also welcomes opportunities to undertake 'Enter and View' visits to service areas as a critical friend and staff and valuable volunteers will continue to be involved in all patient and wider public engagement events, to ensure the voices of local people are heard and responded to.

In a number of instances marked progress was made against the Quality Priority targets set for 2013/14. Nevertheless, some targets were partially rather than fully achieved by the end of the year.

Healthwatch Dudley welcomes the opportunity to work with The Dudley Group to ensure that the views of local people are taken into account, to improve patient experience across all areas of the Trust.

NB: Healthwatch Dudley is unable to comment on number of patients using their Single Assessment Process Folder/Health and Social Care Passport or the number of patients that know how to raise concerns about their care and treatment. We look forward to seeing this data in the final report.

## Statement of directors' responsibilities in respect of the quality report 2013/14

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013/14*;

- the content of the quality report is not inconsistent with internal and external sources of information including:

    - board minutes and papers for the period April 2013 to June 2014
    - papers relating to quality reported to the Board over the period April 2013 to June 2014
    - feedback from commissioners dated 29/04/2014
    - feedback from governors dated 22/04/2014
    - feedback from the local Healthwatch organisation dated 24/04/2014
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/04/2014
    - national patient survey conducted between September 2013 and January 2014
    - national staff survey conducted between September and December 2013
    - the head of internal audit's annual opinion over the trust's control environment dated 31/03/2014
    - CQC quality and risk profiles dated 21/10/2013 and 13/03/2014

- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information in the quality report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual

reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

**Signed** **Date: 13th of May 2014**

**John Edwards**
**Chairman**

**Signed** **Date: 13th of May 2014**

**Paula Clark**
**Chief Executive**

# Independent Assurance Report to the Council of Governors of The Dudley Group NHS Foundation Trust on the Annual Quality Report

## Independent Auditor's Report to the Council of Governors of The Dudley Group NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of The Dudley Group NHS Foundation Trust to perform an independent assurance engagement in respect of The Dudley Group NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Dudley Group NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Dudley Group NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Dudley Group NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

### Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 day standard for cancer treatment; and
- Clostridium Difficile

We refer to these national priority indicators collectively as the "indicators".

### Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*

- the Quality Report is not consistent in all material respects with the sources specified below:
    - Board minutes for the period April 2013 to March 2014;
    - Papers relating to quality reported to the board over the period April 2013 to March 2014;
    - Feedback from the Commissioners dated 29/04/2014;
    - Feedback from local Healthwatch organisations dated 24/04/2014;
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/04/2014;
    - The latest national patient survey dated 2013;
    - The latest national staff survey dated 2013;

- Care Quality Commission Intelligence Monitoring Profiles dated 21/10/2013 and 13/03/2014;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2013; and
- Any other information included in our review.

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents listed above and specified within the detailed guidance for external assurance on Quality Reports.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

## Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Dudley Group NHS Foundation Trust.

**Conclusion**
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2013/14; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*

Deloitte LLP
Chartered Accountants
Birmingham
22 May 2014

**This leaflet can be made available in large print, audio version and in other languages, please call 0800 0730510**

ਜੇਕਰ ਇਹ ਲੀਫ਼ਲੈੱਟ (ਛੋਟਾ ਇਸ਼ਤਿਹਾਰ) ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ (ਪੰਜਾਬੀ) ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰ ਕੇ ਪੇਸ਼ੰਟ ਇੱਨਫ਼ਰਮੇਸ਼ਨ ਕੋ-ਆੱਰਡੀਨੇਟਰ ਨਾਲ **0800 0730510** ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

यदि आपको यह दस्तावेज़ आपनी भाषा में चाहिये तो पेशन्ट इनफरमेशन को-आरडीनेटर को टैलीफ़ोन नम्बर **0800 0730510** पर फोन करें।

જો તમને આ પત્રિકા તમારી પોતાની ભાષા (ગુજરાતી)માં જોઈતી હોય, તો કૃપા કરીને પેશન્ટ ઈન્ફોર્મેશન કો-ઓર્ડિનેટરનો **0800 0730510** પર સંપર્ક કરો.

আপনি যদি এই প্রচারপত্রটি আপনার নিজের ভাষায় পেতে চান, তাহলে দয়া করে পেশেন্ট ইনফরমেশন কো-অর্ডিনেটারের সাথে **0800 0730510** এই নম্বরে যোগাযোগ করুন।

أذا كنت ترغب هذه الوريقة مترجمة بلغتك الاصلية ( اللغة العربية ) , فرجاء أتصل بمنسق المعلومات للمريض **Information Co-ordinator** على التلفون **0800 0730510**

حسب ضرورت اس لیف لٹ کو اپنی زبان (اردو) میں حاصل کرنے کے لئے، براہ مہربانی ٹیلیفون نمبر **0800 0730510** پر ویلفیئر انفارمیشن کو-اورڈینیٹر (مریضوں کے لئے معلومات کی فراہمی کے سلسلے میں افسر) کے ساتھ رابطہ قائم کریں۔

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