The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 4th July 2013 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – P Assinder**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 6th May 2013	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 6th May 2013	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Verbal	D Mcmahon	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	10.00
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Bland	To Note	10.10
	7.2 Francis Report	Enclosure 5	P Clark	To Note & Discuss	10.20
	7.3 Infection Prevention and Control Exception Report	Enclosure 6	D Mcmahon	To Note	10.30
	7.4 Trust Annual Report (inc. Quality Report) and Quality Report External Assurance Review	Enclosure 7	D Mcmahon	To Note	10.40
	7.5 Board Assurance Framework	Enclosure 8	D Mcmahon	To Note	10.50
	7.6 Quarterly Safeguarding Report	Enclosure 9	D Mcmahon	To Note	11.00
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 10	D Badger	To Note & Discuss	11.10
9.	**Strategic**				
	9.1 Food and Nutrition Report	Enclosure 11	R Beeken	To Note	11.20
	9.2 Schwartz Rounds/Intelligent Kindness	Enclosure 12	P Harrison	To Note	11.30
10.	**Date of Next Board of Directors Meeting** 9.30am 5th September, 2013, Clinical Education Centre		J Edwards		11.40

11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		11.40

Enclosure 1

The Dudley Gr
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 6th June 2013 at 9:30am in the Clinical Education Centre.

Present:
John Edwards, Chairman
David Badger, Non Executive Director
David Bland, Non Executive Director
Ann Becke, Non Executive Director
Richard Miner, Non Executive Director
Jonathan Fellows, Non Executive Director
Richard Beeken, Director of Strategy, Performance and Transformation
Paul Assinder, Deputy Chief Executive/Director of Finance and Information

In Attendance:
Helen Forrester, PA
Elena Peris-Cross, Apprentice
Tessa Norris, Director of Community Services and Integrated Care
Liz Abbiss, Head of Customer Relations & Communications
Richard Cattell, Director of Operations
Annette Reeves, Associate Director for Human Resources
Yvonne O'Connor, Deputy Nursing Director
Jeff Neilson, Clinical Director

13/020 Note of Apologies and Welcome

Apologies were received from Paula Clark, Paul Harrison and Denise McMahon who were attending the Keogh Review Risk Summit.

The Chairman confirmed that the apologies impacted on the quoracy of the Board and stated that any decisions will be made under Chair's delegated powers and ratified at the July Board meeting.

The Chairman welcomed Yvonne O'Connor, representing Denise McMahon, and Jeff Neilson, representing Paul Harrison, to the meeting.

13/021 Declarations of Interest

There were no declarations of interest.

13/022 Announcements

No announcements given.

13/023 Minutes of the previous meeting on 2nd May, 2013 (Enclosure 1)

The Minutes of the previous meeting were agreed as a correct record of the meeting and signed by the Chairman.

13/023.1 Action Sheet 2nd May 2013 (Enclosure 2)

Board members noted all actions were either complete or on the Agenda for discussion.

13/024 Patient Story Report (Enclosure 3)

Yvonne O'Connor, Deputy Nursing Director, presented the Patient Story video.

Board members noted that this story was from a patient wanting to share a positive experience from care received at the Trust.

Yvonne O'Connor confirmed that comments had been fed back to ward staff and the Trust was investigating how positive feedback could be better gathered.

The Deputy Chief Executive/Director of Finance and Information commented that it was an issue of emphasis on how we gather feedback and inviting bad news instead of the good news stories. The Chairman agreed that we need to consider how we achieve inviting more good news stories.

Liz Abbiss, Head of Customer Relations and Communications, confirmed that the Trust was piloting the use of feedback cards on some wards. An increase of positive comments had been witnessed on the NHS Choices website. The Deputy Chief Executive/Director of Finance and Information asked if we collate and analyse feedback. Liz Abbiss confirmed that the Trust is looking at having a simple tick box on the reverse of cards.

David Badger, Non Executive Director, stated that it was important to have a non-technological method of responding.

Jonathan Fellows, Non Executive Director, suggested that we could use charitable funds to purchase pens with the strapline "how did we do today". Richard Miner, Non Executive Director, confirmed that he would look at this.

The Chairman confirmed that we need to make it as simple as possible for people to leave positive feedback and also use good practice to learn from what works well.

Investigate how to make collecting positive feedback as simple as possible and how to use good practice to learn from what works well.

Look at use of charitable fund monies to purchase pens with the strapline "how did we do today".

13/025 Chief Executive's Report (Enclosure 4)

The Deputy Chief Executive/Director of Finance and Information presented the Chief Executives Report given as Enclosure 4, including the following items:

- Friends and Family Test: Board members noted the results for wards areas, A&E, which is a new area, and for the planned expansion into Maternity.

  Board members noted that for ward footfall the Trust was exceeding the target and scores were improving but A&E, in common with other Trusts, was more of a challenge. The Trust was achieving a score of 12% trustwide against a target of 15%.

  David Badger, Non Executive Director, confirmed that it would be useful to see numbers for our position against national responses. The Deputy Chief Executive/ Director of Finance and Information confirmed that we are well within the pack and the Trust is above halfway for footfall and performance.

  Liz Abbiss, Head of Customer Relations and Communications, confirmed that volunteers are assisting with the response rate.

  The Chairman commented that patients in A&E do not recommend the Trust because they have to turn up here as an emergency. The Friends and Family Test is not suitable for application within an A&E environment. David Badger commented that people in Dudley vote with their feet and this is shown by the numbers through the door in A&E. The Deputy Chief Executive/Director of Finance and Information confirmed that Trust's are feeding back on this through the Foundation Trust Network and Confederation.

  Board members noted that the test will be rolled out in Maternity by 1st October, 2013.

- Keogh Review: The Deputy Chief Executive/Director of Finance and Information summarised that the Trust was surprised and perturbed to be included in the review process. The review had been conducted in three phases:

  - Structured interviews during the announced visit
  - Unannounced visits
  - Risk Summit

  Board members noted that the unannounced visits had taken place during a really busy bank holiday period.

  The Deputy Chief Executive/Director of Finance and Information confirmed that the Trust was awaiting the publication of the final public report. He commented that the Trust should be assured that nowhere during the process had anyone found anything that needed reporting "up the line". Richard Cattell, Director of Operations, confirmed that in fact the process had highlighted great care throughout the Trust.

  David Badger agreed that no evidence had been found regarding poor quality of care. David Badger confirmed that the Non Executive Directors had begun to collect their views around the process and a number of issues had been identified that should be highlighted to Sir Bruce Keogh regarding the process.

The Chairman agreed that there should be learning from the process and it should be clear that it is fit for purpose. There was concern about a misunderstanding by the Review team on the role of the Foundation Trust Board and around accountability. It will be important for the Chief Inspector of Hospitals to take on board this learning. The Trust needs to await the final report and reflect on this in a measured way.

The Chairman confirmed that it was reassuring that there had been no surprises identified by the process. A further report will be presented to the July Board.

The Deputy Chief Executive/Director of Finance and Information acknowledged the reaction by staff and confirmed that they had made the Trust very proud.

- Trauma Unit: The Deputy Chief Executive/ Director of Finance and Information confirmed that the Trust had received confirmation of its designation as a Trauma Unit. Dr Jeff Neilson stated that Karen Hanson had invested an enormous amount of work to achieve the status and acknowledged that this now make the Trust a very strong Unit.

13/026 Quality

13/026.1 Clinical Quality, Safety and Patient Experience Committee (Enclosure 5)

David Bland, Committee Chair, presented the Exception Report given as Enclosure 5. The Board noted the following key issues:

- Blood Transfusion and Competency Training: David Bland confirmed that this is an example of the way in which the Committee raises issues. Board members noted that the matter is not fully resolved and will be monitored by the Committee.

- NICE Guidance: David Bland confirmed that a lot of work had been undertaken in this area and numbers had reduced considerably.

- Patient Experience Strategy: Board members noted that work is now really moving forward in this area and lots of good work had been undertaken.

The Chairman asked about the privacy and dignity review by the Local Authority/Social Care Select Committee, and whether there were any issues for the Trust. David Bland confirmed that it was a one-off review and there were no major concerns. The Deputy Chief Executive/ Director of Finance and Information stated that the review had a positive outcome.

The Board noted the report and issues arising.

13/026.2 Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Enclosure 6)

The Deputy Chief Executive/Director of Finance and Information presented the report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, given as Enclosure 6.

The Board had spent time looking at the detail in Francis II and relating back to Francis I. There are a number of issues for the Trust in how we might work differently as a Board and a group of managers and clinicians in the future.

Julie Cotterill, Information Governance Manager, had undertaken a detailed piece of work and was progressing this with the Executive Team. Each area had an identified lead Director.

A number of initiatives are awaiting further work nationally, for example the Code of Conduct for managers.

There are a number of implications to our clinical work and this ties in with learning from complaints.

Yvonne O'Connor, Deputy Nursing Director, confirmed that the report notes areas where work is ongoing. She commented that the Trust needs to improve its feedback process as discussed earlier on the agenda and we are expecting guidance around this formally.

Yvonne O'Connor confirmed that for point 88 and 89 around HSE function for reporting death or serious injury, there was no particular change in process but a more proactive approach to reporting is required. The Trust will also be required to publicise responses to complaints and this will be a challenge.

The Deputy Chief Executive/Director of Finance and Information stated that Francis is not about doing different things, it is about doing what we currently do differently to make us more transparent. We need to examine everything we do and our process behind it.

The Director of Community Services and Integrated Care referred to recommendation 185 about nurses referred to the NMC being notified to the Board. She confirmed that the Board already receives information on medic referrals but the report should include all healthcare professionals and pharmacists to ensure the broader workforce is covered.

Ann Becke, Non Executive Director, raised recommendation 238, and stated this is a patient experience element in an ideal world and the wording is a little ambiguous and should be revised. Ann Becke also suggested the wording for recommendation 179 regarding contracts should be revised.

David Badger, Non Executive Director said he welcomed the report and it gives clarity to the areas that need Board focus. There are no surprises in the paper and the Board now needs to look at its priorities and areas that need emphasis. For recommendations 75 and 76, a great deal of work has been undertaken in these areas and when RAG rated David Badger asked how we can turn some areas to green as this is subjective.

The Deputy Chief Executive/Director of Finance and Information confirmed that the report is the product of Executive Directors trying to establish success factors and is still a work in progress.

Richard Miner, Non Executive Director, agreed that the RAG rating is confusing as you cannot differentiate progress, a further column is required to identify this.

Richard Cattell, Director of Operations, confirmed that for some areas we are awaiting national actions but it is more about cultural change and we need to work hard to make success tangible.

The Chairman endorsed the comments regarding the RAG ratings as the outcomes are about a change of culture and subjective analysis.

David Badger stated that RAG ratings suggest that the Executive Team have been cautious. The Chairman commented that the Trust cannot sit and wait for national guidance and it needs to be brave with issues.

The report shows that the Trust is on top of recommendations and it has clear plans in place. He thanked Bill Hazleton from the Council of Governors for suggesting the approach.

The Chairman confirmed that he had spoken with the Chief Executive and Deputy Chief Executive/Director of Finance and Information regarding the Trust's auditors looking at our Board processes. The Chairman will discuss this further with the Lead Governor.

The Chairman noted the report and the work and actions undertaken and those still to be undertaken.

Recommendations 179 and 238 require re-wording.

Recommendation 185 to include the wider workforce eg Health Care Professionals and Pharmacists.

13/026.3 Infection Prevention and Control Exception Report (Enclosure 7)

Yvonne O'Connor, Deputy Nursing Director, presented the Infection Prevention and Control Report Exception Report given as Enclosure 7**.**

C.Diff: For the year ending March 2013 the Trust had an annual target of 77 cases. For the current year the Trust had a very challenging target of 38 cases and a enormous amount of work was being undertaken to achieve this.

For April 2013 the Trust had one case of C.Diff and two cases had been reported in May. Board members noted that C.Diff is an infection that has a low prevalence in the Summer.

MRSA: For the year ending March 2013 the Trust had an annual target of one case and the Trust reported one case for the year. For the current year the Trust has a zero tolerance target. Board members noted that MRSA screening is key in achieving this.

Norovirus: No confirmed cases, but this is well known as a wintertime infection.

The Director of Strategy enquired about Ward A2. This is a large ward which has a prominent approach in that all visitors and staff undertake hand washing. He asked if this approach should be rolled out across all wards.

Yvonne O'Connor confirmed that hand washing is shown to prevent infection. The Director of Strategy asked if the Nursing Director could mandate this move. Yvonne O'Connor confirmed that to keep a high profile on hand washing a staggered ward approach is a better method.

The Chairman agreed that the Trust needs to reinforce the message in different ways. He had recently met with David Sparks, leader of the Council, David had commented that whilst visiting the hospital he did not feel publicity around the need for handwashing was very apparent.

The Chairman stated that the Trust cannot be in a position where a fine is imposed for breach of target on infection control.

The Chairman noted the good progress and the comments relating to the challenging targets.

13/026.4 Audit Committee Exception Report (Enclosure 8)

Jonathan Fellows, Chair of the Audit Committee, presented the Audit Committee Exception Report given as Enclosure 8 and the Reports recommended by the Audit Committee, given as Enclosure 9.

Highlights from the previous Audit Committee included:

- Year End Accounts: The process had gone smoothly with a recommendation that the documents are approved by the Board.

- Internal Audit: Busy year noted with 30 audits and only one with a red opinion regarding data quality although the Committee felt this rating was harsh.

- Audit Opinion: Sound system of internal control. Jonathan confirmed that this is the best opinion that any Trust can achieve and Board members noted the healthy report.

Jonathan Fellows presented the documents included in Enclosure 9, recommended to the Board by the Audit Committee for approval including:

- Internal Audit Strategy: Board members noted that core financial systems were consistently green rated and it was no longer considered useful to review these every year. The resource will be used to investigate other areas including NCIs. Safety Thermometer, Community, Francis, Data Centre, Business Plan Priorities, Claims and Complaints and Pressure Ulcers. Jonathan Fellows recommended that the Board approve the Plan for the year ahead.

- Local Counter Fraud Plan: Agreed to 80 days work. The Board noted that 72 days of reactive work had been undertaken the previous year and 3 cases had resulted in disciplinary action. Jonathan Fellows proposed that the Board accept 80 days work again for the year ahead.

- Local Audit Plan: For the previous year 290 audits had been registered, with 227 completed and 16 remaining as incomplete. For 2013/14 there are 129 audits on the list included in Enclosure 9. Board members noted that this was an evolving Plan with other audits being considered by the team.

Jonathan Fellows recommended that the Board approve the Strategy and Plans and the Audit Committee will produce its Annual Report for presentation to the Audit Committee in July and Board in September, 2013.

David Bland, Non Executive Director, asked how 80 days work compared to other Trusts. Jonathan Fellows confirmed that there are 4 levels, the Trust was a level 2 and this was identified by the number of reactive days work. The system has changed and the Trust is now graded as a level 3 and this puts us in the top quartile. 80 days work is acceptable whilst the Trust remains at this level.

Richard Miner, Non Executive Director, commented that the Trust benchmarks well against other Trusts and we should take assurance from that.

David Badger, Non Executive Director, welcomed the clear and comprehensive report. He asked about the Clinical Audit Plan and whether we should want assurance that the Plan is suitable for a Trust of our size and nature. Jonathan Fellows to discuss with David Badger further outside of the meeting. Board members noted that the Plan does cover all areas we would want it to and compares well against other Trusts.

The Chairman confirmed that he speaks with the Deloitte and RSM Tenon leads each year and had taken assurance from their comments as we compare favourably against other Trusts. The Chairman and Chief Executive had also met with the auditors to discuss the Local Audit Plan for the year and the Chairman endorsed the comments about devoting time to other areas. For Clinical Audit the Trust also compared very favourably with other Trusts.

The Director of Community Services and Integrated Care commented that the Trust had received positive feedback from Governors following their session with the auditors and suggested that follow on meetings could be arranged in the Autumn.

The Board noted the Audit Committee Exception Report and the Chair under delegated powers noted the strong statement from the auditors, approved the Internal Audit Strategy, Local Counter Fraud Plan and the Clinical Audit Plan.

Audit Committee Annual Report to be presented to the Audit Committee in July and the September Board.

13/026.5 Reports Recommended by the Audit Committee for Approval (Enclosure 9)

Covered in item 13/026.4 above.

13/026.6 Risk and Assurance Committee Exception Report (Enclosure 10)

Ann Becke, Risk and Assurance Committee Chair, presented the exception report from the previous meeting, given as Enclosure 10, including:

- Emergency and Specialist Medicine Risk Register: The Committee took assurance that the mitigating actions were robust.

- National Cardiac Arrest Audit: There has been substantial learning from the report which had been discussed with the Medical Director who would be giving it deeper consideration. An update will be presented to the July Committee.

- Board Assurance Framework: The Committee had considered the updated Framework and noted the seven risks scoring 20 and above.

The Chairman thanked Ann Becke for the comprehensive report and the Board noted the key issues.

National Cardiac Arrest Audit: The Medical Director to give the report further consideration. Update to the Risk and Assurance Committee in July.

13/026.7 Risk and Assurance Committee Annual Report (Enclosure 11)

Ann Becke, Committee Chair, presented the Annual Report of the Risk and Assurance Committee, given as Enclosure 11.

Ann Becke confirmed that the report takes a look back at the work of the Committee over the previous year. Board members noted the decision to move the Committee to quarterly meetings to make it more effective. Highlights from the report included:

- Directorate Risks: Directorates had been invited to attend the Committee to present their risks. Risk management is embedded at Board and Senior Manager level but further work needs undertaking to embed further down in the organisation at workforce level.

- Extraordinary Committee meetings: These had been held to sign off policies.

- Board Assurance Framework: External reviews of the Framework had been undertaken and this had provided the Committee with assurance.

Ann Becke summarised that it had been a good year for the Committee. David Badger, Non Executive Director, agreed that major progress had been achieved over the last 12 months.

The Chairman confirmed that moving the cycle of meetings had given the Committee greater impetus.

The Board received the report and noted and approved the work undertaken.

13/027 Finance

13/027.1 Finance and Performance Report (Enclosure 12)

David Badger, Chair of the Finance and Performance Committee presented the summary of papers received by the Finance and Performance Committee given as Enclosure 12, including:

- Workforce: The Committee had a substantial debate around sickness absence and the major cost to the Trust which equates to a six figure sum. A number of actions had been agreed to address the issue and the Committee will monitor progress.

- Mandatory Training and Appraisals: A new member of staff had been appointed to progress work on mandatory training. Appraisals rates had seen an improvement up to 81.8%. A meeting had taken place with the General Manager for Specialist and Emergency Medicine and a plan should be in place by July 2013 for the coming year.

- Financial Performance: Slightly behind plan with a £300k deficit, there had been early slippage on savings. The position reflected the situation last year. The Trust had received confirmation that it will receive the £3m transition funding from the CCG. There had been a significant increase in elective, emergency and community attendances. The Committee noted with concern the CIP slippage and were closely monitoring the position. The Trust was still aiming to achieve a surplus of £500k.

- Performance Targets:

    - The 4 hour wait position in A&E for April was 90.1% and concern was noted for the first quarters performance following the Trusts failure to meet the quarter 4 target. Board members noted that the position for May put the Trust above 95% and represents a tremendous effort from all involved.

    - Cancer 62 Day Waits: Corrected for the period.

- Annual Plan: The Finance and Performance Committee received the Annual Plan and approved its submission to Monitor.

- Approvals under Delegated Authority: The Committee received and approved the Trust Audited Annual and Quality Accounts, Annual Report and Accounts and Letter of Representation to Deloittes.

- Terms of Reference: The Committee agreed to change its Terms of Reference to enable the Committee to approve the quarterly returns to Monitor. A copy of the Terms of Reference were attached to the report.

The Chairman noted the actions taken under delegated authority and endorsed the change to the Terms of Reference.

13/027.2 Charitable Funds Committee Report (Enclosure 13)

Richard Miner, Committee Chair, presented the Charitable Funds Half Yearly Report, given as Enclosure 13.

Board members noted that the group was now a sub-Committee of the Board as opposed to a working group.

Richard Miner confirmed that the Committee needs a clear fundraising strategy that sets stretching fundraising targets for the fundraiser.

The Committee is looking at how the Trust spends it charitable funds and plans are being produced by the Fund Manager.

Board members noted that £40k had been raised the previous week for the Trust Charity from the Free Radio Walk for Kids.

David Badger, Non Executive Director, asked about the way we spend available money. Richard Miner confirmed that the Committee are making greater donations towards larger proposals.

The Chairman commented that the report does not include detail on the Georgina Unit Charity and as a Board felt we should be sighted on the Georgina Unit activities. The Deputy Chief Executive/Director of Finance and Information confirmed that the Charity have improved their governance arrangements and he receives a copy of their audited accounts. He confirmed that could share details of their annual report and accounts with Board members.

Ann Becke, Non Executive Director, stated that as a Charity they are very much attached to the Trust and there is an obligation for the Board to be aware of their work.

David Badger suggested that the Charitable Funds Committee should be kept informed of the Georgina Unit's position and then advise the Board of its activities. The Deputy Chief Executive/Director of Finance and Information suggested that this should also apply to the Education Centre Charity.

Richard Miner confirmed that he will arrange to meet with the Chair of the Georgina Unit's trustees.

Dr Jeff Neilson commented that there was significant history behind the running of the fund.

The Chairman agreed that it was a good idea to arrange a meeting and the Board noted and adopted the report.

13/ 028 Corporate and Strategic

13/028.1 Security Report (Enclosure 14)

Richard Miner. Non Executive Director lead for Security presented the Security Report given as Enclosure 14.

Richard Miner confirmed that he had met with the previous officer responsible for security but that member of staff was not currently at the Trust. The report had been prepared by an interim security specialist and a number of concerns were noted, including:

- Number of Assaults on Staff: Richard had taken assurance that although this number was high the Trust was not outside of the norm.

- Unathorised Access to Maternity: Board members noted that this issue had now been resolved.

- Restraint Policy: Richard Miner confirmed that he had been assured that this was now dealt with.

The Director of Strategy, Performance and Transformation commented that he was keen to raise the profile of reporting of assaults and confirmed that as Interserve Security staff now use datix reporting the Trust should receive a real time picture of the issue.

Board members noted that the majority of abuse takes place in ED. The Director of Strategy, Performance and Transformation confirmed that the Trust is going to actively look at the reporting of incidents and pursue prosecutions as appropriate.

Board members noted that incidents are report to the Health and Safety Committee and then up through to the Risk and Assurance Committee.

Yvonne O'Connor asked about the level of serious incidents identified. Board members noted that the Trust does not receive a high level of serious incidents reported but they may be as a result of reporting frequency.

The Director of Operations confirmed that he fully supported the push on reporting incidents and confirmed that we also need to give feedback and support to staff after the process has ended.

The Board noted the contents of the report.

13/028.2 Role of the Director of Strategy, Performance and Transformation (Enclosure 15)

The Director of Strategy, Performance and Transformation, presented the description of his role, given as Enclosure 15. He confirmed that it was a brief paper written for the Executive Team to give clarity around his new role.

The paper now aims to give clarity to the Board for responsibility and accountability of delivery and what outputs the Board should expect during the year. Board members noted that the largest and most tangible output it the complete refresh of the organisations Integrated Business Plan. He would be achieving this in an organic way with each Directorate and specialty and the process will ensure that Monitor Annual Plans become more robust.

Interim papers from the Director of Strategy, Performance and Transformation will be presented to the Board setting out the new strategic approach.

David Bland, Non Executive Director, asked about the issue of KPIs and whether there were any 5, 10 or 15 real measures of improvement that can be shown on a single page. The Director of Strategy, Performance and Transformation confirmed that this will be a by-product of the review of the performance management framework.

The Operations Director confirmed that work had already commenced in earnest during performance review meetings with specialties.

David Badger, Non Executive Director, made one minor point about the reporting line. The Report gives this to be the Executive Team but questioned whether this should be the Chief Executive. The Director of Strategy, Performance and Transformation confirmed that this was an error and the paper should in fact state accountable to the Chief Executive.

The Chairman confirmed that the Board had approved the role in the first quarter of the calendar year and it was helpful to see it set out in detail.

The Chairman enquired how much of the work the Trust could undertake itself and how much must the Trust await for guidance from others. The Director of Strategy, Performance and Transformation confirmed that there had been a meeting with the CCG Joint Leadership Team the previous day and it had been agreed that the Director of Strategy, Performance and Transformation would produce a paper on how our strategies align.

The Chairman noted the report and work programme and confirmed that he looked forward to a refreshed and revised Integrated Business Plan.

13/029 Any Other Business

The Chairman confirmed that the Director of Community Services and Integrated Care was attending her last Board meeting. He thanked her for all she has achieved over the past two years. She had taken a significant role in making the transfer of Community Services a success and also her work with Governors had been invaluable. The Chairman and Board members expressed their best wishes for her new role .

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

13/030 Date of Next Meeting

The next Board meeting will be held on Thursday, 4th July, 2013, at 9.30am in the Clinical Education Centre.

Signed …….

Date …….

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 6 June 2013

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
13/017	Listening into Action Update Report	Continue to focus on staff engagement and prepare for re-launch.	JD	5/9/13	
13/024	Patient Story	Investigate how to make collecting positive feedback as simple as possible and how to use good practice to learn from what works well. Look at use of charitable fund monies. For example in purchasing pens with a strapline "how did we do today".	MG RM	5/9/13 29/8/13	
13/026.2	Francis Report	179: Needs re-wording 185: Nurses referred to NMC Report to be taken to the Board – this should include the wider workforce eg Health Care Professionals and Pharmacists. 238: Ambiguous wording requires changing	DM	5/9/13	
13/026.4	Audit Committee Exception Report	Audit Committee Annual Report to July Audit Committee and September Board.	JF	23/7/13 5/9/13	
13/026.6	Risk and Assurance Committee Exception Report	National Cardiac Arrest Audit: The Medical Director taking a deeper look. Update to the next Committee.	PH	23/7/13	
13/027.2	Charitable Funds Committee Report	Charitable Funds Committee Chair to meet with Georgina Unit Fund Chairman Re: their activities.	RM	5/9/13	

Enclosure 3

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 4th July 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Report
- Keogh Review into Quality of Care and Treatment - update
- NHS Constitution 2013
- Refresh of The Healthy Board Guide
- Consultant Level Outcomes

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive Update – July 2013

Friends and Family Report:
Improvements are starting to be seen in A&E completion rates resulting in June weeks 3 and 4 achieving the 15 per cent or more baseline requirement on a Trust-wide basis. However, despite the improvements being made it looks unlikely that the Trust will achieve the CQUIN based on a Trust wide completion rate of 15% for the whole of quarter one.

Feedback from the frontline is that while staff continue to give out the cards to patients it is clear that this methodology is not working for patients in an A&E environment. Uptake of online and freepost options are also minimal. The CQSPE Committee has taken the decision to pilot a token system in A&E. This is now being developed to pilot from August 2013.

	April 13 Overall	May 13 overall	April & May cumulative	June 13 Wk 1	June 13 Wk 2	June 13 Wk 3	June 13 Wk 4
	01.04.13	01.05.13	**01.04.13**	27.05.13	03.06.13	10.06.13	17.06.13
Date range	30.04.13	31.05.13	**31.05.13**	02.06.13	09.06.13	16.06.13	23.06.13
Number of eligible inpatients	*1930*	*1962*	***3892***	*391*	*429*	*477*	*443*
Number of respondents	*408*	*573*	***981***	*127*	*120*	*95*	*413*
Ward FFT score	66	75	**71**	79	79	76	65
Ward footfall (min'm 15% required)	21%	29%	**25%**	32%	28%	20%	32%
Number of eligible A&E patients	*4206*	4380	***8586***	*997*	*1008*	*970*	*970*
Number of respondents	*17*	62	***79***	*15*	*69*	*127*	*101*
A&E FFT Score	53	71	**67**	100	54	61	54
A&E footfall (min'm 15% required)	0%	1%	**1%**	2%	7%	13%	10%
TRUST FFT Score	65	74	**71**	81	70	67	60
TRUST footfall	7%	10%	**8%**	10%	13%	15%	17%

National publication of results is due at the end of July. NHS Choices will publish scores in a range of normal, better or worse than others (based on top/bottom quartile scores yet to be advised). Data will be available for site and ward/A&E level to allow patients to compare hospitals at a specialty level.

Keogh Review into Quality of Care and Treatment:
Both the announced and unannounced visits from the team have now taken place. The data pack produced by Price Waterhouse Coopers (PwC) was published on the NHS Choices website and the Trust worked with the team at PwC to address our concerns about factual accuracy, some of which were accepted in the final publication. The themes under review were mortality indicators, clinical and operating effectiveness, patient experience, workforce and safety. The Risk Summit took place on 6th June, 2013.

NHS Constitution 2013:
The Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution.

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

The full document can be found on:-

http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

NHS Leadership Academy – Refresh of The Healthy Board Guide: The strong relationship between leadership capability and performance is well demonstrated in the evidence. Good leadership leads to a good organisational climate and good organisational climates lead, via improved staff satisfaction and loyalty, to sustainable, high performing organisations.

The Healthy Boards Guide has been updated by the insights of experienced, leaders of NHS, regulatory and patient advocacy organisations to meet the challenges facing Boards today.

The NHS Leadership Academy have suggested that the guide will help the Boards of NHS organisations to use it as a cornerstone for Board development and we should discuss how we will use this in our own Board development programme. The full document can be found at:

http://www.leadershipacademy.nhs.uk/discover/the-healthy-nhs-board/

Consultant Level Outcomes
The Medical Director attended a meeting in London on the 19th June, ahead of the planned publishing by NHS England of consultant level outcomes derived from ten national audits at the end of June. Publishing this information is in line with NHS England's commitment to openness and helping to inform patient choice. It is also seen as an important driver to improve quality and outcomes. Given the fact that individual consultants outcomes will be available, including if they are an outlier in terms of performance, this is a very sensitive issue.

The specialties/audits to be published cover:

- Interventional Cardiology
- Cardiac Surgery
- Vascular Surgery
- Upper Gastrointestinal Surgery
- Colorectal Surgery
- Orthopaedic Surgery
- Bariatric Surgery
- Urological Surgery
- Head and Neck Surgery
- Thyroid and Endocrine Surgery

The latest information available at the pre publishing meeting was that not all of these ten areas will have outcome data released in the first tranche. However, it is still not clear which of these will be released now and which will follow over the next few weeks and months. The plan is for this data to be signposted from the NHS Choices website and all Trusts will be required to have links to this data from their own websites. I would emphasise that this outcome data is not based on hospital episode statistics (HES data) as is the case with mortality indicators, such as HSMR or SHMI.

Clearly, there are a number of issues attached to release of this data, including consent for publication, interpretation of the outcome data and, of course, the quality of the information itself. It is clear that there is an expectation, endorsed by professional bodies such as the Royal College of Surgeons, that consultants should consent to their data being released. Whilst surgery is an area that has been targeted in the first instance, it is likely that this process will be expanded in future and that outcome data will be made public for more specialties, including physicianly specialties.

It is also clear that, wherever appropriate, all clinicians will be expected to take part in relevant national audits and obviously it will be important to ensure that submitted data is as accurate as possible. Taking part in appropriate national audits and including outcome data in appraisals will be required for revalidation purposes and, it has been suggested, taken into consideration for clinical excellence awards.

We will be expecting data from national audits to be presented by Medical Service Heads and Clinical Directors at all future Chairman and Chief Executive Morbidity/Mortality meetings. Obviously, if any consultant is identified as being an outlier when this data is published, we will offer support and help.

Additional issues for the organisation are that there may be a resource issue with respect to completing national audit data going forward and that there may be financial sanctions for Trusts that fail to engage with nationally recognised audits.

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 4th July 2013

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 9th May 2013		
AUTHOR:	Julie Cotterill Governance Manager	**PRESENTER:**	David Bland (NED) CQSPE Committee Chair

CORPORATE OBJECTIVES:
SGO1: Quality, Safety & Service Transformation, Reputation
SGO2: Patient Experience
SGO5: Staff Commitment

SUMMARY OF KEY ISSUES:

Update on the Management of Falls – The Matron Lead for Falls provided an update on the management of falls within the Trust. She outlined the approach adopted and confirmed that a Falls Group had been re-established to develop and progress actions and monitor the effectiveness of the revised arrangements. Falls incidents resulting in a fracture are one of the highest reported incidents and a falls bundle has been developed and is being rolled out across the Trust. Early indications show this is effective in reducing falls.

SAS Doctors QA Review Visit - Dr Whallett presented the SAS Doctors QA Review findings from a visit in January 2013. The visit had gone well and highlighted areas of good practice and areas for development.

Mortality Report - The Deputy Medical Director presented the update on mortality indices and the actions in progress. There had been no change in the SHMI at 1.04 since the last quarter. The Committee discussed the HSMR trends over the last 12 years, the coding of primary and secondary cancer when a patient is admitted for treatment, data sharing, reporting, outlier alerts and excess deaths.

Serious Incident Monitoring Report for April 2013 - 10 new incidents were reported – 9 general SI's and 1 pressure ulcer. There were 41 open general SI's (17 undergoing investigation, 15 awaiting assurance that all actions identified from the RCA investigation had been completed, 2 requiring additional assurance and 1 extension granted by CCG. 6 were recommended for closure). Concerns highlighted from the general SI's included falls resulting in a fracture. There were no breaches in the 2 day reporting from date of identification but there were 2 breaches in the completion of RCAs within the agreed time scales.

Aggregated Incident Report for the period 1st January to 31st March - The total number of incidents reported showed a quarter on quarter increase when compared to the same period in the last two years. The Committee discussed the sub category (detail) level which showed an upward trend or consistently high level of incidents in the Clinical Care, Assessment and Monitoring category. Of the 306 incidents reported in quarter 4, 240 were due to a Delay in Care/Treatment. The Committee discussed the report format and contents and agreed changes to incorporate severity information.

Patient Safety Group held on 12th March 2013 - the following key issues were discussed:

- **Resuscitation** – Crash trolley checks were not completed in all areas. Results showed daily checks at 79% and weekly checks at 80%. Only 4 areas had reached the 100% daily check requirement.
- **National Cardiac Arrest Audit Report** – This joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit and Research Centre) highlighted two risks: average for survival to hospital discharge by shockable presenting/first documented rhythm and lower than average for survival to hospital discharge by non shockable presenting/first documented rhythm. The Resuscitation Group will identify actions and learning from the report.
- **Feedback from the Red Incident Assurance and Learning Group Meeting on 26th February 2013** – there were 73 incidents on the Red Incident Matrix (excluding SI's) of which 27 had breached the timescales for completion of the RCA or to provide assurance that action had been taken.
- **Patient Safety Leadership Walkrounds** – there had been 32 walkrounds since 1st April 2013 from which a number of actions had breached completion dates. The Committee discussed the format of walk rounds, the approach to be taken and possible changes to membership and structure.
- Two further issues were raised at the Patient Safety Group under Any Other Business relating to the checking of RCA's by Matrons and staffing levels.

The Committee discussed the wider staffing issues and measures taken to address staffing levels and skill mix, including the use of bank and agency staff and weekend cover.

Staff Immunity TB Checks - The Committee received the Trust plans to ensure the necessary checks and services were provided to staff and new starters to prevent the spread of TB. Two issues were raised by the CCG Joint Quality Risk Meeting, one requesting assurance relating to measles and workforce immunity and secondly proof of TB testing. The Committee discussed the requirement to vaccinate staff and the challenge of proving immunity.

National Staff Survey – Update on HR Activity - two focus groups had been held to gather staff views on the survey, which had a low uptake. The over whelming concern of staff was the confidentiality of the survey. The survey closed on 24th April with 635 responses equating to a 14% overall response rate. The results and comments would be collated by VaLUENTIS. Live figures of staff engagement would be available for the next meeting. The Committee discussed the concerns raised regarding confidentiality and possible options/solutions for managing future surveys.

Friends and Family Survey Results - scores were showing some fluctuation. ED in line with many Trusts nationally, is struggling to collect the footfall data and has gone into the red. Alternative collection methods including text and token options are being considered. The most cost effective and simple to implement is the token system, which will be trialled first. The Committee discussed the options including emailing and the associated costs and resources required to administer the systems.

Patient Experience Report Results - The Committee received the headline results confirming that local and regional CQUINs have been achieved and the national CQUIN was partially achieved. There was a decrease in real time surveys in March due to Steamplicity food trial surveys taking place. Clinical treatment remains the biggest issue raised in complaints and PALs. There was a total of 49 comments on NHS Choices an increase of 29 on the previous quarter. Many of the NHS choices comments are very positive.

***Please Note**: The full Committee minutes are available for Board members on the Directors drive.*

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 9th May 2013 and refer to the full minutes for further details.

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

Enclosure 5

The Dudley Gro
NHS Foundation Trust

Paper for submission to the Board on July 4th 2013

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

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

SUMMARY OF KEY ISSUES:

At the last meeting the Board received the first update report on progress against the local actions arising from the recommendations of the Francis Inquiry Report.

The attached report confirms the progress since the last meeting. Updates provided are shaded in yellow.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

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

Report to Board June 13 - Francis Inquiry Table of Recommendations requiring Local Action

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
	Availability for implementation of the recommendations These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.				
1	Implementing the recommendations	It is recommended that: • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;	Introduction	Board	The Board has received regular reports on both the Themes arising from the report and the recommendations and has agreed a process for monitoring the progress against local actions quarterly. The Chief Executive issued a formal Statement of Acceptance in February 2013. The Board has requested quarterly update reports on local actions.
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.				
4	Clarity of values and principles	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21	Board	Whilst the NHS Constitution underpins the core values and principles of the Trust, these will be re-visited and re-considered in light of the report and recommendations made.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
	Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.				
11		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements.	20	All	All staff have responsibilities to the public, their patients and colleagues and are expected to contribute to and comply with Trust procedures.
		Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary.	20	Director of Nursing / Medical Director	In place. Evidence report to Board and CQSPE
12		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	2	Director of Nursing	Feedback and learning needs to be further enhanced. **Investigation Manager now identified to review the incident reporting, investigation and monitoring process. Work in progress** **The process for providing feedback to staff who have reported incidents will be reviewed as part of the above including the use of datix for this purpose**.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
	A common culture made real throughout the system – an integrated hierarchy of standards of service No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.				
	Responsibility for, and effectiveness of, healthcare standards				
37	Use of information about compliance by regulator from: • Quality accounts	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them.	11	Director of Nursing	Quality accounts audited by Deloittes. Compliant since 2009/2010
		To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website.			On website
		Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information.			Compliant – all quality measures published.
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions				
75	Enhancement of role of Governors	The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations.
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10	Chairman	Directors are currently required to comply with individual professional codes of practice and professional registrations. Any recommendations to comply with a prescribed code of conduct for directors that is not currently part of directors contracts will be complied with.
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11	Board	
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10	Human Resources/ Board Secretary	This situation has not arisen in the Trust. However should this ever be the case then the Board Secretary together with the Associate for HR would make the necessary referrals.
86	Requirement of training of directors	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	10	Board/Human Resources	Annual appraisals are completed with all board members and their respective line managers. This process includes a review of the previous 12 months objectives, setting the coming year's objectives and the completion and agreement of a personal development plan which is reviewed during the appraisal discussion.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings				
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance	The Health and Safety Manager role is currently vacant and is being considered as part of a restructuring of the F&E function within the Trust. Whilst arrangements for reporting RIDDOR incidents remain sound, the review of this recommendation will have to be deferred until the appointment of a new Health and Safety Manager for the Trust.
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing	We will work with the HSE to meet any new requirements.
	Enhancement of the role of supportive agencies				
97	**National Patient Safety Agency functions**	Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	17	Director of Nursing	We already upload to the NRLS.
	Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.				
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	3	Director of Nursing	• Complaints/PALS email address shown on Trust website • Leaflets available on wards and in clinic areas • Posters on all ward notice boards and in departments • Free phone telephone number to call department • Freepost address available for those who wish to write to us • Staff available to meet complainants to assist with documenting concerns

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	3	Director of Nursing	Advice given regarding patient choice to wait for conclusion of formal complaint investigation before proceeding with litigation. However, if complainants suggest legal action being taken this does not preclude a full complaint investigation and response being provided.
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	3	Director of Nursing	• Posters distributed to wards and departments encourage patients/relatives to raise issues with ward staff. • All wards display photographs of matron, lead nurse and (usually) ward staff at ward entrances. • Comments made on NHS Choices website displayed on Trust's intranet hub for staff to read • Real time surveys undertaken by patient experience team who will refer individuals if appropriate.
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	3	Director of Nursing	• New Trust complaints web-based database will allow all staff with access to computers to have read-only access • This point to be further investigated when new database is installed
113	Complaints handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	3	Director of Nursing	The recommendations made by the Patients Association have been reviewed and will be followed
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	3	Director of Nursing	The new Trust web-based complaints database which automatically links to incidents will trigger automatic alerts when serious complaints or comments are received.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
115	Investigations	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply:	3	Director of Nursing	The complaints process will be reviewed as part of the wider action plan arising from the Keogh Investigation. All Francis recommendations will be considered as part of that review.
		• A complaint amounts to an allegation of a serious untoward incident;			All SIs have an RCA
		• Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;			Process in place
		• A complaint raises substantive issues of professional misconduct or the performance of senior managers;			Nursing staff referred to NMC and Doctors referred to GMC. No process for managers or CSW. Disclosure and Barring used for Safeguarding issues for all staff.
		• A complaint involves issues about the nature and extent of the services commissioned.			Process in place
116	Support for complainants	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	3	Director of Nursing	The Trust's complaints leaflet (sent to all complainants when acknowledgement of complaint is sent) gives details of ICAS – i.e. telephone number and address
117		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	3	Director of Nursing	Local Advocacy service is available for complainants who require specialist support. ICAS can provide expert advice to their Clients if required.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
118	Learning and information from complaints	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	3	Director of Nursing	This is not currently the case complaints are not published on website. The process needs review to include this agreement with the complainant. Refer to 115 above.
119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	3	Director of Nursing	The process needs to be revised to obtain complainants permission to undertake this.
	Performance management and strategic oversight				
142	Clear lines of responsibility supported by good information flows	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	8	Director of Finance and Information	The Trust has recently reviewed the composition and management of Directorate Performance meetings but will consider this in line with the wider review of overall governance structures and reporting lines commissioned in response to the recommendations arising from the Keogh investigation.
143	Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	8	Board	The Trust has developed a comprehensive set of quality metrics and will continue to monitor the effectiveness of these.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.				
173	Principles of openness, transparency and candour	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	22	Board	This is fundamental to the Vision and Values of the Trust "Where People Matter". The Trust will issue a Board statement to all staff re-confirming these principles
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	22	Medical Director	On 14th May the Medical Director advised all Consultants (inc Locums) and Trust Non-Consultant Medical Staff, of these requirements and confirmed that the Trust would not support any approach that was not consistent with these recommendations. Medical Director exploring the possibility of including a clause of openness and candour in all new medical staff contracts and retrospectively in all current medical staff contracts.
175		Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	22	Medical Director	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
176	Openness with regulators	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	22	Board / Chief Executive	The Trust will continue to act with professional integrity at all times when making statements to regulators , commissioners or the public
177	Openness in public statements	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	22	Chief Executive	
179	Restrictive contractual clauses	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	22	Associate Director of Human Resources	The Trust has always used standard comprise agreements that have been obtained from the Trusts Solicitors and do not include gagging orders (reworded)
180	Candour about incidents	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	22	All Executives	The Trust reviewed and updated the Being Open Policy as part of the NHSLA assessment in 2012 and will monitor compliance with this.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
	Nursing				
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the:	23	Director of Nursing and Human Resources	
		– Possession of the appropriate values, attitudes and behaviours;			An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation.
					Interviews for novice programme – entirely on values.
		– Ability and motivation to enable them to put the welfare of others above their own interests;			To include in competencies for novices and new graduates.
		– Drive to maintain, develop and improve their own standards and abilities;			All nursing staff/CSW have appropriate competencies and training programme, required to achieve before promotion to next grade – shortlisted for National Award 2013.
		– Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care;			Process in place. The Way We Care film is on the website and shown to all new nursing starters.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
		• Leadership which constantly reinforces values and standards of compassionate care;			Developing Appraisal questions based on "The Way We Care" and Codes of Conduct The Trust runs 3 Leadership programmes • Clinical leadership in conjunction with the Hay Group aimed at Clinical directors, Medical Service Heads and aspirant Clinical leaders. • A Trust Leadership programme which links to the NHS Leadership competency framework • A Trust Leaders Tool kit, aimed at people who are new to leading and are looking to again basis level technical skills in people management.
		• Involvement in, and responsibility for, the planning and delivery of compassionate care;			Nursing strategy launched May 2013. 'The Way We Care' based on 6 C's and incorporating Trust Values of Responsibility, Care and Respect. KPI will be reported quarterly to Board.
		• Constant support and incentivisation which values nurses and the work they do through: – Recognition of achievement;			Appraisals are managed as per the Trust's appraisal policy and cover both the technical part of any job together with the Trust values and the way the tasks are carried out by the employee. Recognition of good performance is made via "Committed to Excellence "and the Roll of Honour. The Trust also makes regular nominations to external awards
		– Regular, comprehensive feedback on performance and concerns;			Nurses referred to NMC report to be taken to the Board.
185	Focusing on culture of care	Encouraging them to report concerns and to give priority to patient well-being			Continue to nominate for National Awards and Committed to Excellence Awards Advertised on the Hub – fortnightly – open drop in sessions 'The Way We Care'

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
		Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23	Associate Director of Human Resources	An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation.
		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	23	Director of Nursing	Appraisal to include NMC Code of conduct and The Way We Care evidence. Compliments and Complaints also to be included.
		Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward.	23	Director of Nursing	This is being implemented and Matrons are supervising the process. Ward round bundles also require lead nurses to know all patients and be present on rounds.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
		They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.			Skill mix and staffing review to be commenced using AUKUH tool to ensure supernumerary status of lead nurse. (A full skill mix review will be undertaken as part of the Keogh investigation action plan) Datix to be completed when ward nurse managers are not supernumerary. Appraisal process is in place with clear person responsible for each appraisal. Matrons should also be visible to patients and relatives and should be ward based.
199	Key nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient	23	Director of Nursing	Allocation for each shift is in place. Wards round bundle is being rolled out.
	Caring for the elderly Approaches applicable to all patients but requiring special attention for the elderly				
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25	Medical Director	Email from Medical Director to all CDs on 14th May 13) requesting assurance on this issue. Assurance received from multiple CDs and Medical Service Heads. Responses being chased following MD/CD/MSH meeting on 7/06/13. The Medical Director issued a further email to CDs and Medical Service Heads on 25/06/13 requesting assurance that all patients admitted to Dudley Group were at all times under the care of a named consultant and that appropriate systems were in place at directorate level to ensure this happens.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:	25		
		• All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.		Director of Nursing	Matron and Lead Nurse availability will be posted on ward boards. This is being trialled in Paediatrics and will then be rolled out across the Trust.
		• Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients		Director of Ops /Director of Nursing	Every ward has an area that is confidential to converse with patients and visitors.
		• The NHS should develop a greater willingness to communicate by email with relatives.		Director of Ops/Medical Director /Director of Finance & Information	All e-mails from patients relatives and nurses are responded to by the Executive team. Ward level will require more process.
		• The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered		Director of Ops/Medical Director /Director of Finance & information	The trust plans to move to an Electronic Patient Record system in the future and will include this requirement in the system specification
		• Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.		Director of Ops/Medical Director	Care plans available at the bedside. Communication with relatives/visitors sheet being trialled on C7.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations	i) Late night discharge reports to be provided to clinical teams routinely to enable peer review and challenge ii) Review of the criteria for and protocol supporting patient moves at night as a requirement of managing bed capacity during periods of high escalation levels Discharge lounge is now appropriately staffed and furnished to provide care for patients awaiting discharge. Further work is being undertaken to improve the uptake of the service provided by the discharge lounge
240	Hygiene	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	25	Director of Nursing	Hand hygiene audits completed by Infection Control Team which tests this all observational audit. Posters and screen savers support this culture.
241	Provision of food and drink	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	25	Director of Operations	i) MUST assessments and subsequent red tray / food/fluid balance charts implemented for all patients, assurance is gained via nursing care indicators ii) The nursing team are responsible for providing food and drink to elderly patients. They are supported by Nutrition Support Workers (on A2 only) and IFM housekeeping staff who ensure availability on the ward iii) A multi-disciplinary team drawn from nursing teams, nutrition group and housekeeping will identify and agree best practice at DG NHS FT.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
242 243	Medicines administration	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	25	Director of Operations	i) The nurse administering medicines routinely checks for all required medicines and acts on medicines which are not given ii) The medicines management policy and subsequent mandatory training includes the need to constant vigilance in ensuring medicines are given at the appropriate time iii) Medicines link nurses act as a link between the ward nurse and pharmacy, the learning programme for medicines link nurses includes checking administration
	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director/ Director of Finance & Information	Not currently possible to record electronically. Paper charts are at each bedside. Compliance with charts is audited via Nursing Care Indicators.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
	Information				
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	26	Director of Finance & Information	The requirements outlined here will be considered when reviewing the electronic Patient Information Systems. Information is currently shared available via the manual systems in place across the Trust.

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
		• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.			
245	Board accountability	Each provider organisation should have a board level member with responsibility for information.	26	Director of Finance & Information	In place - Director of Finance & Information
247	Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	26	Board secretary	Complied with
248		Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	26	Director of Finance & Information	Complied with
249		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	26	Board secretary	Complied with

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	26	Director of Nursing	1. New web pages for patient experience being developed. 2. Patient experience results posters currently displayed on wards – this are being refreshed and improved.
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26	Director of Nursing	The Friends and Family Test follows patients up on discharge/shortly after. The new website will host more online surveys – awareness will be raised via the ward leaflets
262	Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatments	26	Director of Finance and Information	The Trust had adopted robust manual information sharing arrangements. At present real time information is not available

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 4th July 2013 - PUBLIC

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

CORPORATE OBJECTIVE: SG01 – To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Infection Prevention and Control	
	Risk Register: Y		**Risk Score:**	IC010 12 score M005 – 12 score
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**	Outcome 8 – Cleanliness and Infection Control
	NHSLA	**N**	**Details:**	
	Monitor	**Y**	**Details:**	Compliance Framework
	Equality Assured	**Y/N**	**Details:**	
	Other	**Y/N**	**Details:**	

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

GLOSSARY OF INFECTIONS

MSSA

What is Meticillin Sensitive Staphylococcus aureus (MSSA)?

Staphylococcus aureus is a bacterium that is commonly found on human skin and mucosa (lining of mouth, nose etc). The bacterium lives completely harmlessly on the skin and in the nose of about one third of normal healthy people. This is called colonisation or carriage. *Staphylococcus aureus* can cause actual infection and disease, particularly if there is an opportunity for the bacteria to enter the body e.g. via a cut or an abrasion.

What illnesses are caused by Staphylococcus aureus?

Staphylococcus aureus causes abscesses, boils, and it can infect wounds - both accidental wounds such as grazes and deliberate wounds such as those made when inserting an intravenous drip or during surgery. These are called local infections. It may then spread further into the body and cause serious infections such as bacteraemia (blood poisoning). *Staphylococcus aureus* can also cause food poisoning.

MRSA

What is Meticillin Resistant Staphylococcus Aureus (MRSA)?

MRSA stands for meticillin-resistant *Staphylococcus aureus*. They are varieties of *Staphylococcus aureus* that are resistant to meticillin (a type of penicillin) and usually to some of the other antibiotics that are normally used to treat Staphylococcus aureus infections.

Who is at risk of MRSA infection?

MRSA infections usually occur in hospitals and in particular to vulnerable or debilitated patients, such as patients in intensive care units, and on surgical wards. Some nursing homes have experienced problems with MRSA. MRSA does not normally affect hospital staff or family members (unless they are suffering from a severe skin condition or debilitating disease). In general, healthy people are at a low risk of infection with MRSA.

E Coli

What is *Escherichia coli*?

Escherichia coli (commonly referred to as *E. coli*) is a species of bacteria commonly found in the intestines of humans and animals. There are many different types of *E. coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment.

What types of disease does *E. coli* cause?

The commonest infection caused by *E. coli* is infection of the urinary tract, the organism normally spreading from the gut to the urinary tract. *E. coli* is also the commonest cause of cystitis (infection of the bladder), and in a minority of patients the infection may spread up the urinary tract to the kidneys, causing pyelonephritis.

Otherwise healthy patients in the community may develop cystitis, and patients in hospital who have catheters, or tubes, placed in the urethra and bladder are also at risk. *E. coli* is also present in the bacteria that cause intra-abdominal infections following leakage from the gut into the abdomen, as for example with a ruptured appendix or following traumatic injury to the abdomen.

E. coli bacteria may also cause infections in the intestine. Diarrhoeal infections (intestinal) are caused by a group of *E. coli* known as 'enterovirulent' (harmful to the intestines).

Overspill from the primary infection sites to the bloodstream may cause blood poisoning (*E. coli* bacteraemia). In rare instances, *E. coli* may cause meningitis in very young children.

C difficile

What is *Clostridium difficile*?
*Clostridium difficile (*also known as *"C. difficile" or "C. diff")* is a bacterium that can be found in people's intestines (their "digestive tract" or "gut"). However, it does not cause disease by its presence alone; it can be found in healthy people, about 3% of adults and two thirds of babies with no symptoms. It causes disease when the normal bacteria in the gut, with which *C. difficile* competes, are disadvantaged, usually by someone taking antibiotics, allowing the *C. difficile* to grow to unusually high levels. This allows the toxin they produce to reach levels where it attacks the intestine and causes symptoms of disease.

What are the symptoms of *C. difficile* infection?
Clostridium difficile causes diarrhoea (mild to severe) and, unusually, life threatening inflammation of the intestines. Other symptoms can include fever, loss of appetite, nausea and abdominal pain or tenderness.

How do you catch it?
Another person may acquire C.difficile disease by ingesting the bacteria through contact with the contaminated environment or patient. In most healthy people the C.difficile will not be able to multiply in the gut and they will not develop disease. In some more vulnerable people, particularly those whose normal gut bacteria have been disrupted by antibiotic treatment, the C.difficile may be able to multiply in the gut and go on to cause disease.

SUMMARY OF WARDS AND SPECIALTIES

Area	Speciality
A1	Rheumatology & Pain
A2	Stroke/General Rehabilitation
A4	Acute Stroke
B1	Orthopaedics
B2	Hip & Trauma Orthopaedics
B3	General Surgery
B4	Mixed Colorectal & General Surgery
B5	Female Surgery
B6	Ear, Nose and Throat, Maxillo-Facial & Urology
C1	Renal
C3	Elderly Care
C4	Georgina Unit/Oncology
C5	Respiratory
C6	Respiratory/ Gastro Intestinal Medicine (GI Medicine) Overflow
C7	Gastro Intestinal Medicine (GI Medicine)
C8	Acute Medical Unit/Short Stay Unit
CCU/PCCU	Coronary Care Unit/Post Coronary Care Unit
Critical Care Unit	Critical Care
EAU	Emergency Assessment Unit
ED	Emergency Department
GI Unit	Gastro Intestinal Unit
MHDU	Medical High Dependency Unit
OPD	Out Patients Department
SHDU	Surgical High Dependency Unit

Report to: Board of Directors

Subject: Infection Prevention & Control Report

Summary:

Clostridium Difficile - The target for 2013/2014 is 38 cases; at the time of writing the report nine cases have been recorded.

C.Difficile Cases Post 48 hours – Ward breakdown:

Ward	Totals for 12/13	April '13	May '13	As of 26th June '13	Totals so far 13/14
A1	2	0	0	0	0
A2	12	0	**1**	0	**1**
A4	0	0	0	0	0
B1	0	0	0	0	0
B2	1	0	**1**	0	**1**
B3	4	0	0	0	0
B4	3	0	0	0	0
B5	0	0	0	0	0
B6	2	0	0	0	0
C1	7	**1**	**1**	0	**2**
C3	6	0	**1**	**1**	**2**
C4	4	0	0	0	0
C5	1	0	0	**2**	**2**
C6	3	0	0	0	0
C7	7	0	0	0	0
C8	2	0	0	0	0
MHDU	0	0	0	**1**	**1**
CCU/PCCU	0	0	0	0	0
Critical Care	0	0	0	0	0
EAU	1	0	0	0	0
SHDU	1	0	0	0	0
Total	**56**	**1**	**4**	**4**	**9**

See Appendix 1 – Board Report (2013/2014)

MRSA – Annual Target 2 (Post 48 hrs) - There have been no cases in the last month and no cases so far this financial year.

Norovirus – There has been no confirmed cases of Norovirus in the Trust.

C. difficile – For May and June 2013 there have been 4 cases per month (against a trajectory of 3 per month). There have been several wards with periods of increased incidence during this time frame (C3 and C5) and a meeting to discuss the issues has already been held and a further meeting to discuss the RCAs and ribotyping has been arranged. The numbers, however for the quarter, are on trajectory to date.

TB – A patient with undiagnosed TB was nursed on C5 early in June for a period of 3 days prior to diagnosis this resulted in a further 3 patients requiring contact tracing. A focus group to discuss issues related to this incident and others was held and actions agreed.

Denise McMahon – Director of Nursing
Elizabeth N Rees - Consultant Microbiologist/Infection Control Doctor

(N13) Clostridium difficile infections

Monthly number of C.diff cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-13	1	3	-66.7%	1	3	-66.7%	4	6
May-13	4	3	33.3%	5	6	-16.7%	10	11
Jun-13	4	3	33.3%	9	9	0.0%	5	5
Jul-13		3			12			
Aug-13		3			15			
Sep-13		3			18			
Oct-13		4			22			
Nov-13		3			25			
Dec-13		4			29			
Jan-14		3			32			
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	9	38	-76.3%				19	22

The CCG target for Cdiff is 38 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.
The Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.
The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-13	-	0	0.0%	-	0	0.0%	-
May-13	-	0	0.0%	-	0	0.0%	-
Jun-13	-	0	0.0%	-	0	0.0%	-
Jul-13		0			0		
Aug-13		0			0		
Sep-13		0			0		
Oct-13		0			0		
Nov-13		0			0		
Dec-13		0			0		
Jan-14		0			0		
Feb-14		0			0		
Mar-14		0			0		
FY 2013-14	-	0	-				-

As a Foundation Trust the regulator, Monitor, measures compliance against the contract with our commissioners Dudley CCG. NHS England (previously the NHS Commissioning Board) have established a national zero tolerance approach regarding MRSA bacteraemia for 2013/14 onwards.

MSSA infections

Monthly number of MSSA cases	Month / Year	Total	Cumulative
	Apr-13	6	6
	May-13	6	12
	Jun-13	-	12
	Jul-13		
	Aug-13		
	Sep-13		
	Oct-13		
	Nov-13		
	Dec-13		
	Jan-14		
	Feb-14		
	Mar-14		
	FY 2013-14	12	

E.coli infections

Monthly number of E.coli cases	Month / Year	Total	Cumulative
	Apr-13	25	25
	May-13	13	38
	Jun-13	1	39
	Jul-13		
	Aug-13		
	Sep-13		
	Oct-13		
	Nov-13		
	Dec-13		
	Jan-14		
	Feb-14		
	Mar-14		
	FY 2013-14	39	

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board of Directors 4th July 2013

TITLE:	**Trust Annual Report (inc. Quality Report) Quality Report External Assurance Review**		
AUTHOR:	**Liz Abbiss/Derek Eaves**	**PRESENTER**	**Denise McMahon**

CORPORATE OBJECTIVE: SGO1 Quality, Safety & Service Transformation Reputation SGO2 Patient Experience

SUMMARY OF KEY ISSUES:

Attached is the final version of the Trust Annual Report and Accounts 2012/13 (which includes the Quality Report) that has now been sent to Monitor and laid before Parliament and the Quality report uploaded to NHS Choices. Also attached is the external auditors Quality Report External Assurance Review dated May 2013. The review is a statutory requirement and is primarily commissioned by the Council of Governors and so it has been circulated to Governors and will also be presented at the next Council of Governors Meeting which is held in September. It can be seen (page 3) that the review concludes that the content of the Quality Report and data consistency and data testing all meet the key national standards. With regards to data testing, it can also be seen (page 4) that while the issue of validity for 62 day cancer waits meets the standard there are opportunities for improvement. This was due to the auditors finding two errors in treatment dates in the data extract compared to what was recorded in the clinical records. These errors did not result in any missed breaches of the targets (page 10). The auditors have made recommendations regarding improving systems both with this issue and regarding the collection of patient experience data ensuring that appropriate patients are not excluded from the patient surveys being undertaken (page 19). For both of these recommendations actions have been agreed (page 22). It has been agreed that a review of these actions will be presented in October to the Clinical Quality, Safety and Patient Experience Committee.

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score**	Details:
COMPLIANCE	**CQC**	**N**	Details:
	NHSLA	**N**	Details:
	Monitor	**Y**	Details: Quality Report requirements
	Other	**Y**	Details: DoH Quality Account requirements

ACTION REQUIRED OF COMMITTEE: ***(Please tick below)***

Decision	Approval	Discussion	Other
		Yes	

RECOMMENDATIONS FOR THE COMMITTEE:

To note the final version of the Trust Annual Report (inc. Quality Report) and the contents of the external auditors review of the Quality Report.

The Dudley Group NHS
NHS Foundation Trust

Annual Report and Accounts 2012/13

www.dudleygroup.nhs.uk

RESPECT CARE RESPONSIBILITY

The Dudley Group NHS Foundation Trust

Annual Report and Accounts 2012/13

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

Content

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

We would appreciate any feedback you would like to give us on both the format and content of this report. You can do this by emailing communications@dgh.nhs.uk or phoning 01384 244404 and speaking to a member of the communications team.

Chairman's welcome

Welcome to our annual report for 2012/13, in the coming pages we will take a look back at the year that was, but also look to our plans for the coming year.

It is fair to say that 2012/13 has been one of the most challenging in the history of the NHS. The whole system continues to face the challenges of complete service reform coupled with the financial pressures that only get tougher each and every year. There have been some high profile failures in health and social care and the reviews of these failures are impacting on every NHS organisation. We are working through the recommendations of the second Francis review, whilst continuing to address the recommendations from the first Francis report. The challenges these reviews present for all of us in the health economy in Dudley will resonate for years to come.

Through all of these challenges, The Dudley Group continues to deliver great service to our patients. I am intensely proud of the dedication and hard work of all our staff, be they front line or support services and my personal thanks goes to everyone for their work. The commitment and excellence of our staff is shown, in part, by how we continue to meet stretching targets for the performance of our Trust. As a small sample this year we achieved: referral to diagnosis waiting targets and our infection control targets whilst ensuring the quality of care for our patients did not dip.

The quality of care is exemplified by the reduction in the number of the most severe pressure ulcers in the hospital setting and by the work of our community teams supporting patients in their homes. We strive to ensure that every patient is treated in a clean environment and our infection rates for Clostridium difficile have dropped from 113 in 2011/12 to 56 for 2012/13. All of these achievements have to be measured against increasing pressures on all our services, much of this seen with the increasing demands on emergency care.

The Trust Board of Directors maintains a relentless focus on quality, whilst ensuring we remain financially stable. We have worked with our Council of Governors (many new in post) to ensure they are supported to do their role well in holding the Board to account for our decisions and improving contact with over 13,000 members of our Trust.

I continue with the patient safety walkrounds which are invaluable to myself and all my non executive colleagues in seeing wards and departments first hand, having very open conversations with staff about the quality of patient care they deliver and how the Board can support them in delivering excellent patient care. We celebrated the best in The Dudley Group at our annual awards evening in September 2012 and I was delighted to present David Heath from the Maxillofacial Department with the 'Alf Edwards' award and then to spend an afternoon with David and his team to see the real positive difference they make to the lives of our patients.

I am always humbled by the enthusiasm and quality of our pastoral care lead by Reverand Mark Stobert. I had the privilege of shadowing Mark for an afternoon spending time with patients and their families. Mark is championing the introduction of

Schwartz rounds to the Trust; which are forums where staff can discuss the emotional and social aspects arising in caring for patients, a welcome thinking space for people who, day in day out, focus on the clinical quality of care.

The coming year will present even greater challenges for our Trust. We will maintain a relentless focus on continually improving the quality of care we provide to all our patients, whether that is in the hospital or in their own homes. We have to achieve this against a backdrop of ever tighter finances. We can only achieve this by transforming the way we care for people. This will require the whole health economy in Dudley, in primary, secondary and social care working ever more closely together.

Chairman

John Edwards CBE

Chief Executive's overview

I would like to start my overview with a thank you to all the staff who work across all our sites, hospitals and community alike, for continuing to deliver the best possible care and patient experience you can. It has been one of the toughest years I can remember in the NHS, but despite all the pressures we have faced our loyal and dedicated teams throughout the organisation have risen to the challenge and delivered great care to our patients against the odds.

We have also seen success stories throughout the year and here are just some of the highlights:

We were thrilled to be the successful Trust selected to provide the Black Country Specialist Vascular Hub. The £1.5m state-of-the-art endovascular (EVAR) suite capable of performing advanced surgery for potentially fatal aortic aneurysms was unveiled in March 2012. Find out more on page 16.

Protecting our patients from infection will always remain one of our top priorities. In fact, we have kept it as one of our quality account priorities for 2013/14 to help ensure we meet the extremely challenging targets, check out page 15 of the Quality Report to find out more about infection control and our annual targets. 2012/13 has seen us make huge progress towards our zero tolerance approach to infections with us achieving both our MRSA and Clostridium difficile targets.

The challenge is even greater for next year but we have plans in place to help us achieve this, for example, ensuring our infection control specialists are available seven days per week.

Another key concern for our patients and something that has been very high profile in the media this year is pressure ulcers or bed sores. Some pressure ulcers are unavoidable due to a patient's underlying medical condition, however we are committed to ensuring a zero tolerance approach to all those that can be avoided. This will be very challenging for us but we have already had many wards go over 240 days without a single pressure ulcer developing.

We invested in our Emergency Department to help us ensure we can meet the ever increasing demand on our services for urgent care now and in the future. We continued to achieve the four hour target to see, treat admit or discharge at least 95 per cent of our emergency patients for the year, although sadly not in quarter four.

A real boost for our nursing staff has been the national Nursing Standard 'Ward sister of the Year' award which Sara Davis achieved. We know we are privileged to have fantastic staff who give their all to ensuring patients have the best possible care, but this award just shows we really do have the best in the country. We have also been shortlisted for the Student Nursing Times awards in two categories for Mentor of the Year, (Clare Brown) and Student Placement of the Year. We continue to run our annual 'Committed to Excellence' awards and 2012/13 saw the most entries ever. We hope to improve on that again this year.

We continue to see growing numbers of mums-to-be choosing to have their babies here at Russells Hall Hospital maternity unit which is testament to the service and care our new families receive. We have continued to work hard at ensuring our midwife to birth ratio increases.

The Care Quality Commission (CQC) did their annual unannounced visit in February 2013 visiting several wards and departments to see and hear first-hand what staff and patients think about our services as well as conducting a thorough review of our processes and governance arrangements.

It was gratifying to receive some very positive feedback from them following their unannounced visit.

On 9th June 2010 the Secretary of State for Health announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust. On 6th February 2013 the final report of the public inquiry was published and made 290 recommendations. As part of our organisational response we have assigned lead directors for the five key themes outlined in the report and receive regular reports to Trust Board meetings. One of the first recommendations was for all organisations to "consider the findings and recommendations of this report and decide how to apply them to their own work". We will keep patients and the public informed of our response to the recommendations via our website and updates in our membership magazine.

Following the release of the Francis Report we were disappointed to find ourselves on the list of 14 hospitals to be reviewed by Sir Bruce Keogh for the quality of care and treatment delivered. The basis for the selection of the 14 trusts on the list was that our mortality indicators were higher than expected for two consecutive years. It is important to note that high mortality indicators do not necessarily equate to higher numbers of avoidable deaths in a hospital, but they can act as a prompt for investigation. Since these indicators were launched we have worked hard to understand why our figures have been higher than expected and have used them as a prompt to examine in detail each area, the care we give and, if necessary, make any improvements. These may be into the care itself, or the way we record the information about our patients to ensure we capture and reflect accurately how ill our patients are along with other factors which will have an effect on the indicators. Our work has been successful and we are now within the expected ranges for both our Standardised Hospital Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). We also know that the total number of deaths within the hospital has continued to decline year on year despite the fact we are seeing a steady increase in the age and frailty of our patients. Find out more about mortality indicators on page 33 of the Quality Report. We are pleased to say that on all occasions where we have responded to a mortality alert notified to us by the Care Quality Commission (CQC), both we and the CQC were assured of the quality of our care.

2013/14 is set to be as challenging as ever as funding tightens and the demands on our services continue to grow. I am certain that the staff at The Dudley Group will do their utmost to ensure excellent patient care.

Chief Executive

Paula Clark

Our vision is to be known as an organisation **'Where People Matter'**

This vision is supported by our three values:

- **Care**
- **Respect**
- **Responsibility**

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 passionate workforce to get things right for every patient, every time.

We believe our vision and our values perfectly sum up the journey we are on to achieve our goal of being the best place to receive healthcare, and the best place to work.

Report from 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 we serve 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. We provide the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. We also provide specialist adult community based care in patients' homes and in over 40 centres in the Dudley Metropolitan Borough Council community.

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 we acquired the Adult Services arm of Dudley Primary Care Trust, transferring over 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. Details of those who served as Directors of the Trust and as Governors are set out from page 31 of this Report.

2012/13 has been the most challenging year in recent memory for the NHS in England, as the service has worked to implement the detailed changes instituted 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 real resource reductions.

This trend has once again coincided with local Primary Care Trusts (now Clinical Commissioning Groups) seeking to reduce levels of spending on commissioned patient care, especially in the acute sector. This despite growing demand for our services in Dudley and growing customer expectations. The Dudley Group has delivered cost savings from improved efficiencies of circa £10m during the year, mainly through pay restraint measures and reduced spending on agency staff and non-pay budgets.

Against this challenging background our overall business achievements in 2012/13 have once again been commendable and can be summarised as:

- Financial surplus of £2.9m
- 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
- Achievement of the four hour waiting target in A&E
- Significant further investment in additional substantive clinical staff
- Further investment in buildings and specialist equipment

Page 55 of this Annual Report details our contractual arrangements with local Primary Care Trusts (PCTs) for the provision of services for 2012/13 and details of our performance against key national priorities and performance targets can be found within the Quality Report appendix on page 59.

Whilst performance during 2012/13 across the range of targets and standards has once again been excellent, the Trust did experience problems in meeting the four hours A&E wait target in the final quarter of the year (despite achieving it for the year in total) and experienced a single isolated 'never event' in Russells Hall Hospital's operating Theatres Department.

Once again, during 2012/13 the Board of Directors took the decision to invest heavily in front line clinical services to continually improve the quality of care to patients.

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 an unannounced visit to the Trust in February 2013 and found that the Trust was compliant with each of its standards of care.

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 2012/13 the Trust settled 99 per cent of trade invoices within 30 days.

As an NHS Foundation Trust we have made no political or charitable donations during 2012/13.

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

In addition, the Trust has invested heavily in medical equipment during the year and during 2012/13 commissioned new Day Case theatres costing £1m, a Medical Equipment Replacement Programme costing £2.5m and invested £3m in state-of-the-art IT and Data Centre Technology.

The Directors view investment in state-of-the-art IT functionality as being crucial to the future clinical and business sustainability of the Trust. To this end, we purchased the local PCT's Data Centre business in 2012/13 and it is our intention in 2013/14 to renegotiate elements of our existing PFI contract with Summit Healthcare Ltd, our principal PFI contractor, to bring a greater proportion of IT services 'in house' and escalate the development of new clinical systems. During the year, the Trust also established Dudley Clinical Services Ltd, a wholly owned subsidiary company created to improve the dispensing of pharmaceutical and associated clinical products to out-patients.

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. During the year staff have been appraised of the overall financial health and prospects of the NHS in England through a variety of reports and briefings. A full programme of 'Listening into Action' events has been facilitated on a wide range of issues during the year. This process has complemented the continued roll out of a Lean transformation programme across the Trust.

In summary, 2012/13 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.

Our Services as of 1st April 2013

<table>
<tr><th>Russells Hall Hospital</th><th>Corbett Hospital Outpatient Centre</th><th>Guest Hospital Outpatient Centre</th><th>Community Services</th></tr>
<tr><td>Anaesthetics</td><td>Anaesthetics provide some services at Corbett</td><td rowspan="4">Outpatient clinics including:
Dermatology
Gastroenterology
Neurology
Pain Management
Renal
Respiratory</td><td>Audiology</td></tr>
<tr><td>Anticoagulation</td><td>Day Case Surgery Unit</td><td>Blood Borne Virus</td></tr>
<tr><td>Audiology</td><td>Dietetic clinic</td><td rowspan="2">Chronic Obstructive Pulmonary Disease (COPD) Respiratory Nurse Service</td></tr>
<tr><td>Cancer services</td><td>Multi-professional rehab</td></tr>
<tr><td>Cardiology</td><td>Orthotics</td><td>Continence Service</td></tr>
<tr><td>Clinical Haematology</td><td rowspan="9">Outpatient clinics including:
Cardiology
Dermatology
Gastroenterology
Obstetrics and Gynaecology
Older Persons and Stroke
Trauma and Orthopaedics
Urology</td><td>Pain management programme</td><td>Contraception and Sexual Health</td></tr>
<tr><td>Critical Care Unit</td><td>Pharmacy</td><td>Dermatology</td></tr>
<tr><td>Day Case Surgery Unit</td><td>Physiotherapy and Occupational Therapy</td><td>Diabetes Specialist Team (Primary Care)</td></tr>
<tr><td>Dermatology</td><td>Radiology (X-ray)</td><td>Dietetics</td></tr>
<tr><td>Diabetes and Endocrinology</td><td>Respiratory Assessment</td><td>District Nursing</td></tr>
<tr><td>Dietetics</td><td rowspan="2">Speech and Language Therapy</td><td rowspan="2">ENT – Ear, Nose and Throat</td></tr>
<tr><td>Early Pregnancy Assessment Clinic</td></tr>
<tr><td>Emergency Assessment Unit</td><td></td><td>Heart Failure</td></tr>
<tr><td>Emergency Department (Accident and Emergency)</td><td>Pharmacy</td><td></td><td>Macmillan Community Palliative Care Team</td></tr>
<tr><td>Fracture clinics</td><td>Phlebotomy (blood tests)</td><td></td><td rowspan="2">Neurology Primary Care Service (including MS, Parkinson's Nurse specialists and Integrated Living Team</td></tr>
<tr><td>Gastroenterology</td><td>Physiotherapy</td><td></td></tr>
<tr><td>Genito-urinary medicine</td><td>Podiatry</td><td></td><td>Occupational Therapy</td></tr>
<tr><td rowspan="2">Head and Neck surgery including Ear, Nose and Throat (ENT) and Maxillofacial</td><td>Radiology (X-ray, DEXA bone scanning)</td><td></td><td>Palliative Care Support Team (Joint Agency)</td></tr>
<tr><td>Speech and Language Therapy</td><td></td><td>Physiotherapy</td></tr>
<tr><td>Inpatient wards</td><td>Wheelchair service</td><td></td><td>Physiotherapy – Orthopaedic Assessment</td></tr>
<tr><td>Maternity</td><td></td><td></td><td>Podiatric Surgery</td></tr>
<tr><td>Maxillo Facial Prosthetics</td><td></td><td></td><td>Podiatry – community and biomechanical</td></tr>
<tr><td>Medical and clinical inpatient services</td><td></td><td></td><td>Respiratory Assessment</td></tr>
<tr><td>Medical High Dependency Unit</td><td></td><td></td><td>Speech and Language Therapy</td></tr>
<tr><td>Neurology</td><td></td><td></td><td>Stroke Rehabilitation</td></tr>
</table>

Obstetrics and Gynaecology			Thunderburds – rapid response team to help prevent hospital admissions
Older Persons and Stroke			
Oncology			Tissue Viability (including leg ulcer)
Ophthalmology			
Orthodontics			Virtual Ward
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 GPs)			
Surgical pre-operative assessment			
Surgical High Dependency Unit			
Theatres			
Therapy Services including Physiotherapy and Occupational Therapy			
Trauma and Orthopaedic including fracture neck of femur unit			
Urology			
Women and Children's Outpatient Department			

Patient safety

We give 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 relevant. 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 and improvements 2012/13

Care Plus at The Dudley Group
We continue to build on our Care Plus private patient services of specialist-delivered care at affordable prices.

Our plan for private work is to offer outpatient appointments and day case procedures in the evenings and on Saturday mornings at Russells Hall Hospital. The new private patient service began with a skin lesion clinic to offer people who are seeking private care the option of choosing The Dudley Group.

The clinics are run out-of-hours by our plastic surgeons and offer efficient, safe, consultant-delivered treatment for many procedures, including those no longer available on the NHS.

Conditions we will treat include: moles, seborrhoeic warts, tattoos, torn earlobes and botox injections for excessive sweating.

Private patients have the reassurance of a team of NHS consultants and state-of-the-art facilities with access to a range of diagnostics.

The service will not impact on NHS patients' waiting lists and any income generated from private work will be reinvested into the NHS to develop our services for the benefit of all patients.

Outpatient Parenteral Antimicrobial Therapy (OPAT)
Our Outpatient Parenteral Antimicrobial Therapy (OPAT) service offers intravenous (injections into the vein) antibiotic therapy to people as outpatients instead of admitting them into hospital. The service runs seven days a week and takes place in a clinic on

ward C8 at Russells Hall Hospital, at a clinic in Brierley Hill Health and Social Care Centre and in patients' own homes or care homes.

OPAT not only prevents hospital admissions but also helps to speed up discharge. The new service treats a range of conditions including cellulitis, diabetic urinary tract infections (UTI), diabetic foot ulcers and osteomyelitis.

The OPAT team is made up of a hospital consultant, a consultant microbiologist, an antimicrobial pharmacist, a hospital-based matron, hospital-based nurses, community advanced practitioners and community nurses.

From March 2012 to April 2013, the community team alone looked after 183 patients in their homes or in clinic and increased capacity (making hospital beds available for very sick people) by 1,579 days.

The numbers of conditions treated in the community were:

- Cellulitis = 107
- Diabetic foot ulcer = 6
- Complex UTI = 58
- Other conditions (e.g. osteomyelitis) = 12

The service has proved very popular with patients who have given extremely positive feedback.

Specialist Vascular Centre for the Black Country at Russells Hall Hospital
Evidence shows if people need complex vascular surgery, they have a much better chance of survival if their operation is carried out at a specialist vascular centre which has the best facilities and skilled staff working at the highest level.

The specialist vascular centre for patients across the Black Country is at The Dudley Group's Russells Hall Hospital. We became the specialist centre following an open bidding process with other Trusts in the region.

Since July 2012, patients from Dudley, Walsall and Wolverhampton who need emergency vascular operations – and planned surgery for abdominal aortic aneurysms – have been brought to Russells Hall Hospital.

Surgeons, anaesthetists, radiologists and nurses from New Cross Hospital in Wolverhampton, Manor Hospital in Walsall and Russells Hall Hospital here in Dudley, are working together as part of the Black Country Vascular Centre (BCVC) to improve the care patients with vascular conditions receive.

Vascular day case surgery continues to take place at people's local hospital and they are still sent to their local hospitals for outpatient appointments, further investigations and follow up outpatient appointments. There is no change for people who live in Dudley. They come to Russells Hall Hospital as usual.

During a routine scan, father of three Tom Walker from Wednesfield discovered he had an aneurysm measuring 7.5cm.

Describing the aneurysm as a 'ticking time bomb', Tom had a complex four-hour operation at Russells Hall Hospital performed by Wolverhampton vascular surgeon Mr Andy Garnham.

Mr Garnham said, "Tom's aneurysm would almost certainly have ruptured without the operation."

From April 2013, patients who need a planned operation to clear blockages in their arteries will also come to Russells Hall Hospital to have their surgery.

Maternity funding
We successfully bid for a £41,000 government grant to make improvements to our Midwife Led Unit (MLU) by creating a homely setting for women giving birth. The grant is part of a £25m Department of Health scheme to help improve maternity facilities across the country. Our unit is just one of 100 across the country to be given the funds to make women and their partners more comfortable during the birth of their babies.

We plan to use the money for subdued lighting to resemble a star-lit sky, inspirational artwork by local artists and a variety of birthing balls, stools, mats and bean bags to add to the ever popular birth pool. The unit is also planning to provide Active Birth Classes for women to familiarise themselves with our labour and birth equipment to help them feel less anxious about giving birth.

The MLU is a part of a comprehensive range of maternity and paediatric services provided by the Trust. The unit works closely with community midwives who discuss individual care plans at the very early stages of pregnancy and at ongoing assessments to ensure that individual care plans are in place before the expected due date.

Better training better care
We launched a new training course for newly qualified pharmacists and junior doctors to create a simulated environment where pharmacists and medics can work together to learn more about practical prescribing techniques.

The project is funded by Health Education England – a national body that oversees the training of the whole health workforce. We were one of only 15 trusts out of almost 100 to secure a share of £1m funding allocated.

Trust clinicians have helped to create simulated 'clinical scenarios' and assisted the trainees make decisions with practice drugs charts based on real-life conditions. The course also provides modular online e-learning.

This method of training allows pharmacists and junior doctors to learn the principles of good prescribing practice and how to use medicines effectively in a practice clinical environment.

It is anticipated it will help reduce the amount of time patients need to stay in hospital and reduce unnecessary drug prescribing, for our elderly patients in particular.

Increasing practical understanding of complex medicines will also avoid possible medication errors and adverse drug reactions.

We are working closely with the University of Birmingham's, College of Medical and Dental Sciences and their new School of Pharmacy as an academic partner to the project.

Novice programme success
The Trust is very proud of its 'novice' programme introduced in 2010 to 'grow' our own clinical support workers to recognised standards. Many of the early novices have already developed their practice by completing the Qualifications and Credit Framework Level 2 Diploma and the practice development team are currently accepting nominations for the next Level 3 Diploma course from that group.

2013 has seen an increase of Clinical Support Worker vacancies available in the Trust and therefore an increase in number of appointments to the novice programme. Twenty Eight novices entered training in January 2013 and to date 22 have completed and attained permanent posts with the Trust, with the remainder who are on a part-time contract on target to complete in July 2013.

Forty three applicants were successful in securing a place for the summer programmes as a result of the most recent recruitment campaign held in February 2012. 329 people applied and 71 candidates were invited to interview. The successful applicants are currently going through the clearance process for the two courses commencing in June and July this year.

It is anticipated that the next novice recruitment drive will take place at the end of July 2013.

Listening and learning

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.

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

- Lead nurse walkrounds allow time for face to face patient feedback
- Our Governors provide feedback from our Members and wider communities
- Patient Panels on specific topics
- NHS Choices and Patient Opinion online feedback
- Patient Advice and Liaison Service (PALS)
- Complaints data
- National and real-time surveys

- Liaison with our Local Involvement Network (LINk), 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.

See pages eight to 11 of our Quality Report (appended to this Annual Report) for more information about our priorities for patient experience.

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

During the year we maintained close contact with our Local Involvement Network (LINk), patient groups and the Dudley Health and Adult Social Care Scrutiny Committee (HASC). We have attended the HASC Committee to report on geographic restrictions to our popular maternity service, elderly care services, integrated living and rehabilitation, privacy and dignity, mortality indicators and progress on our quality priorities for our Quality Report 2012/13.

Patient Advice and Liaison Service (PALS) – welcoming concerns and compliments

At The Dudley Group we try to make sure that our service is the best it can be but sometimes, despite our efforts, things can go wrong. The Patient Advice and Liaison Service, or 'PALS', is here to help when patients or relatives have concerns and, whenever possible, will try to help put things right.

The PALS team acts as the first point of contact for patients who need help with a concern and will provide advice, support and information. During 2012/13 our PALS team helped 820 people with a wide variety of concerns and queries. This is a 12.5 per cent decrease from 2011/12. Our PALS team can be contacted on 0800 073 0510.

How many people have PALS helped in 2012/13

Quarter	Concerns	Compliments & gifts
Q1	207	221
Q2	238	244
Q3	219	441
Q4	156	232
TOTAL	820	1138

Main concerns related to perceptions around clinical treatment, appointment delay or cancellation and communication and information.

During the 2012/13 year we received 140 formal thank you letters, plus a further 998 thank you cards and gifts; this does not include the many verbal thanks we receive.

Complaints
We believe we should do everything we can to address the concerns of patients and relatives and carers in a timely manner. During 2012/13, 99 per cent of our 373 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 is to remedy situations as quickly as possible and to provide an explanation to complainants. We try 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 our services, and we are 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 seven complaints were investigated by the Health Service Ombudsman and the outcome was that one complaint was upheld.

The number of complaints against patient activity during 2012/13 was 0.05 per cent (also 0.05 per cent in 2011/12). We saw a decrease in complaints of 0.05 per cent on the previous year in terms of numbers of complaints (375 complaints in 2011/12).

Main concerns related to perceptions around clinical treatment, attitude of staff and communication and information.

There is currently a review of the PALS/Complaints process, which is not yet finalised. The aim of the review is to ensure that any complaint about treatment or care is handled by one department.

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

(a) take immediate action to resolve an issue quickly and to the satisfaction of the complainant,
(b) arrange a face to face meeting with appropriate staff to resolve issue(s) as quickly as possible,
(c) conduct a more detailed enquiry when complex issues are raised, with a written response sent from the Chief Executive.

For more information about complaints for 2012/13 please see our Quality Report page 45.

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

We have hundreds of leaflets on various conditions and treatments, as well as aftercare advice. Information can be made available in plain English as well as large print, audio, Braille and alternative languages on request.

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

The primary development in patient information during 2012/13 has been the introduction of bespoke Welcome to the Ward leaflets which are given to all inpatients on admission. The leaflet contains useful information such as: visiting times, mealtime routines, uniforms who's who and ward contact numbers both for relatives and in case of health concerns once patients go home.

Hospital 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 our Patient Experience team and is managed by the volunteer co-ordinator. Individuals volunteer for a variety of reasons including: the satisfaction of knowing that 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. Our volunteers range in age from 16 to 86.

Some of the tasks volunteers have undertaken include:

- Mealtime assistance
- Changing patients' drinking water
- Undertaking patient surveys
- Clerical support
- Patient friends
- General ward volunteers
- Outpatient hosts
- Emergency Department hosts
- X-ray Department support
- Main reception way-finding
- Enquiry desk
- Chaplaincy
- Fundraising

The dedicated work of all our 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 the second largest employer in the Dudley borough with 3,977 full time equivalent (FTE, previously called WTE) staff, an increase of 67 from 2012. The table below gives a breakdown of staff numbers by professional group.

Staff Group	As at 31st March 2013 Full time equivalent
Add Prof Scientific and Technical	158.65
Additional Clinical Services	765.67
Administrative and Clerical	783.75
Allied Health Professionals	271.06
Estates and Ancillary	0.44
Healthcare Scientists	103.32
Medical and Dental	473.24
Nursing and Midwifery Registered	1412.26
Students	9.00
Grand Total	3977.38

*see note on page 24

Communication in such a large 24/7 operation is always a challenge. We have a number of ways we communicate with staff, patients and Members depending on the target audience and the message. These include the ever popular Trust intranet 'The Hub' where staff can access information on Trust issues, policies, finance, news and views from colleagues. During 2012 the Hub was moved to a more stable operating platform. This provided the opportunity to revamp and refresh the information already on it and the way in which it will develop further as a tool. It is also used as a forum to gather views from staff before decisions are made.

Our popular staff and Members magazine 'Your Trust' continues to be published up to four times per year and is available on both our intranet and website as well as in printed form. Our Chief Executive also maintains a monthly CE Update staff briefing to keep staff up-to-date on the Trust's strategic direction, new policies and other timely staff news. During 2012 we issued the first video CE update on the Hub and we are looking at doing more video clips of important information to staff. To forge stronger links with our community colleagues our Chief Executive has been holding communications surgeries for the past 12 months within community settings.

The Trust has continued with its Listening into Action and Transformation programmes this year which have enabled staff to get involved in changes that affect the areas where they work. Both programmes are proving invaluable in making service changes to improve patient experience of our services. More information on these programmes can be found on pages 26 to 28. Staff can also get involved via the Patient Safety 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 and then develop an action plan which is followed up at the next walkround. More on the Patient Safety Walkrounds can be found in our Quality Report on page 49.

Work has also continued with our Clinical Directors to ensure that each month they are provided with a statement of their directorates' financial and governance position. This enables them to make proactive decisions at their management meetings and review performance set against objectives for their teams. Messages about the Trust's performance are also communicated via The Hub and Chief Executives' team briefing.

Staff sickness rates for the year have risen to 4.15 per cent set against a target of 3.50 per cent. The Trust turnover rate for year 2012/13 has remained steady at 7.94 per cent.

Staff sickness rates 2012/13

Q1 actual	4.07%
Q2 actual	3.83%
Q3 actual	4.44%
Q4 actual	4.24%
Full year actual	4.15%

We take the health and safety of our 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 Health and Safety Team is being enhanced by the addition of a part time Health and Safety Assistant post to give greater resource and depth to the team and give more support to our community staff.

The Trust's Health and Safety Department is committed to raising occupational health and safety awareness amongst all of its employees and that of its 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.

In the 2012 Royal Society for the Prevention of Accidents (RoSPA) Occupational Health and Safety Awards the Trust won the **Healthcare Services Sector category**.

Dating back to 1956, the RoSPA Occupational Health and Safety Awards scheme is the largest and longest running programme of its kind in the UK. It recognises commitment to accident and ill health prevention and is open to businesses and organisations of all types and sizes from across the UK and overseas.

The scheme does not just look at accident records, but also entrants' overarching health and safety management systems, including important practices such as strong leadership and workforce involvement.

Equality and diversity

The Trust's Single Equality Scheme, Equality Assurance and Objectives have been audited this year with very positive results, assuring us that we are meeting our Equality Duty. The scheme and our objectives are published on the Trust website. A second audit to measure progress will be undertaken towards the end of 2013.

The Equality and Diversity Management Group has set up sub-groups, with specific objectives across the four strategic themes of the Single Equality Scheme. Updates against objectives are reviewed quarterly.

All our policies are equality and diversity impact assessed before being approved. We are passionate about ensuring both our employment statistics from NHS Jobs and our training activity is available to everyone. A new Equality Impact Assessment (EIA) guidance and tool will be introduced for the next stage of further embedding EIAs into our services, policies and culture. A sub-group of the Equality and Diversity Management Group has responsibility for EIAs and will be rolling out a programme of awareness and education in the forthcoming year.

This year we have again been awarded the two tick's disability symbol – a national standard which recognises that we are positive about employing disabled people.

The Trust's induction programme includes all protected characteristics and training is a mandatory requirement of the Trust.

Policies now contain a spreadsheet identifying how they will be monitored for effectiveness and any actions required to ensure the policy is robust are identified and undertaken. Our policies undergo an in-depth process of consultation. All policies affecting employees are reviewed by the Staff Side Representative Group and Joint Negotiation Committee prior to submission to the Policy Review Group, for recommendation to the Risk and Assurance Committee for ratification, prior to being published.

Management Guides for specific employment related policies also include a manager's feedback questionnaire to help us ensure policies are workable and provides a process to monitor progress. This is new for 2013 and we look forward to being able to provide feedback in 2014.

Disability employment statistics 2012/13

		% of all applications received	% of applicants shortlisted	% of applicants appointed
Disabled Person	**Yes**	3.50%	4.44%	3.24%
	No	95.7%	94.66%	94.99%
	Undisclosed	0.80%	0.90%	1.77%
These figures are progressive, for example, 3.50% of applicants stated they had a disability. Of those 3.50%, 4.44% were shortlisted. Of those 4.44% shortlisted, 3.24% were appointed.				

Note regarding whole time equivalent HR and finance difference in number

Human Resources reporting (p22) obtains the full time equivalent (FTE) in post for a specific date where as Finance reporting (p64) 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.

NHS workforce statistics

An analysis of our workforce statistics indicates they are comparable with both the local Dudley population and other NHS Acute Trusts. Historically the Trust has seen a higher proportion of female workers than males, and this is typically reflected across other NHS Acute Trusts.

Age	**Workforce**	
	1st April 2011 to 31st March 2012	1st April 2012 to 31st March 2013
18-19	0.18%	0.35%
20-24	5.46%	5.73%
25-29	12.63%	12.94%
30-34	12.36%	12.65%
35-39	12.27%	11.58%
40-44	15.06%	14.59%
45-49	15.55%	14.98%
Age	Workforce	
	1st April 2011 to 31st March 2012	1st April 2012 to 31st March 2013
50-54	12.63%	13.73%
55-59	8.78%	8.55%

60-64	4.20%	3.82%
65+	0.88%	1.08%
Gender		
Male	16.01%	16.60%
Female	83.99%	83.20%
Ethnicity		
White	73.88%	72.34%
Mixed	0.86%	0.83%
Asian or Asian British	8.87%	9.03%
Black or Black British	2.32%	2.79%
Other	1.48%	0.00%
Not stated	12.58%	13.71%

Listening into Action
Listening into Action (LiA) has been running in the Trust for two 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.

The teams who were involved in LiA in the last two and half years and the changes they agreed include:

Cancer Services: to agree an acute oncology service. A medical secretary from within the Cancer Services team took on this role earlier this year.

Benefits to patients, staff and Trust include:
- Reduced length of stay for patients admitted with conditions related to their cancer diagnoses
- Enhanced communication between all healthcare professionals involved
- Provides early referral and specialist assessment

The appointment of an Acute Oncology Administrator has greatly helped clinical staff spend more time with patients and has also facilitated a helpline service which can be used by GPs and patients for rapid advice regarding treatment of patients with cancer.

Clinical Audit: to work with staff to review standards and capture changes in practice giving improved patient care.

Benefits to patients, staff and Trust include:
- Communication: raising awareness on how to request clinical audit support and updated information for staff included in the 'It's a Risky Business' governance booklet. Staff contact numbers and roles are included in monthly Clinical Audit &

Effectiveness newsletter with data collection tools available for staff on the Clinical Audit Intranet page.
- Awareness and effectiveness audits: the review of the clinical audit proposal form to prioritise audits effectively has been completed. No audits are now considered without clear measurable standards. Improved audit scoring tool is included in revised Clinical Audit Policy (October 2012).
- Promoting Clinical Audit: a monthly newsletter is produced with positive feedback.

Dietetics: to improve the quality of referrals to the department and reduce inappropriate referrals.

Benefits to patients, staff and Trust include:
- Referral forms have been improved: ambiguous wording has been removed. Forms now include patients with pressure sores as a reason for referral. There are also hyperlinks on the forms to diet advice sheets.
- Community referral forms: these are in final draft and are being circulated for comments
- Dietetics ordering form: the team is working with IT to improve the functionality and look of the form.

The plan for 2013/14 is to encourage another phase of 30 teams to embrace LiA to help make changes and improvements.

Transformation
There has been a Transformation programme running within the Trust for the past three 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 we are a major part.

To enable the transformational change required it was determined that a Transformation Programme Board, chaired by the Trust Chairman was essential to drive the change agenda more vigorously. The Transformation Programme Board has been established as a formal sub-committee of the Board of Directors and meets bi-monthly. The Clinical Commissioning Group (CCG) Chief Officer will be in attendance at the Programme Board as well as representatives from other partner organisations, such as West Midlands Ambulance Service and Dudley Metropolitan Borough Council, who will be invited to attend as appropriate. Their full participation in project steering groups will be essential. The improvement goals proposed 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 improvements
- Long term condition management
- Responsive services resulting in services being provided at the right time in the right place

Three priority projects were agreed, those being: 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

1. A Clinical Champion has been appointed – Dr Matthew Banks, Medical Service Head for Cardiology Services has volunteered himself to be a clinical sponsor and champion for the initiatives the project is seeking to roll out, organisation wide.
2. The pilot of the Multi-Disciplinary Team (MDT) White Board review has been undertaken by the consultant Gastroenterologists and ward based team on C7. There has been significant enthusiasm for the introduction and, continuation of the Board round process on the ward. Early indications show an increase in the total number of discharges per week achieved on C7 since the introduction of the pilot.
3. Dr Banks will lead the introduction of the MDT Board round process and ward rounds and bundles in his own specialty in Cardiology, as the next part of the roll out process.

Urgent Care Project

1. Extremely positive initial meetings of the Urgent Care Project Steering Group have taken place, with full and active participation of the CCG Urgent Care Lead GP and Urgent Care Commissioning Managers.
2. Redesigning and improving the access to appropriate pathways for patients requiring urgent care.
3. NHS Emergency Care Intensive Support Team Recommendations on the configuration of and functioning of the Emergency Department will be incorporated into the project charter of the project.

The Outpatients Project Steering Group

1. The Outpatient project is essentially to be made up of three elements:
   a) Technological and process based improvements to our appointment booking system, choose and book and telephone call handling capacity, thereby improving both patient experience and GP experience.
   b) Specialty-specific improvements in demand and capacity planning. Improvement to be measured against a range of indicators including DNA (Did Not Attend) rates and Patient Experience.
   c) Improved communication (electronic) with Primary Care following outpatient attendance.
2. The biggest financial efficiencies and patient experience gains will be made as a result of improving capacity and demand management and establishing an improvement programme within each specialty (element b above).

National Staff Survey 2012

The 2012 Annual National Staff Survey was completed between October and December 2012 with a sample of 850 randomly selected individuals invited to participate. The results are used by the Care Quality Commission to benchmark against other Trusts to represent the organisation when measured against other acute trusts. The response rate has decreased for 2012 at 35.8 per cent a 6.9 per cent fall since 2011 and is within the lowest 20 per cent of acute trusts in England.

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

- Compared to national average results for 2012
- Compared to last year's Trust results
- Compared to other local trusts

A diagnostic tool is also available for each of the Trust's directorates to help understanding of the results and engagement of teams.

Overall Staff Engagement

Overall Staff Engagement (the higher the score the better)	**Score out of 5**	**Ranking**
Trust Score 2012	3.64	Below (worse than) average
Trust Score 2011	3.66	Above (better than average)
National Average 2012 (for Acute Trusts)	3.69	

The Department of Health published summary of top and bottom key findings

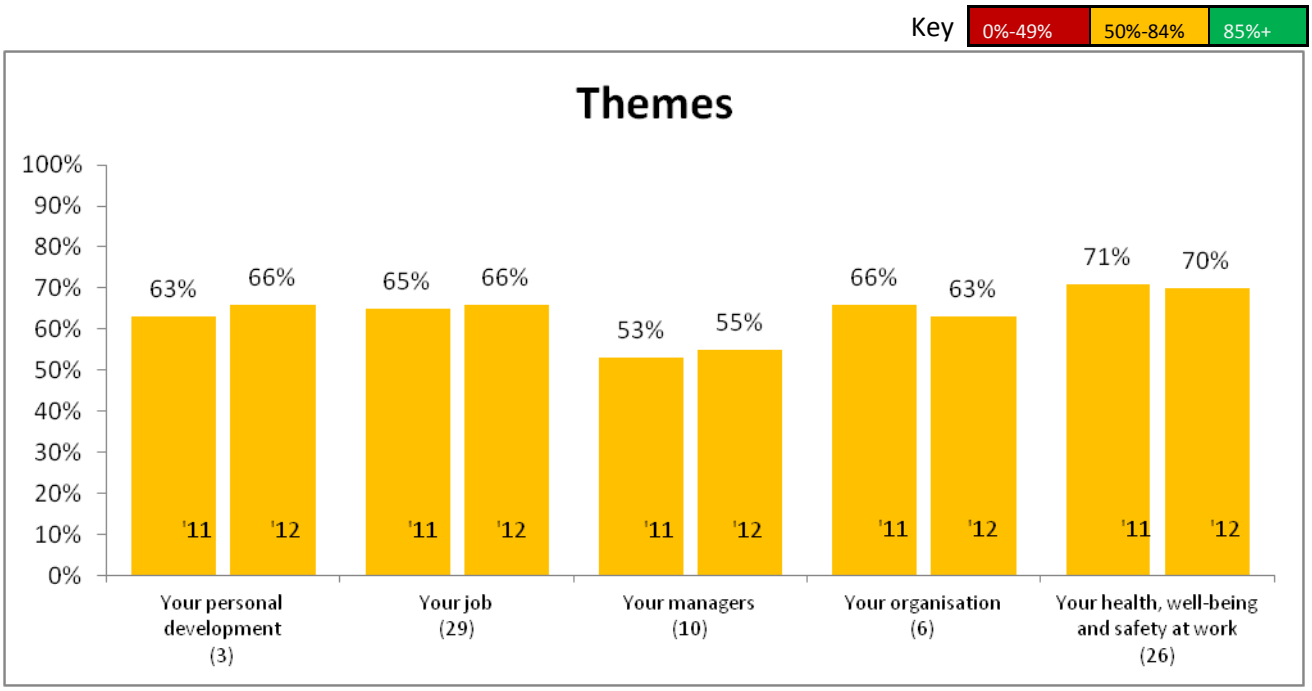
Top four key findings (KF) overall (those compare most favourably with other acute trusts in England)	**Ranking compared with all acute trusts 2012**	**Comparison to 2011**
KF 20 Percentage of staff feeling pressure in the last three months to attend work when feeling unwell (the lower the better)	Lowest (best) 20%	No change
KF 28 Percentage of staff experiencing discrimination at work in the last 12 months (the lower the better)	Below (better than)average	No change
KF 12 Percentage of staff saying hand washing materials are always available	Above (better than) average	No change
KF 11 Percentage of staff suffering work related stress in last 12 months	Below (better than) average	No change
Bottom four key findings (KF) overall (those compare most favourably with other acute trusts in England)	**Ranking compared with all acute trusts 2012**	**Comparison to 2011**
KF 16 Percentage of staff experiencing physical violence from patients, relatives or public in last 12 months	Highest (worst) 20%	No change
KF 14 Percentage of staff reporting errors, near misses or incidents witnessed in the last month	Lowest (worse than) 20%	Decrease
KF 10 Percentage of staff receiving health and safety training in the last 12 months	Lowest (worse than) 20%	Decrease
KF 25 Staff motivation at work	Lowest (worse than) 20%	No change

Key findings commentary:
Inviting staff to take part in the 2012 staff survey further established some initiatives introduced in 2011, namely, personally addressed surveys, incentives and time allocated to complete the surveys whilst at work.

Reminder letters were not used in 2012 following feedback that staff questioned the confidentiality of this.

A mood meter will be used to gauge the ongoing feelings of staff and how they feel about working in the Trust. The questions that are used to rate the overall staff engagement score will be used in the mood meter. Appropriate actions will then take place to address any concerns. Focus groups held by directors are taking place to help us better understand some of the responses upon which we can build our action plans.

The graph below illustrates the average score for questions in each sub-category. Data for the last two years is shown. The figure in brackets shows the number of questions asked in each sub-category.



There are no red rated themes, and in three out of five the scores have improved compared to 2011.

The themes that have improved since 2011 are: Your managers, Your job, and Your personal development. The highest scoring theme is Your health, well being and safety at work.

The graph below illustrates the average score for questions in each sub-category. Data for the last two years is shown. The figure in brackets shows the number of questions asked in each sub-category.

Council of Governors and Members

Our Council of Governors was formed with effect from the 1st October 2008. The Council is responsible for holding the Trust Board of Directors to account for its stewardship of the organisation. The majority of our Governors are elected through our 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 our key stakeholders – 4 Governors

Tables summarising the Council of Governors and the constituencies they represent can be found on page 32.

The Trust Board works closely with our Council of Governors with regular Director and Non Executive Director attendance at both full Council meetings and the Committees of the Council. During 2012/13 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 also nominated attendees at the Council sub committees along with Executive Directors and this has enabled detailed discussion and debate on strategy, performance, quality and patient experience and enabled the Governors to see Non Executive Directors function. Governors were also invited to attend shadow 'Board meetings in public' to comment and advise the Board on how they might prepare and function from 1st April 2013 when meetings are held in public.

The Board is accountable to the Council of Governors ensuring it meets its terms of authorisation. General Meetings of the full Council of Governors are held in public. A register of interests is maintained by the Trust and is available on request from the Foundation Trust office by calling (01384) 321124 or emailing foundationmembers@dgh.nhs.uk

Council of Governor Committees
The Trust has developed a primary and secondary governance model on which to structure the Council of Governors and its committees supporting Governors to discharge their responsibilities effectively. Primary governance is the responsibility of the Board of Directors who are the decision makers and oversee the performance of the organisation. Secondary governance is the role of the Governors and provides the framework to support their primary role of holding the Board to account.

The Council has established the following committees:

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

The Council of Governors has the following key roles*:

- Appointment and/or removal of the chair, including appraisal and performance management
- Appointment and/or removal of the Non Executive Directors
- Appointment of external auditors
- Advising the Trust Board 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 Members
- Advising on strategic direction

Ongoing training and development is provided by the Trust allowing experts from within and outside the Trust to work with 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.

*The implementation of the Health and Social Care Act 2012 will see some changes to the key duties and responsibilities for Governors from April 2013.

Council of Governors membership as at 31st March 2013

Public Elected Governors	**Constituency**
David Stenson	Public: Brierley Hill
Robert Edwards	Public: Brierley Hill
Bill Hazelton	Public: Central Dudley
Fred Allen	Public: Central Dudley
Brian Chappell	Public: North Dudley
Vacant	Public: North Dudley
Rob Johnson	Public: Halesowen
Vacant	Public: Halesowen
Darren Adams	Public: Stourbridge
Roy Savin	Public: Stourbridge
Patricia Price	Public: Rest of the West Midlands
Diane Jones	Public: South Staffordshire and Wyre Forest
Jason Whyley	Public: Tipton and Rowley Regis
Staff Elected Governors	**Staff Group**
Anne Gregory	Staff: Allied Health Professionals and Healthcare Scientists
Jackie Smith	Staff: Allied Health Professionals and Healthcare Scientists
Ian Dukes	Staff: Medical and Dental
Karen Jaunzems	Staff: Non Clinical Staff
Joanne Hamilton	Staff: Nursing and Midwifery
Julie Walklate	Staff: Nursing and Midwifery

Alison Macefield	Staff: Nursing and Midwifery
Terry Venables	Staff: Partner Organisations' Staff
Appointed Governors	**Appointing organisation**
Gill Cooper	NHS Dudley
Professor Martin Kendall	University of Birmingham Medical School
Vacant	Dudley Council for Voluntary Service (CVS)
Cllr Steve Waltho	Dudley Metropolitan Borough Council

Council of Governors meetings

The Council of Governors meet a minimum of four times per year. In the year 2012/13, the full Council met on six occasions including the Annual Members Meeting held in September 2012.

Governor attendance at full Council meetings 2012/13		Attendance
Darren Adams	Public: Stourbridge	6/6
Nazir Ahmed (resigned September 2012)	Public: Central Dudley	0/1
Kacey Akpoteni (end of term February 2013)	Public: Rest of the West Midlands	1/4
John Balmforth (resigned January 2013)	Public: Halesowen	4/4
Brian Chappell	Public: North Dudley	3/6
Gill Cooper	Appointed: NHS Dudley	3/6
Ian Dukes (end of term January 2013)	Staff: Medical and Dental	1/4
Robert Edwards	Public: Brierley Hill	6/6
Bill Etheridge	Public: North Dudley	3/6
Anne Gregory (elected August 12)	Staff: Allied Health Professionals and Healthcare Scientists	4/5
Joanne Hamilton	Staff: Nursing and Midwifery	6/6
Pauline Harris (resigned September 2012)	Public: Stourbridge	1/2
Bill Hazelton	Public: Central Dudley	6/6
David Heath (resigned June 2012)	Staff: Allied Health Professionals and Healthcare Scientists	1/1
Karen Jaunzems	Staff: Non Clinical	5/6
Rob Johnson	Public: Halesowen	5/6
Diane Jones	Public: South Staffordshire	5/6
Jackie Kelly (resigned November 2012)	Appointed: Dudley CVS	1/3
Professor Martin Kendall	Appointed: University of Birmingham Medical School	6/6
Alison Macefield	Staff: Nursing and Midwifery	4/6
Stephanie Pritchard (resigned May 2012)	Public: Tipton and Rowley Regis	1/1
Major Robins (resigned June 2012)	Public: Stourbridge	1/1

Governor attendance at full Council meetings 2012/13		Attendance
Roy Savin (elected August 2012)	Public: Stourbridge	3/3
Jackie Smith	Staff: Allied Health Professionals and Healthcare Scientists	4/6
David Stenson	Public: Brierley Hill	6/6
Terry Venables	Staff: Partner Organisations' Staff	0/6
Julie Walklate	Staff: Nursing and Midwifery	5/6
Cllr Steve Waltho	Appointed: Dudley Metropolitan Borough Council	4/5
Jason Whyley (elected July 2012)	Public: Tipton and Rowley Regis	3/5

Director and Non Executive Director attendance at full Council meetings 2012/13*		Attendance
Paul Assinder	Director of Finance and Information and Deputy Chief Executive	6/6
David Badger	Senior Independent Non Executive Director and Deputy Chair	6/6
Ann Becke	Non Executive Director	1/6
Richard Beeken	Director of Operations	2/6
David Bland	Non Executive Director	1/6
Paula Clark	Chief Executive	6/6
John Edwards	Chair	6/6
Jonathan Fellows	Non Executive Director	1/6
Paul Harrison	Medical Director	4/6
Denise McMahon	Director of Nursing	4/6
Richard Miner	Non Executive Director	1/6
Tessa Norris	Director of Community Services and Integrated Care	6/6
Annette Reeves	Associate Director of Human Resources	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.

Council of Governors Review 2012/13

Since authorisation, the Council has regularly conducted a review of its effectiveness in discharging its statutory and other duties. During 2012/13 the Council decided to conduct a review of effectiveness annually and the schedule for this is being finalised to commence 2013/14.

In December 2012, nominations were sought from the members of the Council of Governors to fill the role of Lead Governor and Chairs of the three core Council Committees – Governance Committee, Membership Engagement Committee and Strategy Committee.

Chairs of Council of Governors Committees up to February 2013

- **Mr Darren Adams,** Lead Governor
  Chair, Membership Engagement Committee
  Chair, Remuneration Committee
- **Mr Rob Johnson**
  Chair, Governance Committee
- **Mr John Balmforth**
  Chair, Strategy Committee
- **Professor Martin Kendall**
  Chair, Appointments Committee

Chairs of Council of Governors Committees after February 2013

- **Mr Rob Johnson,** Lead Governor
  Chair, Governance Committee
- **Mr Bill Hazelton**
  Chair, Membership Engagement Committee
- **Mr David Stenson**
  Chair, Strategy Committee
- **Professor Martin Kendall**
  Chair, Appointments Committee
- **Mr Darren Adams**
  Chair, Remuneration Committee

Governor resignations, elections and re-appointments

Governors reaching end of term of office or resigning during the year:

Governor	Constituency
Mr Major Robins	Public: Stourbridge
Mrs Stephanie Pritchard	Public: Tipton & Rowley Regis
Mr David Heath	Staff: Allied Health Professionals and Healthcare Scientists
Mrs Pauline Harris	Public: Stourbridge
Mr John Balmforth	Public: Halesowen
Mr Nazir Ahmed	Public: Central Dudley
Mr Jackie Kelly	Appointed: Dudley CVS
Mr Bill Etheridge	Public: North Dudley

During the year, elections were held for vacancies in the Public Constituencies of Central Dudley, the Rest of the West Midlands and in the staff constituency of Medical and Dental.

In accordance with our 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.

RSM Tenon was appointed by the Trust to oversee the election process. The process concluded in March 2013 and returned the following Governors for a three year term:

Public Elected Governors	**Constituency**
Fred Allen	Public: Central Dudley
Patricia Price	Public: Rest of the West Midlands
Staff Elected Governors	**Staff Group**
Ian Dukes	Staff: Medical and Dental

Governors engagement with Members and local communities

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

Throughout the year Governors have continued to reach out into their constituencies. They have attended more than 55 events including a number of community and support groups such as Older Peoples Forum, Brierley Hill Cancer Support Group, Halesowen Asian Elders Associations, 'Need to Know' library sessions across the Dudley Borough, Kinver Country Fayre, Wellington Road Community Centre and several GP patient panels.

Council of Governors meetings are held quarterly and Trust members and the wider public are welcome to attend and observe. They are regularly attended by Executive and Non Executive Directors and often include presentations and question and answer sessions with key clinicians and staff from across the Trust to help Governors understand how the organisation works. Approved minutes from the full Council of Governor meetings can be found on the Trust website at www.dudleygroup.nhs.uk

Contact procedures for people to talk to their Governors and/or Directors of the Trust Board

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

- Council of Governors meetings in public
- Trust 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 for these meetings and other members events, please visit our 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 of our Governors are also happy to be contacted directly and their details can be found on the Members section of our website or via telephone (01384) 321124.

Membership recruitment and engagement

Our Members are local people and staff. 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 our 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 our constituencies. Trust staff are automatically included as a Members within the staff groups as set out on page 32 unless they choose to opt out.

This year we have continued to promote Trust membership to our local communities and the importance of having a voice by encouraging them to share with us their experiences. All of our events this year have been successful in terms of promoting the Trust and have also been successful in increasing membership as a whole, including our underrepresented groups. The table below shows the top five most successful recruitment activities.

Top five most successful recruitment activities during 2012/13

Date		Members recruited
November 2012	Health and Environment Fair – Halesowen College	225
2012/13	Volunteers/via post/through Governors	196
September 2012	Dudley College Freshers Fayre	166
March 2013	Halesowen College Higher Education event	87
2012/13	From appointment letters sent to patients	66

At the end of March 2013 we had a total of 13,122 public members (including those Outside of the West Midlands).

Membership growth and target

Membership sector	31/03/2012 actual	31/03/2013 actual	2013/14 Target
Public (including Outside of the West Midlands)	12,505	13,122	13,000
Staff	5,165	5,167	5,167
Total	17,670	18,289	18,167

Our recruitment strategy for 2012/13 focused on developing opportunities to reach our target of 13,000 public Members by the end of March 2013, refine recruitment activity to target areas of shortfall and continue to strive to ensure our membership is reflective of the communities we serve and the protected characteristics as set out in the Equality Act 2010. Our strategy also included developing more opportunities for engaging with our Members to gain feedback that the Trust can use to improve the patient experience.

Our 'Meet your Experts' health fair events and 'Behind the Scenes' tours continue to prove a real success with both our Trust Members and members of the wider community. Many have provided valuable feedback and learned more about our services, including some of our younger Members who show a keen interest in the work of our hospitals as a potential career choice.

We have hosted five Member events, ranging from health fairs to behind-the-scenes tours and seminars, with more than 350 Trust members and their guests attending.

We also aim to recruit Members who wish to be actively involved with the Trust. There are two levels of membership: passive and active. We are pleased that we have increased our total 'active' membership by 651 to 4,151 from 3,600 at the end of March 2012.

All Members will continue to receive information about the Trust via our newsletter 'Your Trust' and also:

- Be involved in shaping the future of healthcare in Dudley by sharing their views*
- Be able to vote in Governor elections*
- Be able to stand for election to represent their constituency**
- Be invited to attend our health fairs and Member events

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

Membership report as at 31st March 2013

Public constituencies	**Number of Members**
Brierley Hill	1,680
Central Dudley	2,248
Halesowen	1,143
North Dudley	1,369
Rest of West Midlands	1,414
South Staffordshire and Wyre Forest	1,231
Stourbridge	1,650
Tipton and Rowley Regis	2,172
Total Public Members *(excluding outside of the West Midlands)*	**12,907**
Staff constituencies	**Number of Members**
Medical and Dental	494
Nursing and Midwifery	2,521
Allied Health Professionals and Healthcare Scientists	626
Non Clinical	903
Partner Organisations	623
Total Staff Members	**5,167**

Public Membership breakdown by age, gender and ethnicity

	Public Membership	
	31st March 2012	31st March 2013
0-16	168	133
17-21	2,176	2,478
22+	9,552	9,940
Not stated	609	571
Male	4,755	4,631
Female	7,750	8,491
White	10,582	10,928
Mixed	295	344
Asian or Asian British	844	962
Black or Black British	285	341
Other	68	81
Not stated	431	466

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 it to undertake a formal and rigorous 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 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.

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

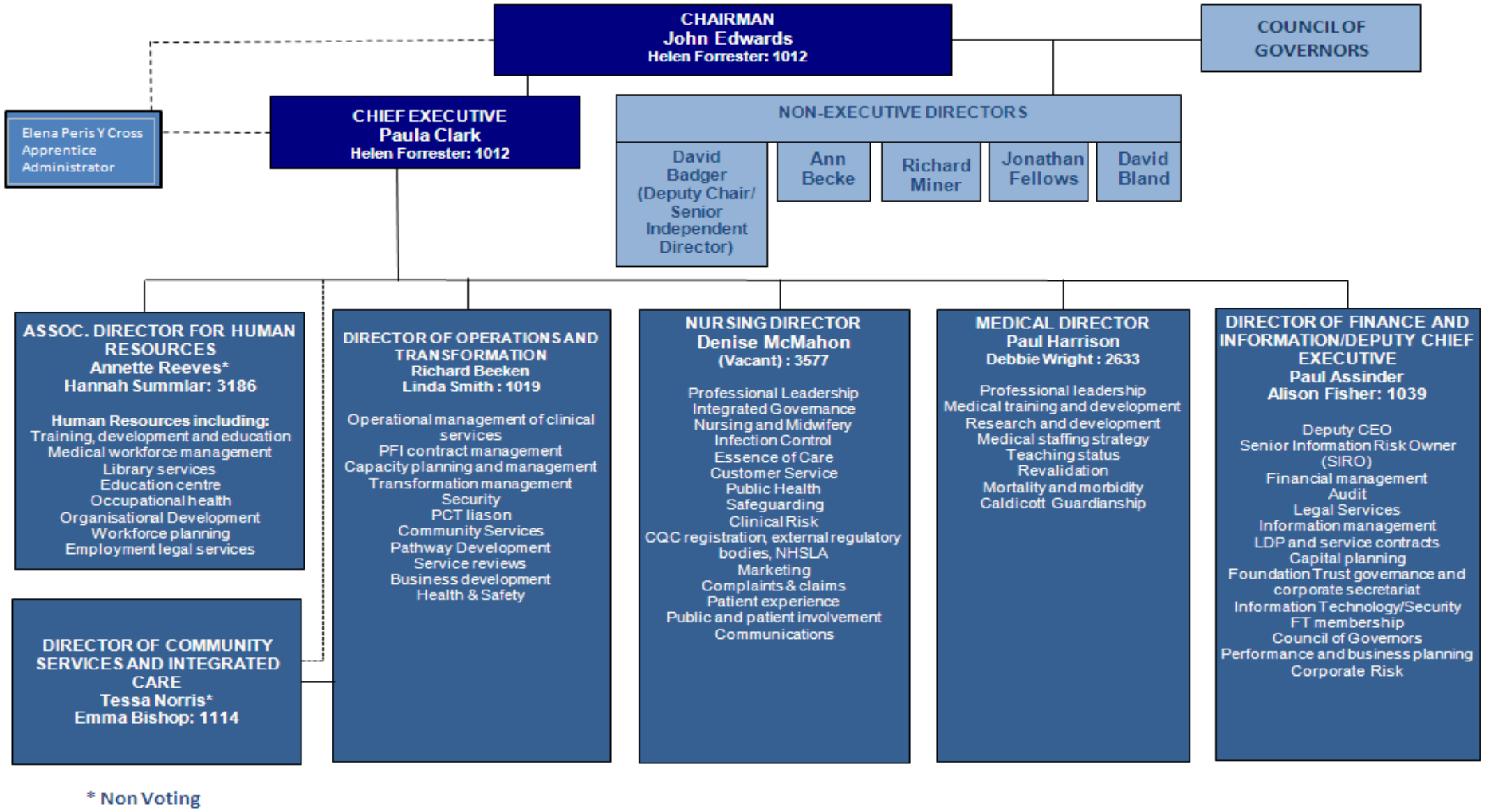
Position	Name	Commencing	End
Chairman	John Edwards	01.11.10	31.10.13
Chief Executive	Paula Clark	01.10.09	
Director of Finance and Information	Paul Assinder	22.08.05	
Director of Operations and Transformation	Richard Beeken	15.06.10	
Medical Director	Paul Harrison	01.06.06	
Nursing Director	Denise McMahon	12.05.08	
Non Executive Director/Deputy Chairman and Senior Independent Director	David Badger	01.12.02	30.11.15
Non Executive Director	Ann Becke	01.11.05	31.10.14
Non Executive Director	Jonathan Fellows	25.10.07	30.09.14
Non Executive Director	Kathryn Williets*	01.05.04	30.04.12
Non Executive Director	David Bland	01.08.10	31.07.13
Non Executive Director	Richard Miner	01.10.10	30.09.13

*Mrs Williets served on the Board between 1st April to 30th April 2012

**Mr Miner previously served as an Associate Director of the Board for period 1st October 2010 to 30th April 2012

More detailed information about each Director can be found on page 42 onwards.

BOARD OF DIRECTORS STRUCTURE



* Non Voting

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 is overseeing the development of the International Institute for Product and Services Innovation (IIPSI) and also chairs the 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.

John is committed to help lead The Dudley Group to become an even better performing organisation committed to providing the best quality care to all our patients.

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 Trust Board, Governors and our 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 6 years. She is Chair of the Risk and Assurance 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 and also 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 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.

Kathryn Williets – Non Executive Director (until 30th April 2012)
Kathryn joined the Trust as a Non Executive Director in May 2004, bringing with her a background in criminal, family and childcare law. She qualified at the Bar in 1989 and then re-qualified as a solicitor in 1994. She holds a teaching qualification and has taught in a range of legal subjects. Kathryn is a member of the Law Society.

Kathryn is currently a sole practitioner providing agency services to other solicitors' firms and to local authorities in the areas of childcare and family law. She lives in Halesowen. She spent some years involved in school governance, and is a former Chair of the Governing Body at Manor Way Primary School.

During the process to achieve Foundation Trust status, Kathryn delivered presentations to stakeholders, partners and the public. As a member of the Trust Board, Kathryn is interested in public and patient issues, especially those surrounding elderly care. She is also keen to contribute to audit and governance policies implemented by the Trust. She chairs the Charitable Funds working group and is the Trust lead on issues of patient safety and security management.

Kathryn's term of office with Trust ended on 30th April 2012 and she decided to step down from the Board at this point. The Trust thanks Kathryn for her support and dedication during her eight years of service.

Executive Directors

Paula Clark – Chief Executive
Paula joined the Trust as Chief Executive on 1st October 2009 from Burton Hospitals NHS Foundation Trust. During her four years as Chief Executive of Burton Hospitals she led the trust through turn-round and on to Foundation Trust status in 2008. Paula has worked in the NHS for over 22 years, with more than 14 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 Operations and 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 in 2007.

Richard is responsible for service delivery in our clinical services, delivered through our 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.

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 – Nursing Director
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.

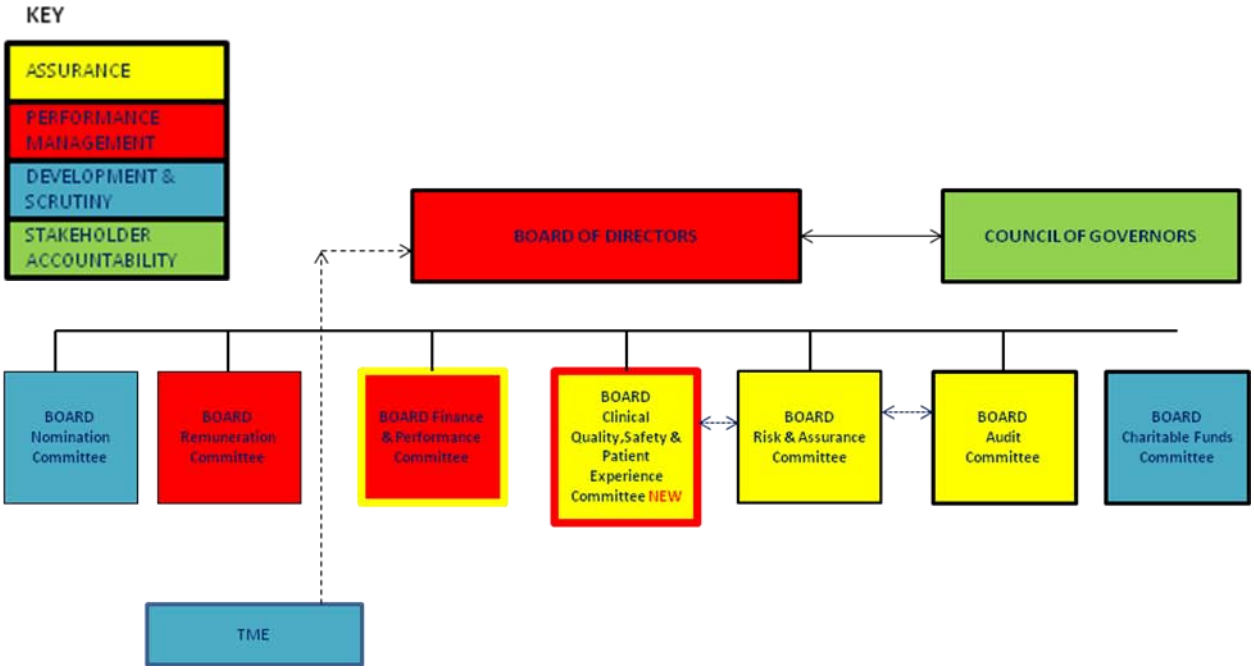
Denise is passionate about patient care and has continued to do clinical shifts throughout her career.

Board of Directors Committees

In January 2012 the Board of Directors reviewed their Committee structure and recognising the broadening Quality Agenda, established a new Clinical Quality, Safety and Patient Experience Committee to provide dedicated time and appropriate resource to this. At the same time, the role of the Risk Committee was expanded to include assurance and now has responsibility for the risk, control and governance processes which have been established across the Trust.

The Terms of Reference for the remaining Committees were reviewed and updated to reflect changes to membership and to the supporting working groups. Changes came into effect on the 1st April 2012 for the 2012/13 year.

Structure 2012/13



TME (Trust Management Executive)

Board and committee meetings attendance

		Attendance at Board of Directors out of 11 meetings
John Edwards	Chair	11
David Badger	Non Executive Director/ Deputy Chair/Senior Independent Director	11
Ann Becke	Non Executive Director	11
Jonathan Fellows	Non Executive Director	10
Kathryn Williets	Non Executive Director (left 31/4/12)	1
David Bland	Non Executive Director	11
Richard Miner	Non Executive Director	11
Paula Clark	Chief Executive	11
Paul Assinder	Director of Finance and Information	9
Paul Harrison	Medical Director	7
Denise McMahon	Nursing Director	9
Richard Beeken	Director of Operations and Transformation	7

Audit Committee

The Audit Committee is a Sub Committee of the Board of Directors. The Committee provides the Board 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. 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	3
Paul Assinder	Director of Finance and Information	4
Denise McMahon	Nursing Director	4
Deloitte LLP	External auditors representative	4
RSM Tenon	Internal auditors representative	4

Independence of external auditor
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.

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 2012/13 on the 6th December 2012.

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

Sustainability Report

The Trust takes its sustainability responsibilities very seriously and the Sustainability Development Unit sets out in its 'NHS Carbon Reduction Strategy' the contributions the NHS can make to reduce its carbon impact. The Trust supports the view that it should measure and progressively reduce its own carbon footprint in order to save resources and contribute to reducing the impact of its activities on the environment.

The Trust works very closely in this matter with our Private Finance Initiative (PFI) partner, Summit Healthcare, who has a responsibility under the PFI contract to purchase utility resources and manage their effective use and also to dispose of waste that is created by the Trust and its partners. The Trust has a Sustainable Development Group comprising of senior technical, financial and procurement management personnel, drawn from the Trust and its PFI partner.

Our Strategy
The Trust's overall sustainability strategy was developed to replace obsolete healthcare facilities with modern purpose built buildings, based over three locations around the Dudley district. Supporting the district general hospital at Russells Hall Hospital are two outpatient centres that help minimise travel distances for patients.

The Trust's strategy is based on the following criteria:

- The use of energy and the carbon emission implications that arise from using the estate
- Waste - minimisation and recycling of materials
- Procurement of products and equipment
- IT
- Raising awareness

Energy
The committee set up to manage and monitor the forward management of the Energy Agenda within the Trust has received a number of status and investment reports from the Trust's PFI Partner.

These proposals are currently being analysed and subsequent investment decisions will take place over the coming months.

A new Energy Manager is to be appointed with a revised brief and this role will include implementing a new energy philosophy across the Trust.

Waste Management
Significant progress has been made in this area of activity. The overall amount of waste leaving the Trust has been reduced by approximately 10 per cent. Significant amounts of waste which previously went to landfill, are now sent for recycling.

Incinerated waste has increased slightly over the year, but the vast majority of waste that was originally disposed of through this medium is now processed through a different waste stream which is more eco-friendly.

Procurement
The Trust will continue to follow good practice in the procurement of sustainable products by following the Office of Government list of Sustainability Minimum Mandatory Standards 'Quick Wins'. The Trust Board have approved a Trust wide 'Sustainable Procurement Policy.'

Travel
Limitations on staff car parking facilities have been introduced, with the aim of reducing vehicle journeys to and from Trust sites. Staff are being encouraged to use public transport, cycle, walk or car share where possible for their journeys to work.

IT
The Trust is in the process of upgrading its IT facilities to incorporate Wi-Fi and continues to purchase environmentally friendly equipment.

Raising Awareness
The Sustainable Development Group will work with the Communications Manager to raise awareness about the sustainability agenda among staff and the Trust's stakeholders.

Communication of information about sustainable development is a prime factor for the Trust. The appointment of a new Energy Manager will provide significant assistance in this process.

Governance
The Trust's Sustainable Development Group is responsible through the Trust Management Executive to the Trust Board of Directors. An annual energy and carbon reduction report to the Trust Board will monitor and show how the Trust and its PFI Partners are progressing.

Summary
There are a number of contributing factors which relate to the performance and effective use of energy and other utility services in the Trust at the present time:

(a) the increased demand for cooling facilities within clinical areas of the estate as large areas of the hospital are ventilated by natural ventilation only,
(b) the increased use of modern computer technology and the tendency for staff to leave equipment on standby when not in use,
(c) the need to update and replace energy control systems,
(d) though there are areas of the buildings that have movement sensors fitted to the lighting systems, there are significant other areas where the lighting is left on. This needs to be managed and controlled by those who use the facilities,
(e) improved use of thermal insulation to buildings and engineering services,
(f) updating of Combined Heat and Power Plants (CHP) Plants,
(g) providing new heat sources,
(h) the use of Light Emitting Diode (LED) lighting.

Area	Measure	Non financial data 2011/12	Costs 2011/12	Non financial data 2012/13	Costs 2012/13
Greenhouse Gas Emissions In kwh	Electricity (kwh) Gas (kwh) Oil (kwh)	17,682,611 56,689,651 1,551,731	£1,380,741 £1,389,880 £87,438	16,940,468 60,617,514 2,406,635	£1,464,328 £2,185,453 £150,366
Waste Minimisation	Total Waste Produced by the Trust (Tonnes)	1,517	£ 447,036	1,376	£371,067
	Domestic waste for recycling, which originally went to landfill (tonnes)	Zero	Zero	392,18	£35,296
	Landfill Waste (tonnes)	396	£35,640	Zero	Zero
	Incinerated Waste (tonnes)	34.80	£102,000	40.92	£23,283
	Alternative Treated Waste (tonnes)	876	£303,096	811	£296,951
	Recycled Waste, including cardboard, paper, plastic, metal, glass, batteries, wood etc. (tonnes)	210	£6,300	132	£15,537
Finite Resources in M^3	Water	173,257	£145,330	202,744	£364,665
Emissions Tonnes of CO^2	EUETS	10,191	-- ------	10,799	- ------
Emissions Tonnes of CO^2	Electricity		---------	9,324	--------

Regulatory Ratings

The Trust set the 2012/13 regulatory ratings plan based on the annual risk assessment of the coming financial year 2012/13. Analysis for each area of rating compared with that expected in the annual plan is summarised below:

Financial risk rating

The Trust planned for a rating of '3' in the annual plan. The Trust entered the financial year with a challenging cost improvement programme which was achieved in full. 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. The Trust's overall performance for the year showed Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) margin of £23.98m, 8.0 per cent, equivalent to £2.2m above plan and net surplus at £2.9m, £2.4m above plan. Although the Trust encountered a difficult 2012/13 financially we were still able to deliver a rating of '3' on our final outturn.

Governance risk rating
The Trust planned for a rating of 'Amber-Red' in the annual plan. This was due to the Trust having a single 'major' concern and an associated compliance action, outstanding against CQC outcome eight (cleanliness and infection controls). This related exclusively to excess C-Difficile numbers in the first half of 2011/12 and although the Trust had achieved C-Difficile targets in the later part of 2011/12 the CQC action was still in place at the time of the plan. A report from the CQC was sent to the Trust in June 2012 which stated that the Trust was now compliant with outcome eight. This report was sent to Monitor and our governance rating was adjusted accordingly to 'Green'. In quarter 4 of 2012/13 the Trust breached the A&E maximum waiting time of four hours from arrival to admission/transfer/discharge (95 per cent) target and the Cancer 62 day wait for first treatment from an urgent GP referral (85 per cent). This led to a final governance rating of 'Amber-Red' for the Trust.

Mandatory services
The Trust planned for a rating of 'Green' in the annual plan. The Trust made no changes to the range of services provided, nor to mandatory assets during the year. A rating of 'Green' was maintained throughout all quarters.

2011/12	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Amber-Red	Amber-Red	Amber-Red	Amber-Red
Mandatory services	Green	Green	Green	Green	Green

2012/13	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial risk rating	3	3	3	3	3
Governance risk rating	Amber-Red	Green	Green	Green	Amber-Red
Mandatory services	Green	Green	Green	Green	Green

Financial Performance

In line with the rest of the NHS, the Trust has faced a challenging year financially in 2012/13. Total income has increased by 4.2 per cent, to £298.3 million, above the previous year, representing an increase in activity but a real terms reduction to overall funding.

The Trust recorded Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) of £23.98 million which equates to eight per cent of turnover.

This means in overall terms the Trust has achieved a Financial Risk Rating of '3' by Monitor.

The over-achievement of our income plan links largely to additional contract income mainly in relation to non-elective care, high cost drugs and Accident & Emergency complexity. Similarly, the additional expenditure compared to our plan correlates closely with the costs of providing the additional care particularly in the areas of pay, clinical supplies and drugs.

Table 1 below summarises the Trust Performance for the year:

Table 1: Trust Financial Performance 2012/13	**Plan**	**Actual**	**Variance**
	£000's	**£000's**	**£000's**
Income	286,333	298,329	11,996
Expenditure	(264,558)	(274,347)	(9,789)
EBITDA	**21,775**	**23,982**	**2,207**
Net Surplus	**500**	**2,898**	**2,398**
EBITDA Margin	7.6%	8.0%	0.4%
EBITDA % Plan Achieved	95.8%	110.1%	14.3%
Net Return After Financing	0.2%	1.1%	0.9%
IS Surplus Margin	0.2%	1.0%	0.8%
Liquidity Days	34.9	37.8	2.9

Income and Expenditure

The table below compares the original planned income and expenditure with the outturn position for 2012/13.

	Plan	**Actual**	**Variance**	**Notes**
	£000's	**£000's**	**£000's**	
Activity Income	272,108	278,413	6,305	**1**
Other Clinical Income	1,502	3,945	2,443	
Other Operating Income	12,723	15,971	3,248	**2**
Total Income	**286,333**	**298,329**	**11,996**	
Pay Spend	(168,008)	(173,297)	(5,289)	**3**
Non-Pay Spend	(96,550)	(101,050)	(4,500)	**4**
Total Expenditure	**(264,558)**	**(274,347)**	**(9,789)**	
EBITDA	**21,775**	**23,982**	**2,207**	**5**
Retained Surplus	**500**	**2,898**	**2,398**	

Note 1. Activity Income

The Trust signed Acute Care contracts totalling £246.2m for 2012/13 including £6.0m for specific quality improvements. The main PCT Acute contracts are held with Dudley (£178.2m), Sandwell (£32.8m), South Staffordshire (£9.6m) and Specialised Services (£15.5m). In addition the Trust's responsibility for running adult community services across the Dudley Borough resulted in additional contract income of £21.6m, including £0.5m for specific quality improvements.

The activity plan was based upon signed contracts with PCT's that is income secured rather than 'at risk'. The plan for Accident & Emergency attendances used the 2011/12 outturn and whilst the 2012/13 performance is in keeping with this level

of activity, the complexity of patients treated has increased significantly giving rise to additional income of £0.6m.

Similarly, the plan for elective spells was modelled on the 2011/12 outturn plus growth less activity that could no longer be undertaken (aesthetic procedures and procedures of limited clinical value). Despite a significant level of cancelled elective operations (due to increased non-elective pressures), the plan is broadly in balance due to additional weekend day case work to manage the waiting list.

The starting point for both non-elective spell plan and the outpatient attendance/ procedure plan would have again been the 2011/12 outturn adjusted for estimated growth and PCT commissioning intentions designed to reduce the level of activity requiring hospital treatment. For non-elective spells this resulted in a plan that was lower than the 2011/12 outturn but the Trust has seen a continued rise in emergency activity resulting in an over-performance against plan. Whilst an increase of 1,382 spells is minor in comparison to previous years, it should be noted that this includes a reduction of 1,102 maternity spells resulting from a cap on births. There is thus an increase of 2,484 non-elective admissions (excluding Maternity) across paediatrics, surgery and medicine. Some of this will be attributable to the Trust successfully winning the tender to provide specialist Vascular Surgery services to Dudley, Walsall and Wolverhampton.

For outpatient attendances/procedures, the Trust has fallen short of the reduced plan, largely within follow up attendances and linked to PCT commissioning intentions to reduce inappropriate review clinics. Specific areas of reduction include physiotherapy, ophthalmology, trauma & orthopaedics, paediatrics, general surgery and chemical pathology. However, new referrals to the Trust continue to grow with an additional 1,485 in comparison to 2011/12.

2012/13 represents the second year that the Trust has been responsible for providing adult community services and as such a more realistic baseline plan has been agreed along with improvements in recording data. The result is an outturn that is exceptionally close to plan.

	Annual Plan	Outturn	Variance	Growth (%)
Accident & Emergency attendances	98,417	98,232	(185)	(0.2)%
Elective spells	48,400	48,418	18	0.0%
Non-elective spells	52,321	53,703	1,382	2.6%
Outpatient attendances/ procedures	512,369	508,391	(3,978)	(0.8)%
Community attendances	394,239	393,987	(252)	(0.1)%

In undertaking additional activity over and above the plan, the Trust has earned additional income under the NHS tariff, commensurate with the extra work. However, current tariff rules effectively penalise the Trust for undertaking too much non-elective work above a threshold, with activity only recompensed at 30 per cent of the full tariff. The agreement of a local price for those admissions that are discharged home within a certain timeframe has negated the impact of this rule, resulting in all activity being paid at full price. Further rules regarding the non-payment for a proportion of non-elective re-admissions within 30 days of the original attendance would have resulted in a loss to the Trust of £2.3m. We have worked in partnership

with the PCT and secured the return of those funds to invest in schemes designed to reduce the number of unnecessary re-admissions. A large part of this investment is aimed at an increased medical and nursing model within the Acute Medical Unit. Further funds of £0.4m were also made available to assist with the maintenance of key targets within an environment of winter pressures.

Note 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 Road Traffic Accident (RTA). 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 2012/13 had no impact on its provision of goods and services for the purposes of the health service in England.

Note 3. Pay spend
Pay costs exceeded the original budget plan by £5.28m. Similar to the previous year, this was a direct impact of the significant increase in work with all available capacity open throughout the year

During the year, employed staff increased from 3,877 to 3,989 Whole Time Equivalents. On average the Trust employed 53 more people every month than in 2011/12. There were notable increases for unqualified and qualified nurses and medical staff. The increase for nursing staff reflects the Trust policy to develop its own nursing pool via both the novice and graduate programmes that occur several times a year. The increase in medics was targeted at reducing high agency costs.

In addition to the staffing increases, the Trust's internal staff bank has increased significantly. The majority of the spend is for nursing and this has increased from £4.674m in 2010/11, to £6.777m in 2011/12, to £9.497m in 2012/13.

However, despite the growth in substantive staff and bank usage, the need to keep all capacity open throughout the year and ensure safe staffing levels in wards has also meant that agency costs continue to be incurred. The Trust had achieved a reduction of agency costs from £10.308m expended in 2010/11 to £3.208 million expended in 2011/12. For 2012/13, the agency figure has increased to £3.698m. The increase of £0.490m is explained by £0.516m for nursing, £0.358m for other (scientific/administrative staff) and £0.384m less for agency medics.

Note 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.

Note 5. Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA)

EBITDA for the year as a whole exceeded plan by £2.207m with additional income outstripping the extra costs of managing non-elective pressures. This also resulted in a retained surplus of £2.898m representing a figure that is £2.398m in excess of the original plan.

Capital

In 2012/13 the Trust invested £9.1m on new facilities and equipment. New and replacement IT infrastructure and equipment made up £4.4m of the investment. The two biggest scheme were the purchase of a data centre from Dudley PCT and the upgrade of the network infrastructure within the Trust estate. £916k was also invested in an upgrade to the day case theatre area, this allowing for better patient flow within the department and therefore improving the patient experience. The Trust also spent £2.1m on new and replacement medical equipment.

Investment 2012/13	Amount
	£000's
Endoscope decontamination area	296
Imaging equipment replacement	460
Other medical equipment	2,090
Day case theatre upgrade	916
Information technology	4,435
Imaging equipment enabling works	182
Other works including PFI lifecycle	714
Total	**9,093**

Cashflow

The Trust ended the year with a healthy cash balance of £32.9m, all held within the Government Banking Service. This will be used to support our planned capital expenditure over the next three years.

During 2012/13 the Trust operated with a Prudential Borrowing Limit (PBL) set for the year by Monitor of £156.3m of long-term borrowing. The Trust maintained, but did not utilise, a committed working capital facility with Barclays Bank of £10m.

During 2012/13 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 2012/13 the Trust paid 99 per cent of non-NHS invoices in value terms and 99 per cent in quantity terms.

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.

	2012/13		2011/12	
	Number	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	49,554	115,650	45,113	107,060
Total non-NHS trade invoices paid within target	49,073	115,060	44,199	105,930
Percentage of non-NHS trade invoices paid within target	99%	99%	98%	99%

Audit
So 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.

Countering fraud and 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 i.e. disciplinary/criminal action, and use of the civil law to recover funds.

Off payroll engagements
As at 31st January 2012 the Trust had one off payroll engagement at a cost of over £58,200 per annum. During 2012/13 this arrangement has been re-negotiated to include contractual clauses allowing the Trust to seek assurances as to their tax obligations.

Accounts

For the Period 1st April 2012 to 31st March 2013

Foreword to the Accounts

These accounts for the period 1st April 2012 to 31st March 2013 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 23rd May 2013

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 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, 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 23rd May 2013

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: 23rd May 2013

Paula Clark

Chief Executive

Signed Date: 23rd May 2013

Paul Assinder

Director of Finance

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 2013 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk
The Nursing Director 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 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.

The Board of Directors focuses on the corporate risks taking assurance from the Risk and Assurance and Audit Committees. Papers received at the Board and at Board Committees identify the risks to the achievement of Trust objectives and provide a 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) the Directors are currently managing 24 corporate risks. The Board Assurance Framework focuses on those scoring 20–25 only (7 risks in total). Positive assurance to date confirms the effectiveness of the management and control of these risks. Action plans are in place, or being developed, to address any perceived gaps in control or assurance.

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. This is informed by partnership working across the health care region and through working with the Clinical Commissioning Group (CCG) and formerly the Primary Care Trusts (PCT), Council of Governors, community wide Safeguarding Boards and other stakeholders.

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

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

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

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 Risk and Assurance Committee, and whose remit is to review and monitor all risks relating to data

security and governance. The Trust complies with the NHS Information Governance Toolkit and is currently achieving a minimum of Level 2 conformance 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 2013-14, 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).

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

As an employer with staff entitled to membership 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 pension scheme members' 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 our 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 UK Climate Impacts Programme (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 independent regulator.

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. Monthly performance reviews 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 a financial and governance risk rating is assigned. The Trust received a financial risk rating of 3 from Monitor for the 2012/13 financial year and a governance rating of "amber/red" as a result of the quarter four non achievement of the A&E and 62 day cancer targets.

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 the Standing Financial Instructions and 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 and Management Executive Meeting 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.

- **Quality Strategy**

Building on the framework adopted in previous years, the Trust’s strategy comprises a number of Trust-wide ‘Quality Goals’, to address the three quality themes of patient safety, clinical effectiveness and patient experience. The development of the Quality Report is led by the Director of Nursing with the full support of the Board of Directors and the Council of Governors. Executive Directors are accountable and have overall responsibility for ensuring that their Directorates implement the strategy and achieve the agreed quality key performance indicators. The Quality Strategy defines the processes and responsibilities for implementation including indicators to monitor progress.

- **Systems and processes**

The systems and processes which support the development of the quality accounts focus on engagement activities with public, patients and staff, 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. The following priorities were agreed by the Trust Board on the basis of their local and national perspective: patient experience, infection

control, pressure ulcers, nutrition and hydration. They were endorsed at a Listening into Action (LiA) event for Governors, staff, the public and partner representatives. Two of the topics (nutrition and hydration) were new in 2012/13 with the others rolling over from previous years (patient experience/infection control have been continual priorities since the commencement of Quality Accounts in 2009/10 and pressure ulcers were introduced in 2011/12).

The Trust also works in partnership with others on quality improvement activities including LINKs (Local Involvement Network), Select Committee on Health and Adult Social Care, Independent Complaints Advocacy Service (ICAS) and local commissioning organisations.

The Trust takes part in all applicable national audits and reviews clinical services accreditation schemes (e.g. laboratories) and related national quality improvement initiatives that provide data to make comparisons with other providers. Additionally, all serious incidents, overall trends of incidents, complaints and claims provide comparative data to benchmark against other organisations or areas for organisation learning.

- **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 to ensure that patients have a positive experience and are treated with courtesy, respect and kindness. Clinical Directorate Management Teams develop specific objectives within their service plans to provide a quality service and action plans in response to local and national patient survey results and other quality indicators.

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 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.

A quarterly Quality Account Priorities Report is presented to the Board, confirming the progress made against each priority and sharing the results of local and national surveys on patient experience. Additionally, a number of different Key Performance Indicator reports and dashboards are available and used by a wide variety of staff groups to monitor quality on a day to day basis. The organisation's performance on key quality indicators is also benchmarked against national/international comparisons to identify areas for prioritisation and improvement.

The Board recognised the need to improve the monitoring and reporting systems associated with the Quality Account and established the Clinical Quality, Safety and

Patient Experience Committee to manage the wider quality agenda and focus on the key clinical priorities arising from the Quality Accounts and Report. The Committee meets monthly and is chaired by a Non Executive Director.

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.

During 2012/13, the work of the Internal Auditors and the Board review of the Board 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:

- Nurse staffing levels – Recruitment, skill mix and retention of staff is monitored. Pro-active vacancy management for both graduate and novice programmes continues. Whilst there has been significant investment in the workforce, bank and agency staff are used to support wards when required.
- Impact on admission of emergency patients (due to externally caused delayed discharge/transfer) – The Board monitors the continuing partnership arrangements to improve services for patients on discharge or transfer to the community.
- Urgent care demand exceeds capacity – The Board continues to monitor the impact of measures implemented during the year to manage demand and has supported a length of stay project as part of the Transformation Programme which aims to reduce length of stay and therefore bed occupancy.
- Management of diabetes patients - The Trust has focussed on improving the training for all staff and reviewing supporting policies and guidelines available for the management of diabetes patients.
- Failure to deliver financial balance or achieve the CIP target – The Board continues to manage the financial pressures, identifying cost saving/efficiency opportunities and risk assessing the impact of financial proposals on clinical services.

The Head of Audit confirmed that, "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."

The Head of Audit Opinion 2012/13 also confirmed that, "Based on the work undertaken in 2012/13, 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."

On the 19th and 27th February 2013, the CQC undertook a routine (scheduled) inspection to check that essential standards of quality and safety were being met. They looked at the personal care or treatment records of people who use the service and observed they were being cared for at each stage of their treatment and care. They talked to people who use the service, reviewed information provided by the Trust and inspected some wards and departments. The following standards were inspected:

- Care and welfare of people who use services
- Meeting nutritional needs
- Management of medicines
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints

The CQC confirmed that the Trust met all the above standards.

The Trust was also assessed by the National Health Service Litigation Scheme (NHSLA) in October and November 2012 and achieved Level 1 for both the General Risk Management and Maternity Standards achieving a score of 50 out of 50 on both assessments.

Following the publication of the Francis Report into Mid Staffordshire Hospitals NHS Foundation Trust in February 2013, the Board considered the report findings, key themes and recommendations, and identified action to be taken to share the learning from this. Local action plans have been drafted and reporting arrangements established to monitor progress against these. The Council of Governors and Trust staff have been briefed and will receive regular updates.

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 Mortality Index and the Hospital Standardised Mortality Ratio.

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.

Date 23rd May 2013

Signed

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 2012/13 in January 2013.

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

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.

The Trust Board of Directors had a pay freeze in 2009/10 and this has continued through 2010/11, 2011/12 and 2012/13.

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

Salary and Pension entitlements of Senior Managers (audited information) 2012/13

A) Remuneration

Name and Title	Note	2012-13			2011-12		
		Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	* Benefits in Kind (Rounded to the nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	* Benefits in Kind (Rounded to the nearest £100)
		£000	£000	£00	£000	£000	£00
Paula Clark, Chief Executive		175-180			175-180		
Paul Assinder, Director of Finance & Information		140-145			140-145		
Paul Harrison, Medical Director		60-65	100-105		60-65	100-105	
Richard Beeken, Director of Operations & Transformation		120-125			120-125		
Denise McMahon, Nursing Director		120-125			120-125		
John Edwards, Chairman		45-50		1,100	45-50		1,700
David Badger, Non Executive Director		15-20			15-20		
Kathryn Willietts, Non Executive Director	a	0-5			10-15		100
Ann Becke, Non Executive Director		10-15		200	10-15		
Jonathon Fellows, Non Executive Director		10-15			10-15		
David Bland, Non Executive Director		10-15		900	10-15		
Richard Miner, Non Executive Director	b	10-15		100	10-15		
Aggregate Total		715 -775	100-105	2,300	725 -785	100-105	1,800

Notes:
* 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 30th April 2012
b Richard Miner became a Non Executive on 1st May 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 2012/13 is £175,000 - £180,000 (2011/12 £175,000 - £180,000). This was 7.9 times (2011/12 7.9 times) the median remuneration of the workforce, which was £20,000 - £25,000 (2011/12 £20,000 - £25,000).

On 1st April 2011 the number of staff increased by 642 following the transfer of Adult Community Services from Dudley PCT.

In 2012/13, there were no (2011/12 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 2013 *(bands of £5,000)*	Lump sum at age 60 related to accrued pension at 31 March 2013 *(bands of £5,000)*	Cash Equivalent Transfer Value at 1 April 2012 *to nearest £1,000*	Real Increase in Cash Equivalent Transfer Value *to nearest £1,000*	Cash Equivalent Transfer value at 31 March 2013 *to nearest £1,000*
		£000	£000	£000	£000			
Paula Clark, Chief Executive		0-2.5	5.0-7.0	45-50	145-150	877	120	997
Paul Assinder, Director of Finance and Information		(0-2.5)	(2.5-5.0)	50-55	155-160	1,001	62	1,063
Richard Beeken, Director of Operations and Transformation		0-2.5	0-2.5	25-30	80-85	363	29	392
Paul Harrison, Medical Director	1	(0-2.5)	(0-2.5)	50-55	160-165	893	63	956
Denise McMahon, Nursing Director		(0-2.5)	(2.5-5.0)	50-55	155-160	944	55	999

Note: 1. The 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 end of the period.

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 2012/13 was £7,500 - £10,000 (2011/12 £7,500 - £10,000).

Signed

Paula Clark

23rd May 2013

Chief Executive

The Dudley Group NHS Foundation Trust

Statement of Comprehensive Income

for the Year Ended 31 March 2013

	Note	Year Ended 31 March 2013	Restated Year Ended 31 March 2012
		£'000	£'000
Operating Income from operations	3 & 4	298,441	285,354
Operating Expenses of operations	5	(283,212)	(273,448)
OPERATING SURPLUS / (DEFICIT)		**15,229**	**11,906**
FINANCE COSTS			
Finance income	9	485	433
Finance expense - financial liabilities	10	(10,472)	(9,769)
PDC Dividends payable		(2,344)	(1,943)
NET FINANCE COSTS		**(12,331)**	**(11,279)**
Corporation tax expense		0	0
Surplus/(Deficit) from operations		**2,898**	**627**
SURPLUS/(DEFICIT) FOR THE YEAR		**2,898**	**627**
Other comprehensive income			
Impairments		0	(2)
Revaluations		0	16,937
Transfer to retained earnings on disposal of assets		0	0
Other recognised gains and losses		0	0
Other reserve movements		0	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**2,898**	**17,562**
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**2,898**	**17,562**

The notes on pages 77 to 110 form part of these accounts.
All income and expenditure is derived from continuing operations.

There are no Minority Interests in the Trust, therefore the surplus for the year of £2,898,000 (2011/12 £627,000) and the Total Comprehensive Income of £2,898,000 (2011/12 £17,562,000) is wholly attributable to the Trust.

* Restated - In the 2011/12 Income Statement £42,000 was incorrectly included as negative income. This has been corrected between income and expenditure.

The Dudley Group NHS Foundation Trust

Statement of Financial Position
as at 31 March 2013

	Note	31 March 2013	31 March 2012
Non-current assets		£'000	£'000
Intangible assets	11	1,281	576
Property, plant and equipment	12	218,509	219,000
Investment Property		0	0
Other Investments		0	0
Trade and other receivables	14	9,314	8,733
Other Financial assets		0	0
Other assets		0	0
Total non-current assets		229,104	228,309
Current assets			
Inventories	13	3,088	2,837
Trade and other receivables	14	7,318	6,289
Other financial assets	25.7	0	0
Non-current assets for sale and assets in disposal groups	12.8	0	0
Cash and cash equivalents	20	32,906	36,346
Total current assets		43,312	45,472
Current liabilities			
Trade and other payables	15	(15,728)	(15,135)
Borrowings	19	(4,978)	(4,897)
Other financial liabilities		0	0
Provisions	17	(430)	(706)
Other liabilities	16	(245)	(2,048)
Liabilities in disposal groups		0	0
Total current liabilities		(21,381)	(22,786)
Total assets less current liabilities		**251,035**	**250,995**
Non-current liabilities			
Trade and other payables		0	0
Borrowings	19	(146,855)	(151,365)
Other financial liabilities		0	0
Provisions		0	0
Other liabilities		0	0
Total non-current liabilities		(146,855)	(151,365)
Total assets employed		**104,180**	**99,630**
Financed by Taxpayers' equity			
Public Dividend Capital		22,579	20,927
Revaluation reserve		52,649	52,709
Available for sale investments reserve		0	0
Other reserves		0	0
Merger Reserve		0	0
Income and expenditure reserve		28,952	25,994
Total Taxpayers' equity		**104,180**	**99,630**

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

Signed……
Paula Clark
Chief Executive

Date: 23rd May 2013

The Dudley Group NHS Foundation Trust

Statement of Changes in Taxpayers Equity

for the Year Ended 31 March 2013

	Public Dividend Capital £'000	Revaluation Reserve £'000	Income and Expenditure Reserve £'000	Total £'000
Taxpayers' Equity at 1 April 2011	**20,927**	**37,160**	**23,982**	**82,069**
Surplus / (Deficit) for the year	0	0	627	627
Transfers between reserves	0	(1,386)	1,386	0
Impairments	0	(2)	0	(2)
Revaluations - property, plant and equipment	0	16,937	0	16,937
Other recognised gains/losses	0	0	0	0
Other reserve movements	0	0	(1)	(1)
Taxpayers' Equity at 31 March 2012	**20,927**	**52,709**	**25,994**	**99,630**
Surplus / (Deficit) for the year	0	0	2,898	2,898
Transfers between reserves	0	(59)	59	0
Impairments	0	0	0	0
Revaluations - property, plant and equipment	0	0	0	0
Other recognised gains/losses	0	0	0	0
Public Dividend Capital Received	1,652	0	0	1,652
Other reserve movements	0	(1)	1	0
Taxpayers' Equity at 31 March 2013	**22,579**	**52,649**	**28,952**	**104,180**

The Dudley Group NHS Foundation Trust

Statement of Cash Flows
for the Year Ended 31 March 2013

	31 March 2013 £'000	Restated 31 March 2012 £'000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	**15,229**	**11,906**
Operating surplus/(deficit) of discontinued operations	0	0
Operating surplus/(deficit)	**15,229**	**11,906**
Non-cash income and expense:		
Depreciation and amortisation	8,859	8,727
Impairments	0	340
Reversals of impairments	0	0
(Gain)/Loss on Disposal	2	(291)
Non-cash donations/grants credited to income	(98)	(89)
Amortisation of PFI credit	0	0
(Increase)/Decrease in Trade and Other Receivables	(1,960)	(1,241)
(Increase)/Decrease in Other Assets	0	0
(Increase)/Decrease in Inventories	(251)	346
Increase/(Decrease) in Trade and Other Payables	1,344	1,063
Increase/(Decrease) in Other Liabilities	(1,803)	1,008
Increase/(Decrease) in Provisions	(276)	93
Tax (paid) / received	0	0
Movements in operating cash flow of discontinued operations	0	0
Movements in operating cash flow in respect of Transforming Community Services transaction	0	0
Other movements in operating cash flows	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS	21,046	21,862
Cash flows from investing activities		
Interest received	480	435
Purchase of financial assets	(258,000)	(171,000)
Sales of financial assets	258,000	171,000
Purchase of intangible assets	(967)	(31)
Sales of intangible assets	0	0
Purchase of Property, Plant and Equipment	(8,309)	(5,674)
Sales of Property, Plant and Equipment	8	2,026
Net cash generated from/(used in) investing activities	(8,788)	(3,244)
Cash flows from financing activities		
Public dividend capital received	1,652	0
Loans received	0	0
Loans repaid	0	0
Capital element of finance lease rental payments	0	0
Capital element of PFI Obligations	(4,889)	(4,216)
Interest paid	0	0
Interest element of finance lease	0	0
Interest element of PFI Obligations	(10,472)	(9,769)
PDC Dividend paid	(1,989)	(1,728)
Cash flows from (used in) other financing activities	0	0
Net cash generated from/(used in) financing activities	(15,698)	(15,713)
Increase/(decrease) in cash and cash equivalents	**(3,440)**	**2,905**
Cash and Cash equivalents at 1 April	36,346	33,441
Cash and Cash equivalents at 31 March	**32,906**	**36,346**

* Restated - additional analysis was included in the 2012/13 accounts and therefore 2011/12 has been restated to reflect this.

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 2012/13 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.

1.1 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 in 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.

1.2 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 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. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 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 at 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) will be used to replace 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.

1.3 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.

1.4 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 de-recognised 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-balance sheet' 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 pre-determined 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.

1.5 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

1.6 Government Grants
Government grants are grants from Government bodies other than income from Primary Care Trusts 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.

1.7 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.

1.8 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.

1.9 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 'closely-related' to those contracts are separated-out 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 debtors, accrued income and 'other debtors'. 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 recorgnised 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 regognised 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.

1.10 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.

1.11 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 discount rate of 2.2% (2011/12 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 2.8% (2011/12: 2.8%) 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.

1.12 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 22 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 22, 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.

1.13 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) net cash balances held with the Government Banking Services, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iii) 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 'pre-audit' 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.

1.14 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.

1.15 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.

1.16 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 26 to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

1.17 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

1.18 Charitable Funds

The Trust is not required to apply IAS 27 in 2012/13 following dispensation obtained by Monitor. However, this only applies to the consolidation of NHS Charitable Funds.

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 but are not required to be followed until 2013/14. These are not expected to impact upon the Trust financial statements.

IAS 19 (Revised 2011) Employee Benefits

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.

2. Segmental Analysis

The Board as 'Chief Operating Decision Maker' has determined that the Trust operates in one material 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 15. Other operating income is analysed in note 4 to the accounts on page 16 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 23 to the accounts on page 106.

	Year Ended 31 March 2013		Year Ended 31 March 2012	
	£'000	%	£'000	%
Trust Income *	298,329		284,825	
Expenditure - aggregated healthcare segment	(222,845)	75.4%	(249,369)	87.7%
Expenditure - other **	(72,586)	24.6%	(34,829)	12.3%
Total Expenditure	(295,431)	100.0%	(284,198)	100.0%
Operating Surplus	2,898		627	

* Trust income was not split into individual Directorates in the monthly Finance Report to the Board during 2012/13 and 2011/12.

** Other Expenditure is made up of Corporate Directorates, Depreciation, Impairments, PFI Finance Lease Interest and Interest Receivable.

3 Revenue from Activities

3.1 Income By Source	Year Ended 31 March 2013 £'000	Restated Year Ended 31 March 2012 £'000
NHS Foundation Trusts	0	0
NHS Trusts	37	14
Strategic Health Authorities	146	133
Primary Care Trusts	279,982	268,427
Local Authorities	184	238
Department of Health - grants	0	0
Department of Health - other	0	0
NHS Other	78	132
Non NHS: Private patients	46	50
Non-NHS: Overseas patients (non-reciprocal)	62	20
NHS injury scheme (was RTA)	1,451	995
Non NHS: Other	5	1
Total income from activities	**281,991**	**270,010**

This income is also analysed by income type below:

3.2 Revenue from Activities	Year Ended 31 March 2013 £'000	Year Ended 31 March 2012 £'000
Acute Trusts		
Elective	49,836	51,294
Non Elective	90,735	85,680
Outpatient	47,754	49,095
A&E	10,464	9,483
Other NHS Clinical Income	55,938	49,146
Community Trusts		
Income from PCT's	21,647	21,040
Income not from PCT's	183	234
Income at Tariff	**276,557**	**265,972**
Private Patients	46	50
Other non-protected clinical income	5,388	3,988
Total income from activities	**281,991**	**270,010**

3.3 Income from Mandatory and Non-Mandatory Services	Year Ended 31 March 2013 £'000	Year Ended 31 March 2012 £'000
NHS Clinical Income	280,243	268,706
Non-Mandatory / Non-Protected Income	1,748	1,304
Income from Activities	281,991	270,010
Other Operating Income	16,450	15,344
Total Income	298,441	285,354

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 (protected 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.

* Restated - additional analysis was included in the 2012/13 accounts and therefore 2011/12 has been restated to reflect this.

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 2013 £'000	Year ended 31 March 2012 £'000
Research and development	751	393
Education and training	8,074	7,370
Charitable and other contributions to expenditure	108	89
Non-patient care services to other bodies	1,855	1,714
Profit on disposal of fixed asset investments	0	0
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	4	5
Gain on disposal of assets held for sale	0	341
Reversal of impairments of assets held for sale	0	0
Amortisation of PFI deferred credits		
Main scheme	0	0
Additional lifecycle assets received	0	0
Income in respect of Staff Costs	1,784	1,926
Other	3,874	3,506
Total other operating income	**16,450**	**15,344**

Other income is derived from Staff Recharges £1,784,000 (2011/12 £1,926,000); Pharmacy Drugs £925,000 (2011/12 £1,002,000); settlement of an insurance claim £214,000 (2011/12 £ nil) and numerous other small amounts.

5. Operating Expenditure	Year ended 31 March 2013	**Restated** Year ended 31 March 2012
5.1 Operating Expenses	£'000	£'000
Services from NHS Foundation Trusts	148	130
Services from NHS Trusts	85	155
Services from PCT's	0	0
Services from other NHS Bodies	103	100
Purchase of healthcare from non NHS bodies	72	15
Employee Expenses - Executive directors	802	779
Employee Expenses - Non Executive directors	129	142
Employee Expenses - Staff	173,416	166,836
Drug costs (non inventory drugs only)	25,250	24,442
Drugs Inventories consumed	1,733	1,649
Supplies and services - clinical (excluding drug costs)	21,954	20,294
Supplies and services - general	1,957	1,763
Establishment	2,484	2,429
Research and development	0	0
Transport	2,536	2,263
Premises	3,465	3,439
Increase / (decrease) in bad debt provision	71	51
Other impairment of financial assets	0	0
Rentals under operating leases - minimum lease receipts	130	94
Depreciation on property, plant and equipment	8,597	8,434
Amortisation on intangible assets	262	293
Impairments of property, plant and equipment	0	340
Impairments of intangible assets	0	0
Audit fees		
audit service - statutory audit	64	67
audit services - audit related regulatory reporting	26	18
Other auditor's remuneration	0	0
further assurance services	0	0
other services	0	0
Clinical negligence	6,460	5,644
Loss on disposal of investments	0	0
Loss on disposal of intangible fixed assets	2	0
Loss on disposal of land and buildings	0	3
Loss on disposal of other property, plant and equipment	4	52
Loss on disposal of assets held for sale	0	0
Legal fees	0	0
Consultancy costs	347	639
Training, courses and conferences	0	0
Patient travel	0	0
Car parking & Security	0	0
Redundancy	0	4
Early retirements	0	0
Hospitality	0	0
Publishing	0	0
Insurance	0	0
Other services, eg external payroll	0	0
Losses, ex gratia & special payments	0	0
Other	33,115	33,373
TOTAL	**283,212**	**273,448**

Other expenditure includes £27,710,000 (2011/12 £27,088,000) in relation to payments to the Trust's PFI Partner for services provided and numerous other small amounts.

* Restated - additional analysis was included in the 2012/13 accounts and therefore 2011/12 has been restated to reflect this.

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

During the year 2012/13 (2011/12 £ 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 2013 £'000	Year ended 31 March 2012 £'000
Minimum lease payments	130	94
Contingent rents	0	0
Sub-lease payments	0	0
	130	94
Total future minimum lease payments Payable:		
Not more than one year	61	64
Between one and five years	186	151
After 5 years	0	39
Total	247	254

7. Directors' Remuneration and other benefits

	Year ended 31 March 2013 £'000	Year ended 31 March 2012 £'000
Aggregate Remuneration	882	892
Employer Contributions to a pension scheme	103	103
	985	995

8. Employee Expenses and Numbers

8.1 Employee Costs

	Year Ended 31 March 2013			Year Ended 31 March 2012		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	142,147	112,980	29,167	134,282	127,926	6,356
Social security costs	11,135	10,437	698	10,745	10,303	442
Pension costs - defined contribution plans						
Employer's contributions to NHS Pensions	15,760	15,370	390	15,423	15,149	274
Termination benefits	0	0	0	0	0	4
Agency/contract staff	5,176	0	5,176	7,165	0	7,165
Total	174,218	138,787	35,431	167,615	153,378	14,241

8.2 Average Number of Persons Employed

	Year Ended 31 March 2013			Year Ended 31 March 2012		
	Total	Permanent	Other	Total	Permanent	Other
Medical and dental	463	427	36	450	418	32
Administration and estates	762	697	65	716	668	48
Healthcare assistants and other support staff	1,016	1,016	0	827	827	0
Nursing, midwifery and health visiting staff	1,399	1,148	251	1,280	1,093	187
Nursing, midwifery and health visiting learners	10	10	0	11	11	0
Scientific, therapeutic and technical staff	261	254	7	348	343	5
Bank and agency staff	360	0	360	25	0	25
Total	4,271	3,552	719	3,657	3,360	297

8.3 Employee Benefits

Employees benefits include payment of salaries/wages and pension contributions. There were no other employee benefits paid in 2012/13 (2011/12 £ nil).

8.4 Retirements due to Ill-health

During the period 2012/13 there were 8 (in 2011/12 there were 4) early retirements from the Trust on the grounds of ill-health.
The estimated additional pension liabilities of these ill-health retirements will be £712,163 (2010/11 £390,149).
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:

	2012/13	2011/12
Absence Full Time Equivalent (FTE)	59,072	51,509
Available Employee Time (FTE) for the year	1,423,819	1,409,519
Sickness Rate	4.15%	3.65%

8.6 Exit Packages

The Trust's expenditure includes local MARS scheme payments to 14 members of staff totalling £247,000 (2011/12 22 staff £313,000) but does not include any payments relating to redundancy packages (2011/12 1 payment of £4,000).

Exit Package Cost Band	Number of MARS departures agreed
< £10,000	6
£10,000 - £25,000	4
£25,001 - £50,000	2
£50,001 - £100,000	2
Total number of exit packages by type	14
Total resource cost	£247,319

9. Finance Income	Year ended 31 March 2013 £'000	Year ended 31 March 2012 £'000
Interest on bank accounts	485	433
Interest on available for sale financial assets	0	0
Interest on held-to-maturity financial assets	0	0
	485	433

10 Finance Costs - Interest Expense	Year ended 31 March 2013 £'000	Year ended 31 March 2012 £'000
Finance Costs in PFI obligations		
Main Finance Costs	6,106	6,255
Contingent Finance Costs	4,366	3,514
	10,472	9,769

11. Intangible Assets

11.1 2012/13

	Computer Software	Total
	£'000	£'000
Gross Cost as at 1 April 2012	1,862	1,862
Transfers by Absorption *	564	564
Additions Purchased	854	854
Additions Donated	0	0
Disposals	(15)	(15)
Gross Cost as at 31 March 2013	3,265	3,265
Amortisation as at 1 April 2012	1286	1,286
Transfers by Absorption *	451	451
Provided during the Year	262	262
Disposals	(15)	(15)
Amortisation as at 31 March 2013	1,984	1,984
Net Book Value		
Purchased at 1 April 2012	576	576
Donated at 1 April 2012	0	0
Total at 1 April 2012	576	576
Net Book Value		
Purchased at 31 March 2013	1,281	1,281
Donated at 31 March 2013	0	0
Total at 31 March 2013	1,281	1,281

* 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.

11.2 2011/12

	Computer Software	Total
	£'000	£'000
Gross Cost as at 1 April 2011	1,831	1,831
Additions Purchased	31	31
Additions Donated	0	0
Disposals	0	0
Gross Cost as at 31 March 2012	1,862	1,862
Amortisation as at 1 April 2011	993	993
Provided during the Year	293	293
Disposals	0	0
Amortisation as at 31 March 2012	1,286	1,286
Net Book Value		
Purchased at 1 April 2011	838	838
Donated at 1 April 2011	0	0
Total at 1 April 2011	838	838
Net Book Value		
Purchased at 31 March 2012	576	576
Donated at 31 March 2012	0	0
Total at 31 March 2012	576	576

12. Tangible Assets

12.1 2012/13

	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	6,520	0	2,060	0	50	2,475	0	1,923	12
Additions - donated	108	0	0	0	0	108	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	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
Reclassified as held for sale	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
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	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

* Transfers By Absorption are IT Equipment purchased from Dudley PCT on 1 January 2013.

12. Tangible Assets

12.2 2011/12

	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 2011	228,978	25,990	169,640	512	906	29,756	223	1,325	626
Additions - purchased	8,214	0	2,515	0	1,245	4,237	0	217	0
Additions - donated	89	0	5	0	0	84	0	0	0
Impairments	(2)	0	(2)	0	0	0	0	0	0
Reclassifications	0	0	679	0	(906)	203	0	24	0
Revaluations	7,590	(1,200)	8,865	(75)	0	0	0	0	0
Reclassified as held for sale	(627)	(190)	0	(437)	0	0	0	0	0
Disposals	(1,806)	0	0	0	0	(1,708)	(94)	(4)	0
Gross Cost at 31 March 2012	242,436	24,600	181,702	0	1,245	32,572	129	1,562	626
Accumulated depreciation at 1 April 2011	25,785	0	4,431	28	0	20,056	108	747	415
Provided during the year	8,434	0	4,576	0	0	3,564	18	197	79
Impairments	340	0	340	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	(9,347)	0	(9,347)	0	0	0	0	0	0
Reclassified as held for sale	(28)	0	0	(28)	0	0	0	0	0
Disposals	(1,748)	0	0	0	0	(1,654)	(94)	0	0
Accumulated depreciation at 31 March 2012	23,436	0	0	0	0	21,966	32	944	494
Net book value									
NBV - Owned at 1 April 2011	52,169	25,990	16,536	484	906	7,368	115	572	198
NBV - PFI at 1 April 2011	150,776	0	148,561	0	0	2,215	0	0	0
NBV - Donated at 1 April 2011	248	0	112	0	0	117	0	6	13
NBV total at 1 April 2011	203,193	25,990	165,209	484	906	9,700	115	578	211
NBV - Owned at 31 March 2012	49,758	24,600	17,010	0	1,245	6,072	97	613	121
NBV - PFI at 31 March 2012	169,089	0	164,687	0	0	4,402	0	0	0
NBV - Donated at 31 March 2012	153	0	5	0	0	132	0	5	11
NBV total at 31 March 2012	219,000	24,600	181,702	0	1,245	10,606	97	618	132

12. Tangible Assets

12.3 Analysis of Tangible Assets

Net Book Value	Total £'000	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under Construction & POA £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
NBV - Protected Assets at 31 March 2013	196,111	24,600	171,511	0	0	0	0	0	0
NBV - Unprotected Assets at 31 March 2013	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
NBV - Protected Assets at 31 March 2012	197,485	24,600	172,885	0	0	0	0	0	0
NBV - Unprotected Assets at 31 March 2012	21,515	0	8,817	0	1,245	10,606	97	618	132
	219,000	24,600	181,702	0	1,245	10,606	97	618	132

Protected assets are land and buildings owned or leased by the Foundation Trust, the disposal of which may affect the Trust's ability to provide it's mandatory goods and services.

12.4 Net Book Value of property, plant and equipment in the Revaluation Reserve at 31 March 2013

	Total £'000	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under Construction & POA £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
As at 1 April 2012	52,709	19,170	33,361	0	0	177	0	0	1
Movement in year	(60)	0	0	0	0	(60)	0	0	0
As at 31 March 2013	52,649	19,170	33,361	0	0	117	0	0	1

12.5 Net Book Value of property, plant and equipment in the Revaluation Reserve at 31 March 2012

	Total £'000	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under Construction & POA £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000
As at 1 April 2011	37,155	20,824	15,151	858	0	315	2	3	2
Movement in year	15,554	(1,654)	18,210	(858)	0	(138)	(2)	(3)	(1)
As at 31 March 2012	52,709	19,170	33,361	0	0	177	0	0	1

12.6 Impairment Losses

The Trust carried out an impairment review of its non-current assets in March 2012. For land and buildings the Trust received a valuation report from the District Valuer prepared on a 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 a fall in value of land and a general increase in value of buildings compared to the carrying value at 31st March 2012. In line with IFRS the Trust was able to offset the fall in value of land against the relevant revaluation balance held for the applicable assets. However for one element of the Trust's buildings there was no remaining revaluation balance and this led to a charge to the Statement of Comprehensive Income relating to the impairment loss. The Trust carried out an impairment review in 2012/13 and was satisfied that the value of its non-current assets is not materially different from the fair value of these assets at that date.

Impairment of Assets	31 March 2013	31 March 2012
	£'000	£'000
Loss or damage from normal operations	0	0
Over specification of assets	0	0
Changes in market price	0	342
Reversal of impairments	0	0
TOTAL IMPAIRMENTS	0	342

12.7 Asset Valuations

The Trust received a MEA valuation from the District Valuer in March 2012. 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 £25,800,000; £163,833,000 and £nil respectively.

12.8 Non Current Assets Held For Sale

	Total	Property, Plant and Equipment
	£'000	£'000
NBV of Non Current Assets Held For Sale in disposal groups at 1 April 2012	0	0
Assets classified as available for sale during the year	0	0
Assets sold during the year	0	0
NBV of Non Current Assets Held For Sale in disposal groups at 31 March 2013	**0**	**0**
NBV of Non Current Assets Held For Sale in disposal groups at 1 April 2011	1,078	1,078
Assets classified as available for sale during the year	599	599
Assets sold during the year	(1,677)	(1,677)
NBV of Non Current Assets Held For Sale in disposal groups at 31 March 2012	**0**	**0**

The assets sold during 2011/12 represented the remaining housing stock held by the Trust which were sold at Auction.

12.9 Capital Commitments

Commitments under capital expenditure contracts at the end of the period, not otherwise included in these financial statements were £168,000 (31 March 2012 £1,341,000). This amount relates entirely to property, plant and equipment. There are no contracted capital commitments for intangible assets.

13. Inventories

	Year ended 31 March 2013 £'000	Year ended 31 March 2012 £'000
Drugs	1,849	1,733
Work in progress	0	0
Consumables	1,159	1,032
Energy	37	33
Inventories carried at fair value less costs to sell	0	0
Other	43	39
TOTAL Inventories	3,088	2,837

14. Trade Receivables and Other Receivables

14.1 Trade Receivables and Other Receivables

Current	Year Ended 31 March 2013 £'000	Restated Year Ended 31 March 2012 £'000
NHS Receivables - Revenue	4,897	3,846
Other receivables with related parties	35	81
Provision for impaired receivables	(824)	(790)
Prepayments (non PFI)	1,040	706
PFI Prepayments		
Prepayments - Capital contributions	0	0
Prepayments - Lifecycle replacements	0	0
Accrued income	119	150
Interest Receivable	10	5
Corporation tax receivable	0	0
Finance Lease Receivables	0	0
PDC dividend receivable	19	374
VAT Receivable	833	864
Other receivables	1,189	1,053
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	7,318	6,289
Non Current	£'000	£'000
Prepayments (non PFI)	3,396	3,661
PFI Prepayments		
Prepayments - Capital contributions	0	0
Prepayments - Lifecycle replacements	4,611	3,887
Other Receivables	1,307	1,185
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	9,314	8,733

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

The purchase and disposal of CRC Allowances are in settlement of the Carbon Reduction Commitment Scheme (CRC) which is a mandatory cap and trade scheme for non-transport CO2 emissions. As the Trust is registered with the CRC scheme, it is required to purchase and surrender allowances to the Government in settlement of the CO2 liability. Allowances are recorded in Note 17 Provision for Liabilities and Charges in the year of emission and allowances purchased and disposed the year. The first year of liability was 2011/12. There were no allowances held at 31 March 2013.

* Restated - additional analysis was included in the 2012/13 accounts and therefore 2011/12 has been restated to reflect this.

14.2 Provision for impairment of receivables

	As at 31 March 2013 £'000	As at 31 March 2012 £'000
At 1 April	790	757
Increase in provision	129	167
Amounts utilised	(37)	(18)
Unused amounts reversed	(58)	(116)
At 31 March	824	790

14.3 Analysis of impaired receivables

	As at 31 March 2013		As at 31 March 2012	
	Trade	Other	Trade	Other
Ageing of impaired receivables	£'000	£'000	£'000	£'000
0 - 30 Days	4	0	21	0
30 - 60 Days	0	0	0	0
60 - 90 Days	4	0	0	0
90 - 180 Days	7	0	0	0
over 180 Days (over 6 months)	42	767	17	752
Total	57	767	38	752
Ageing of non-impaired receivables past their due date	£'000	£'000	£'000	£'000
0 - 30 Days	5,024	99	269	153
30 - 60 Days	42	107	15	138
60 - 90 Days	7	132	32	99
90 - 180 Days	5	354	30	196
over 180 Days (over 6 months)	4	792	22	738
Total	5,082	1,484	368	1,324

15. Trade and Other Payables

	As at 31 March 2013	As at 31 March 2012
Current	£'000	£'000
Receipts in advance	0	0
NHS payables - revenue	451	834
Amounts due to other related parties	2,101	1,975
Trade payables - capital	609	1,360
Other trade payables	0	0
Taxes payable	3,737	3,647
Other payables	5,542	4,386
Accruals	3,288	2,933
PDC dividend payable	0	0
Reclassified to liabilities held in disposal groups in year	0	0
TOTAL CURRENT TRADE & OTHER PAYABLES	15,728	15,135
Non-current		
Receipts in advance	0	0
NHS payables - revenue	0	0
Amounts due to other related parties	0	0
Trade payables - capital	0	0
Other trade payables	0	0
Taxes payable	0	0
Other payables	0	0
Accruals	0	0
TOTAL NON CURRENT TRADE & OTHER PAYABLES	0	0

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.

16. Other Liabilities	As at 31 March 2013 £'000	As at 31 March 2012 £'000
Current		
Deferred Income	245	2,048
Deferred PFI credits	0	0
Net Pension Scheme Liability	0	0
TOTAL OTHER CURRENT LIABILITIES	245	2,048
Non-current		
Deferred Income	0	0
Deferred PFI credits	0	0
Net Pension Scheme Liability	0	0
TOTAL OTHER NON CURRENT LIABILITIES	0	0

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

17. Provision for Liabilities and Charges

	Current		Non Current	
	31 March 2013	31 March 2012	31 March 2013	31 March 2012
	£'000	£'000	£'000	£'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Other legal claims	192	138	0	0
Agenda for Change	0	404	0	0
Other	238	164	0	0
Total	430	706	0	0

	Total	**Pensions - former directors**	**Pensions - other staff**	**Other legal claims**	**Agenda for Change**	**Other**
	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April 2012	706	0	0	138	404	164
Arising during the year	408	0	0	167	0	241
Utilised during the year - cash	(419)	0	0	(32)	(229)	(158)
Utilised during the year - accruals	0	0	0	0	0	0
Reversed unused	(265)	0	0	(81)	(175)	(9)
At 31 March 2013	430	0	0	192	0	238
Expected timing of cashflows:						
- not later than one year;	430	0	0	192	0	238
- later than one year and not later than five years;	0	0	0	0	0	0
- later than five years.	0	0	0	0	0	0
TOTAL	430	0	0	192	0	238

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.

Other provisions include assessed liabilities in respect of the balance outstanding for the CRC Scheme, and other litigation.

The NHS Litigation Authority has included in its provisions at 31 March 2013 £61,254,000 (2011/12 £55,401,000) in respect of clinical negligence liabilities for the Trust.

18. Prudential Borrowing Limit

NHS Foundation Trusts are required to comply and remain within a prudential borrowing limit. This is made up of two elements:

* the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
* the amount of any working capital facility approved by Monitor.

As per Section 46 of the Act, the Trust has a Prudential Borrowing Limit of £172,300,000 in 2012/13 (2011/12 £174,700,000). The Trust has not borrowed in 2012/13 (2011/12 £ nil) and at 31 March 2013 its long term borrowing was £151,833,000 (2011/12 £156,262,000) in relation to the finance lease of the Trust PFI Scheme. The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £156.3M and
(ii) Approved Working Capital Facility not to exceed £16.0M

Financial Ratio	2012/13		2011/12	
	Actual	Plan	Actual	Plan
Maximum Debt / Capital Ratio	56.0%	56.0%	57.0%	62.0%
Minimum Dividend Cover	6.0x	5.0x	5.8x	5.0x
Minimum Interest Cover	2.3x	2.1x	2.2x	2.2x
Minimum Debt Service Cover	1.6x	1.4x	1.5x	1.5x
Maximum Debt Service to Revenue	5.1%	5.4%	4.9%	5.0%

The Trust has an approved working capital facility of £10.0M. The Trust had not utilised any of its working capital facility at 31 March 2013 (2011/12 £ nil).

Further information on the NHS Foundation Trust Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

There has been no necessity to make use of the Trust's Prudential Borrowing Limit or to use its overdraft facility. The decrease in the Trust's Prudential Limit to £156.3M (31 March 2012 £158.7M) is in relation to compliance with the International Financial Reporting Standards (IFRS) which require the assets and liabilities of the Trust's PFI Initiative scheme to be accounted for within its Statement of Financial Position, see note 24 to the accounts.

	2012/13	**2011/12**
	£'000	£'000
Total long term borrowing limit set by Monitor	156,300	158,700
Working capital facility agreed by Monitor	16,000	16,000
TOTAL PRUDENTIAL BORROWING LIMIT	**172,300**	**174,700**
Long term borrowing at 1 April	156,262	158,251
Net actual borrowing/(repayment) in year - long term	(4,429)	(1,989)
Long term borrowing at 31 March	151,833	156,262

19. Borrowings

	As at 31 March 2013	As at 31 March 2012
	£'000	£'000
Current		
Obligations under Private Finance Initiative contracts (excl lifecycle)	4,978	4,897
Total Current borrowings	4,978	4,897
Non Current		
Obligations under Private Finance Initiative contracts	146,855	151,365
Total Other non Current Liabilities	146,855	151,365

20 Cash and Cash Equivalents

	As at 31 March 2013	As at 31 March 2012
	£'000	£'000
At 1 April	36,346	33,441
Transfers By Absorption	(1,611)	0
Net change in year	(1,829)	2,905
At 31 March	32,906	36,346
Broken down into:		
Cash at commercial banks and in hand	2	3
Cash with the Government Banking Service	32,904	36,343
Other current investments	0	0
Cash and cash equivalents as in Statement of Financial Position	32,906	36,346
Bank overdraft	0	0
Cash and cash equivalents as in Statement of Cash Flows	32,906	36,346

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.

21 Events after the reporting period

There have not been any events after the reporting period.

22 Contingencies

The Trust does not have any contingent assets or liabilities in 2012/13 (2011/12 £nil).

23. 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. 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 2013	31 March 2012
Compensation	£ million	£ million
Salaries and short-term benefits	0.88	0.80
Post-employment benefits	0.70	0.70
	1.58	1.50

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of Monitor. 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 department. These entities are listed below:

	Year ended 31 March 2013				Year ended 31 March 2012			
	Income	Expenditure	Receivable	Payable	Income	Expenditure	Receivable	Payable
	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million
Black Country Partnership FT	1.06	0.54	0.18	-	0.90	-	0.26	-
West Midlands Strategic Health Authority	7.48	-	-	-	7.77	-	-	-
Birmingham East & North PCT	18.05	0.02	0.29	-	11.74	-	-	-
Dudley PCT	206.93	3.03	1.62	-	204.17	3.44	2.35	0.02
Dudley and Walsall Mental Health Trust	1.36	0.04	0.08	-	1.12	-	-	0.02
Royal Wolverhampton NHS Trust	0.19	1.05	-	0.16	0.32	1.00	-	-
Sandwell PCT	33.82	-	0.76	-	33.75	-	0.51	-
Sandwell and West Birmingham Hospitals	0.19	0.59	-	0.09	0.27	0.80	-	0.03
South Staffordshire PCT	10.02	-	0.30	-	9.38	-	0.19	-
University Hospital Birmingham FT	0.59	0.16	-	0.03	1.12	0.16	-	-
Walsall PCT	1.15	-	0.64	-	0.49	-	-	-
Wolverhampton City PCT	4.17	-	0.54	-	3.44	-	0.22	-
Worcestershire Acute Hospitals Trust	0.27	0.53	-	0.08	0.15	0.65	0.05	-
Worcestershire PCT	3.75	-	-	-	4.01	-	0.02	-

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. These entities are listed below:

	Year ended 31 March 2013				Year ended 31 March 2012			
	Income	Expenditure	Receivable	Payable	Income	Expenditure	Receivable	Payable
	£ million	£ million	£ million	£ million	£ million	£ million	£ million	£ million
HM Revenue & Excise	-	-	0.83	-	-	-	0.86	-
NHS Blood and Transplant Agency	-	1.45	0.02	-	-	1.54	-	0.02
NHS Business Services Authority	-	-	-	-	-	-	-	0.19
NHS Litigation Authority	-	6.46	-	-	-	5.81	-	-
NHS Pensions	-	15.77	-	-	-	15.47	-	1.98
Dudley Metropolitan Borough Council	0.63	1.38	0.02	-	0.64	1.31	-	-

24. Private Finance Initiatives

24.1 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 'on-balance 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 2013 £'000	31 March 2012 £'000
Gross PFI Liabilities		162,587	166,727
of which liabilities are due			
- not later than one year;		15,732	15,362
- later than one year and not later than five years;		19,912	19,588
- later than five years.		126,943	131,777
Finance charges allocated to future periods		(10,754)	(10,465)
Net PFI liabilities		**151,833**	**156,262**
- not later than one year;		4,978	4,897
- later than one year and not later than five years;		19,912	19,588
- later than five years.		126,943	131,777

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 2013 £'000	31 March 2012 £'000
Within one year	21,064	20,420
2nd to 5th years (inclusive)	84,254	81,679
Later than 5 Years	484,464	490,075
Total	**589,782**	**592,174**

Total length of the project (years)	36
Number of years to the end of the project	28

25. 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:

25.1 Financial Risk

Because of the continuing service provider relationship that the Trust has with Primary Care Trusts (PCT's) and the way those PCT's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. From April 2013 the NHS reorganisation replaces PCT's with a NHS England and Clinical Commissioning Groups (CCG's). This reorganisation means the same continuing service provider relationship will exist and does not increase the financial risk. 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.

25.2. 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.

25.3 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.

25.4 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 2013 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.

25.5 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. NHS Foundation Trusts are committed to comply with the Prudential Borrowing Code made by Monitor, the Independent Regulator of Foundation Trusts, and further details of the Foundation Trusts compliance can be found at note 18 “Prudential Borrowing Limit.”

The Trust is therefore not exposed to significant liquidity risk.

25.6 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.

25.7 Financial Assets and Liabilities By Category

The following tables show by category the Trust's financial assets and financial liabilities at 31 March 2013 and 31 March 2012.

Financial Assets	As at 31 March 2013		As at 31 March 2012	
	Total	Loans and Receivables	Total	Loans and Receivables
	£'000	£'000	£'000	£'000
NHS Trade and other receivables excluding non financial assets	4,932	4,932	3,846	3,846
Non NHS Trade and other receivables excluding non financial assets	381	381	431	431
Other Investments	0	0	0	0
Other Financial Assets	0	0	0	0
Non current assets held for sale and assets held in disposal group excluding non financial assets	0	0	0	0
Cash and cash equivalents (at bank and in hand)	32,906	32,906	36,346	36,346
	38,219	38,219	40,623	40,623

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

Financial Liabilities	As at 31 March 2013		As at 31 March 2012	
	Total	Other financial Assets	Total	Other financial Assets
	£'000	£'000	£'000	£'000
Borrowings excluding Finance lease and PFI liabilities	0	0	0	0
Obligations under finance leases	0	0	0	0
Obligations under Private Finance Initiative contracts	151,833	151,833	156,262	156,262
NHS Trade and other payables excluding non financial liabilities	2,552	2,552	2,953	2,953
Non NHS Trade and other payables excluding non financial liabilities	9,439	9,439	8,493	8,493
Other financial liabilities	0	0	0	0
Provisions under contract	430	430	706	706
Liabilities in disposal groups excluding non-financial assets	0	0	0	0
	164,254	164,254	168,414	168,414

25.8 Maturity of Financial Liabilities

	As at 31 March 2013	As at 31 March 2012
	£'000	£'000
In One Year or Less	17,399	17,049
In more than one year but not more than two years	4,978	4,897
In more than two years but not more than five years	14,934	14,691
In more than five years	126,943	131,777
Total	164,254	168,414

26. Third Party Assets

The Trust held £29,000 as cash at bank or in hand at 31 March 2013 (31 March 2012 £ nil) 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.

27. 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. In the period reported for 2012/13 the Trust had 99 (2011/12 38) separate losses and special payments, totalling £135,000 (2011/12 £75,000). These were in relation to cash losses and ex-gratia payments to patients.

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.

28. 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 7 January 2013.

The Dudley Group NHS
NHS Foundation Trust

Quality Report
2012/13

RESPECT

CARE

RESPONSIBILITY

Content

PART 1

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE TRUST BOARD

PART 3

OTHER QUALITY INFORMATION

PART 3

ANNEX

Throughout the document are a number of quotes from patients, the majority of which are from conversations with independent outside assessors.

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 April 2012 to the end of March 2013.

The very core of our work is to provide high quality care for all of our patients.

By this we mean we aim 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 given 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.

With regards to the report's format, 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 six. More information on each priority can be found on the page numbers listed in the table. This further information includes progress made to date, as well as our new targets for 2013/14. 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 three of the elements of quality listed above. These hopefully give a rounded view of what is occurring across the whole of the Trust. Although some parts of the report are divided into hospital and community sections, we have deliberately not included a separate distinct section for community services as we take the patient perspective that services should be seamless and integrated and many of our services cross the hospital and community boundary.

The report indicates that we are constantly monitoring the quality of our care in a variety of ways in order to both assure patients and ourselves of where we are doing well and to learn where we need to change practice and improve our services. We believe the wide range of measures and checks detailed in this report 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. This view is based not only on our internal monitoring but, as the report shows, on many outside organisations' reviews of the Trust. I am particularly pleased to report that the main hospital inspectorate, the Care Quality Commission, has visited the Trust on a number of occasions during the year, both announced and unannounced, and after talking to staff and patients and checking a variety of documentation, always found the Trust compliant with its standards.

Our quality objectives

The Trust's strategic objectives for quality, as set out in the 'Annual Forward Plan' dated May 2012, are:

- To exceed all internal quality targets by 2014 and to be recognised as the highest quality service provider in the region by patient groups, staff and other key stakeholders.
- To provide excellent service and care making patients feel involved, valued and informed.

Our quality priorities

You will see in the following pages that we have performed very well in relation to our 2012/13 priorities. In fact, we have achieved or exceeded them all except one. The successful priorities relate to: positive patient experience feedback of our hospital, reducing inpatient MRSA and Clostridium difficile infections, improving the recording of fluid intake and output of patients, improving the assessing of patients' nutritional status and reducing significantly the numbers of both hospital and community acquired pressure ulcers. I am particularly pleased by our 50 per cent reduction in stage three and four pressure sores in the hospital as we also managed to reduce the numbers by half in the previous year. In saying that, we are not complacent, and recognise we need to be working towards further reductions next year. With regards to the patient experience target in the community that was only partially achieved, we realise that we need to improve the implementation and patients' understanding of the Single Assessment Process. With regards to 2013/14, we have retained all of the topics from 2012/13 due to their importance, although we have amended the specific targets dependant on the detailed outcomes in 2012/13.

Measuring quality

Although the report includes a range of objective indicators of quality, we have also included a number of specific examples of quality initiatives at the Trust. We couldn't include them all but hopefully the examples give a flavour of the quality of care, awards, innovation and initiatives that Trust staff have achieved and implemented in the year.

I am especially pleased to report that the Trust is receiving positive feedback from our patients in the new 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 particularly glad to report that one of our nurses has won the prestigious national Ward Sister of the Year award and the skills of our newly appointed Head of Medical Education have been recognised (Section 3.4.2).

I hope you will find useful the information on the quality priorities we have chosen to focus on, the ways in which we assure ourselves of 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 account and also the priorities we have chosen. You can either phone the communications team on (01384) 244404 or email communications@dgh.nhs.uk

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

Signed:

Paula Clark, Chief Executive Date: 08/05/2013

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE TRUST BOARD

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 2013/14. (N/A applies to priorities not being in place at that time).

Priority	2009/10	2010/11	2011/12	2012/13	2013/14	Comments	More info
PATIENT EXPERIENCE Increase in the number of patients who report positively on their experience on a number of measures	√ Achieved	We improved on one measure but had a slight decrease in another	Hospital: Partially Achieved Community: √ Achieved	Priority 1 Hospital: √ Achieved Community: Partially Achieved	Priority 1		8-11
PRESSURE ULCERS Improve systems of reporting and reducing the occurrence of avoidable pressure ulcers	N/A	N/A	Hospital: √ Achieved Community: Partially Achieved	Priority 2 Hospital: √ Achieved Community: √ Achieved	Priority 2		12-15
INFECTION CONTROL Reduce our MRSA rate in line with national and local priorities Reduce our Clostridium Difficile rate in line with (or better than) local and national priorities	√ Achieved	√ Achieved	√ Achieved Not Achieved	Priority 3 √ Achieved	Priority 3		15-17
NUTRITION Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission	N/A	N/A	N/A	Priority 4 √ Achieved	Priority 4		18-22
HYDRATION Increase the number of patients who have fluid balance charts completed	N/A	N/A	N/A	Priority 5 √ Achieved	Priority 5		18-22
HIP OPERATIONS Increase the number of patients who undergo surgery for hip fracture within 36 hours of admission (where clinically appropriate to do so)	N/A	√ Achieved	√ Achieved	N/A	N/A	*As the target was achieved for two consecutive years this priority has now been replaced for 2012/13.*	N/A
CARDIAC ARRESTS Reduce the numbers of cardiac arrests	√ Achieved	√ Achieved	N/A	N/A	N/A	*With a decrease from 32 per month in 2008 to 13 per month by 2011 this issue no longer remained a challenge.*	N/A

2.1.2 Choosing Our Priorities for 2013/14

The Quality Account Priorities for 2012/13 covered the following five topics:

Patient Experience **Infection Control** **Pressure Ulcers**

Nutrition **Hydration**

These topics were agree by the Trust Board on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Indicators (see Section 3.3.4)) 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, at which 55 people attended, comprising 24 staff (three of which are governors), five other governors (four public, one appointed), 21 Foundation Trust members and five others from the following organisations: Dudley LINK, Dudley PCT, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC).

Two of the above topics (Nutrition/Hydration) were new in 2012/13 with the others rolling over from previous years (Patient Experience/Infection Control have been continual priorities since the commencement of Quality Accounts in 2009/10 and Pressure Ulcers were introduced in 2011/12).

In November 2012, the Trust Board agreed that the existing topics should be retained for 2013/14. This is because Nutrition and Hydration remain important and were new in 2012/13 and so improvement trends over time need to be seen before they are removed as a priority. The other three topics remain important issues both from a local and national perspective. Patient experience is at the core of why the Trust exists; the reduction and maintenance of low infection rates are a key commissioner and patient requirement and there is a national campaign of zero tolerance to pressure ulcers.

As stated above, the five priority topics originated from an event attended by staff, governors, Foundation Trust Members and representatives from local organisations. The retention of the topics was further discussed and agreed at a Governors workshop in November 2012 and at the full Governors meeting in December 2012. Input from members was also canvassed through the Trust members magazine 'Your Trust' and from the general public via the Trust website.

> "The care, professionalism and willingness to answer questions was excellent."

2.1.3 Our Priorities
Priority 1 for 2012/13

PATIENT EXPERIENCE	
Hospital	**Community**
(a) Increase the number of patients who receive enough assistance to eat their meals from 81 per cent to 85 per cent. (b) Increase the number of patients who receive enough information about ward routines from 57 per cent to 65 per cent.	(a) Increase the number of patients who use their Single Assessment Process folder to monitor their care from 75.3 per cent to 80 per cent. (b) Increase the number of patients who would know how to raise a concern about their care and treatment if they wished to do so from 80.8 per cent to 85 per cent.

How we measure and record this priority

Hospital

This priority has been measured using our real-time survey system. A random sample of inpatients are asked to share their experiences by participating in the survey about their stay before they leave hospital. Responses to the surveys are inputted directly into a hand-held computer and downloaded straight into our database to provide timely feedback.

During 2012/13 the Trust has continued to develop its real-time survey system resulting in 3063 patients participating, more than double the response rate from the previous year (1286).

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. There were 1183 responses to the survey, with question (a) answered by 326 respondents and (b) answered by 1140 – the difference in responses is because not all patients have a Single Assessment Process folder, which is a useful document that acts as a communication tool for staff from all services who contribute to the care and management of people with long-term conditions.

Developments that occurred in 2012/13

Monthly Essence of Care meetings continue to reinforce the need to identify patients who require assistance at mealtimes by utilising the behind the bed boards, red tray system and electronic handover. This has been complemented by a poster campaign to raise awareness of the 15 minute meal bell alert, compliance of which is monitored via mealtime audit. The mealtime audits check usage of the behind the bed boards which share important information around nutritional needs.

Nutrition support workers remain in post on ward A2 since May 2011. During 2012/13 a staffing review discussed adopting the nutrition support worker role more widely; however, it was decided to appoint clinical support workers who could assist patients with additional tasks as well as assisting with nutritional needs.

During 2012/13 we also introduced bespoke welcome leaflets for each ward. The 'Welcome to the Ward' leaflets contain important information such as: visiting times, mealtime routines, uniforms, who's who and ward contact numbers both for relatives and for patients if they have health concerns once they return home.

The leaflets are printed on A5 card to sit on the bedside cabinet where visitors can also read the important information contained within.

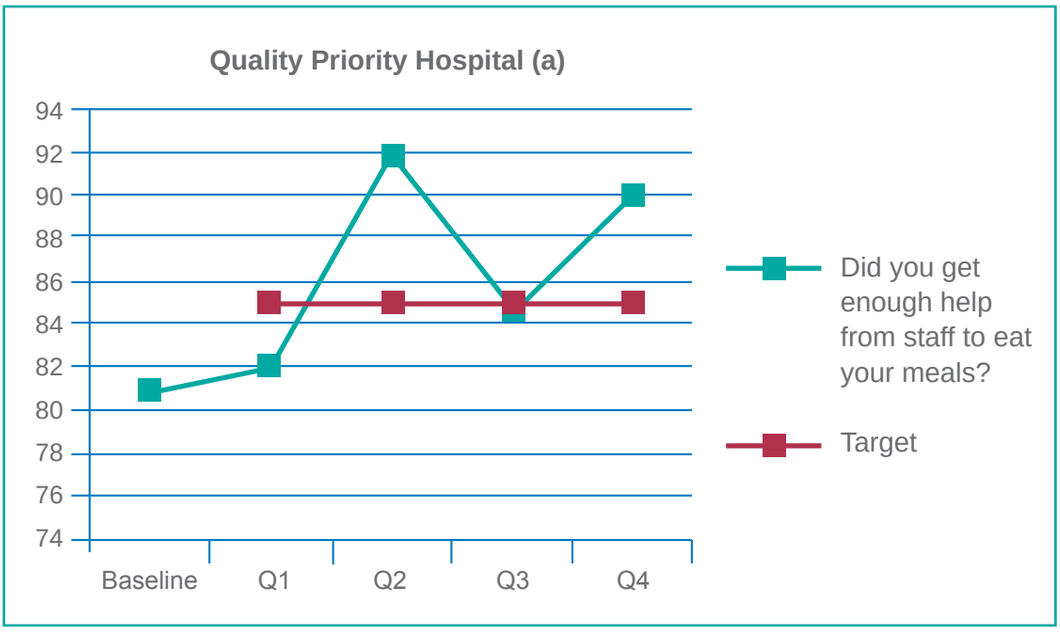
In the community, we have been working with Dudley Council to develop an improved Single Assessment Process folder and this has taken longer to complete than we expected. The document is now almost complete so will be launched in 2013/14.

We have also ensured that PALS leaflets are available for patients, refreshed posters are in clinic areas advising patients how to complain if they wish to and have given PALS advice as part of assessments.

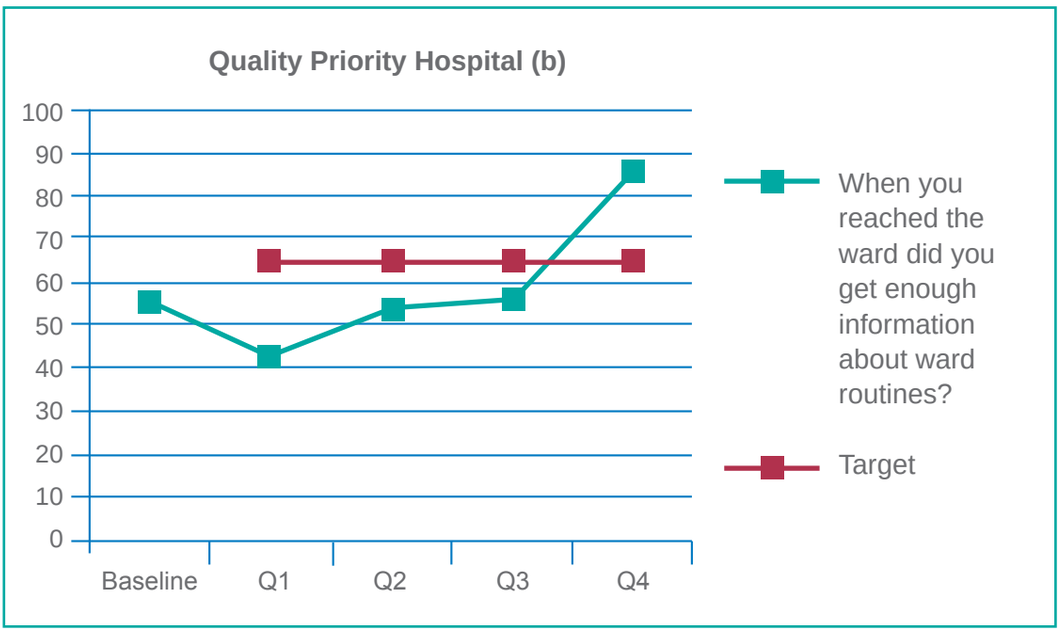
Current status

Hospital

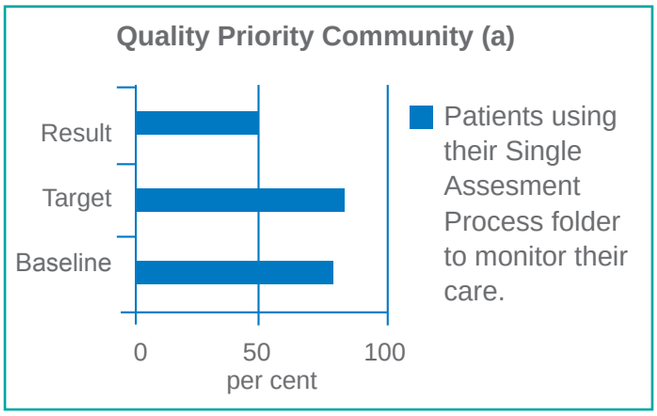
(a) The Trust exceeded its target in quarter two and quarter four achieving a score of 92 and 90 respectively against a target of 85. However, some fluctuation in the score was apparent during the year and, therefore, this priority will be carried forward to 2013/14 to aim for a consistent service.

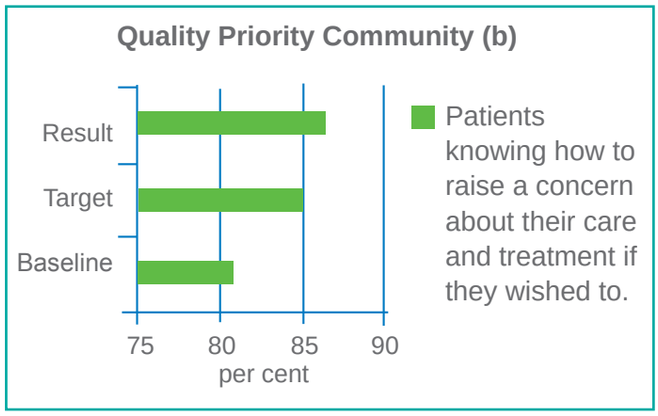


(b) The introduction of the new 'Welcome to the Ward' leaflets in January 2013 has seen this priority being achieved in quarter four with the score rising to 87.2 against a target of 65. We will continue to monitor that leaflets are given out but will remove this as a priority as the actions taken have been successful.



Community





The patient experience quality priority for community has been partially achieved for 2012/13. We are pleased that the number of patients reporting that they would know how to raise a concern about their care and treatment if they wished to do so has risen from 80.8 per cent to 86.8 per cent against a target of 85 per cent. However, the number of patients using their Single Assessment Process folder to monitor their care has dropped from 75.3 per cent in 2011/12 to 49.4 per cent. While this is disappointing, we recognise that finalising the new Single Assessment Process folder and educating patients and families/carers on its use will help us to improve next year.

New Priority 1 for 2013/14

PATIENT EXPERIENCE	
Hospital	**Community**
a) Maintain an average score of 85 or above throughout the year for the patients who report receiving enough assistance to eat their meals. b) By the end of the year, at least 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. 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.

Rationale for inclusion

We have retained, and in most cases strengthened, three out of the four patient experience targets from 2012/13. The reason we have carried these forward is because we felt that there was still progress to be made.

The hospital (a) target had seen fluctuation during the year and we are looking for a more consistent approach to this important aspect of patient care. Hospital (b) is a new target for 2013/14 aimed at ensuring timely response to call bells as this is something that patient feedback tells us we could do better.
The community (a) target saw a large decrease in score in 2012/13 so is carried forward with the same target into 2013/14. The newly developed Single Assessment Process folder is being renamed the Health and Social Care Passport; this new name is reflected in the priority above. Community (b) was achieved and is carried forward with a stretched target to ensure that we have processes in place so that patients know how to raise a concern if they wish to.

> I have had good treatment, I couldn't ask for better. They tell me everything they are doing.

Developments planned for 2013/14

- Include the hospital patient experience quality priority in the newly developed Quality Outcome Measures Dashboard, which is a list of key quality indicators, to give lead nurses and matrons timely feedback.
- Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells, thereby allowing sufficient time for patients and nursing staff to adequately prepare for mealtimes.
- Recruit additional nutrition support workers within the Stroke and Elderly Care Department.
- Increase the number of volunteers trained to provide mealtime assistance.
- Include details in our patient information around the welcoming of family members to assist their relatives at mealtime if they wish to do so.
- Launch the new Health and Social Care Passport, which is a document for information sharing between the patient, carers and health and social care professionals. It will be simpler to follow and will encourage patient and carers to use to monitor their care.
- Produce an information leaflet for existing Single Assessment Process folder holders to explain to them how to use the document to monitor their care.
- Extend the annual survey to try to discover the reason for patients choosing not to use the documents to monitor their care.
- Pilot an improved system of call bell answering on the surgical wards, monitor its impact and roll out to other areas dependant on its success.
- Design and trial new posters giving patients clear information on the call bell system.

Board sponsor: Denise McMahon, Director of Nursing

Operational lead: Mandy Green, Deputy Head of Communications and Patient Experience

Priority 2 for 2012/13

PRESSURE ULCERS	
Hospital	**Community**
Reduce avoidable stage three and four hospital acquired pressure ulcers, against activity, so that the number for 2011/12 has been reduced by 50 per cent in 2012/13.	Reduce avoidable stage three and four community acquired pressure ulcers that occur on the district nurse caseload through the year, so that the number for the final quarter of 2011/12 has been reduced by 10 per cent at the second quarter of 2012/13 (Jul-Sep) and by 20 per cent at the final quarter of 2012/13 (Jan-Mar).

How we measure and record this priority

Pressure ulcers, also called pressure sores and bed sores, are graded from 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 is 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 by the Strategic Health Authority. It is recognised that pressure damage can occur but not be visible immediately.

> One thing I really like is the way they respect your privacy.
> They are always closing the curtains when they come to talk to you.

Developments that occurred in 2012/13

A new campaign was launched to follow on from the 'We Love Your Skin' campaign. The '50 Day Dash' was an Olympic themed campaign with the aim to reach 50 days free from pressure ulcers, giving wards a visual representation of their progress. Awards were presented to those wards that were successful, and the race continues, with some wards having reached 150 days pressure ulcer free.

There is now a more robust reporting system for the hospital and community to ensure all pressure ulcers are reported through Datix and verified by a Tissue Viability nurse, although further work continues to ensure that nurses correctly differentiate pressure ulcers from moisture lesions.

In order to ensure the same standard of pressure ulcer prevention across the Trust, a joint pathway has been developed between the hospital and community.

The pressure ulcer prevention and management documents were launched in the community in November 2012. This document includes a skin bundle which is a document completed on a regular basis by nursing staff including all the important components of care to prevent pressure ulcers. SKIN is an acronym which stands for *Surface, Keep Moving, Incontinence* and *Nutrition*. Progress is now underway to audit the correct completion of the documentation and skin bundle.

Skin bundle training has taken place for all the Trust's community nurse and specialist teams. In addition, we have organised this training for both carers in residential homes and home carers. It has been recognised that this needs to continue as a rolling programme of education for all carers.

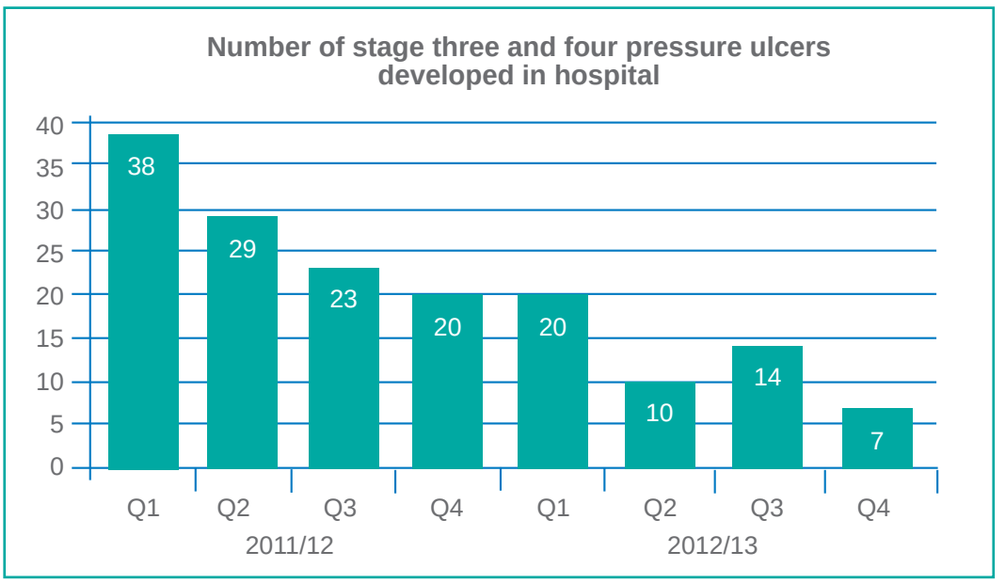
Meetings have taken place with managers of private care agencies as there was some initial resistance to complete this documentation. Initial reservations, however, have since been addressed and plans are in place to initiate their training sessions.

All stage three and four pressure ulcer incidents continue to be discussed and monitored in the pressure ulcer group meetings on a weekly basis, ensuring that lessons are learned to reduce reoccurrence.

Current status

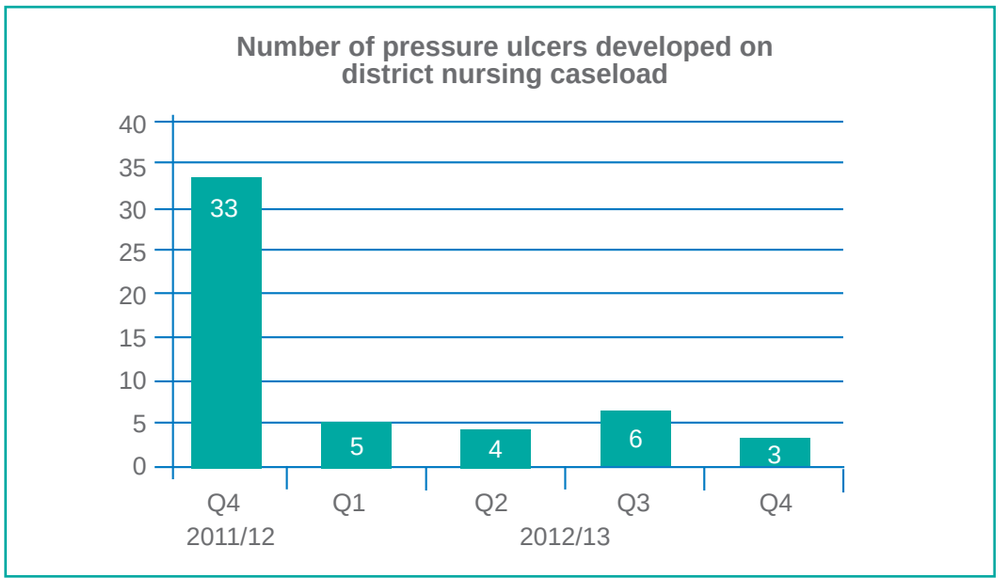
Hospital

The graph below shows the number of stage three and four pressure ulcers that developed in the hospital from the first quarter of 2011/12, including all four quarters of this year (2012/13).



It can be seen that the number of pressure ulcers continues to fall compared to last year. We set ourselves the ambitious target of reducing them by half from last year after successfully reducing them by half from the year before. It can be seen that last year we had 110 of these ulcers but only 51 this year and so we are very pleased to note that we have managed to achieve this ambitious target again due to the efforts of all the staff involved.

Community



The community target of a reduction of 10 per cent in the second quarter from the final quarter of 2011/12 was exceeded considerably with a reduction of over 85 per cent. This means that, in effect, both the half year and end of year targets were met together and in advance.

New Priority 2 for 2013/14

PRESSURE ULCERS	
Hospital	**Community**
Reduce avoidable stage four hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50 per cent in 2013/14. Reduce avoidable stage three hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.	Reduce avoidable stage three and four community 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.

Rationale for inclusion

- Pressure ulcers are difficult to treat and slow to heal, and prevention is therefore a priority.
- Although the Trust achieved its targets in 2012/13, 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.

> They help me move around and they told me that would help.

Developments planned for 2013/14

Actions being undertaken to achieve the Trust target include:

- Continue to promote the '50 Day Dash' campaign.
- The Tissue Viability team is planning a trolley dash for the hospital to continue the message of zero tolerance, and to highlight the importance of elevating patients heels off the surface with a suggestion box on the day for staff to inform the Trust how we can improve pressure ulcer prevention. This trolley dash will also spread the message of a different staging tool to assess the severity of pressure ulcers.
- Regular equipment sessions have been organised to inform community nursing teams about the correct use of equipment and fault finding.
- Education sessions will continue for all Trust staff.
- The team will continue to work with private care agencies and organise education sessions and updates as required.
- The Tissue Viability team will support nursing homes with the formulation of a mattress selection guide.

Board Sponsor: Denise McMahon, Director of Nursing

Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

Priority 3 for 2012/13

INFECTION CONTROL

Reduce our MRSA and Clostridium difficile (C. diff) rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than two post 48hr cases; C. diff is no more than 77 post 48hr cases in 2012/13.

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. The Trust, as part of the local health economy, 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 (PHE) for publication.

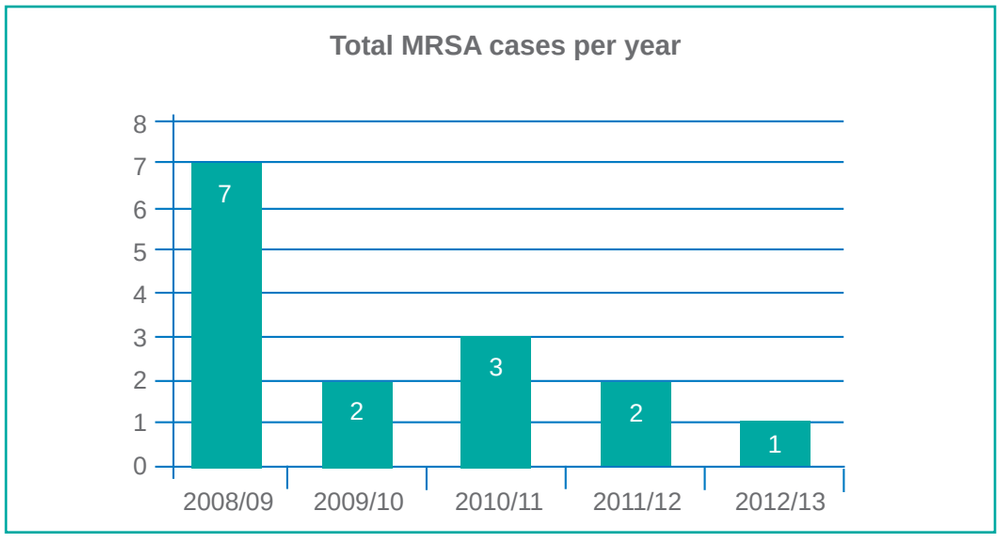
Developments that occurred in 2012/13

- Introduced hydrogen peroxide 'fogging' for the inpatient areas when patients are discharged to reduce cross contamination.
- Improved access to training for antimicrobial (drugs that destroy disease-carrying micro-organisms) prescribing by the development of an online package.
- Agreed competencies for the nursing element of cleaning the environment.
- Agreed and reported competencies of contracted cleaning staff.
- Improved information gathering including feedback and changes in practice regarding anti-microbial prescribing, bringing more senior medical input into the root cause analysis process.
- Introduced the new Department of Health testing algorithm for C. diff.
- Expanded the National Patient Safety Agency (NPSA) infection prevention project into the surgical and high dependency areas.
- Introduced a more systematic process for the usage of protein pump inhibitors medication used for patients with stomach problems.
- Monitored and recorded the time it takes to place patients into side rooms once an infection has been identified.

- Appointed an analyst to assist with the management of all the information required to closely monitor and reduce infection rates.
- Monitored mortality rates when infections are involved.

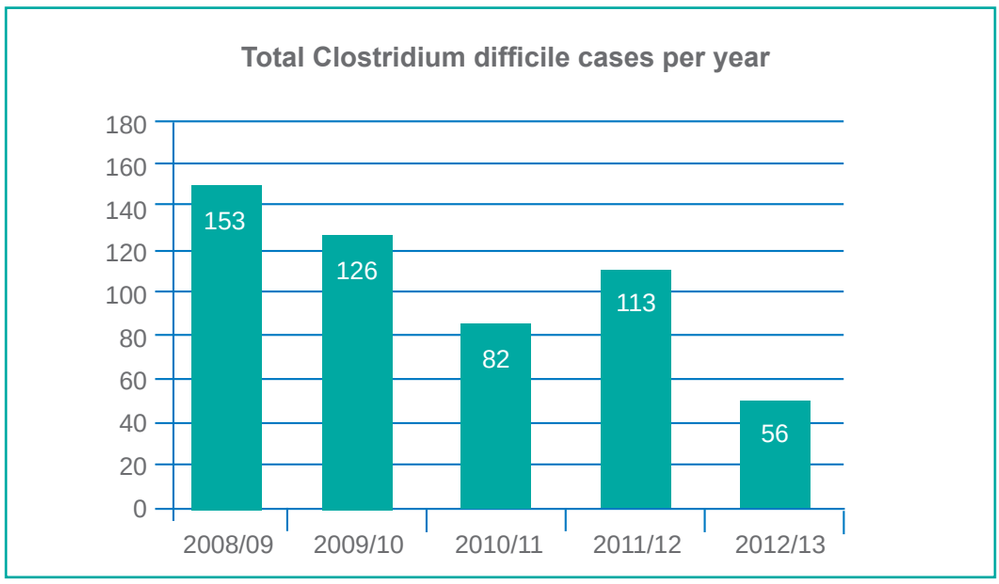
Current status MRSA

We continue our good work to maintain a low level of MRSA Bacteraemia. The graph below shows the continued reduction of MRSA bacteraemia cases (post 48 hr, i.e. patients who acquired it whilst in hospital) from a total of seven in 2008/09 to a total of one in 2012/13.



Current status C. diff

In addition, we have managed to reduce our Clostridium difficile (C. diff) cases both from last year and our previous lowest annual figure (2010/11). This year we have come in under threshold having had 56 in 2012/13. The graph below shows the total number of C. diff cases recorded greater than two days after admission, showing the reduction from a total of 238 in 2007/08 to a total of 56 in 2012/13.



New Priority 3 for 2013/14

INFECTION CONTROL

Reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C. diff is no more than 38 post 48hr cases in 2013/14.

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.
- Feedback from our patients, staff, community groups and Governors indicates this should remain a target.

Developments planned for 2013/14

Actions planned to achieve the above aims include:

- Continue to develop education programmes and improve the attendance of staff at the relevant sessions.
- Increase the rate of MRSA screening for emergency patients.
- Promote effective antimicrobial prescribing.
- Roll out the availability of the 'fogging' service that contributes to the prevention of cross infection.

Board sponsor: Denise McMahon, Nursing Director/Director of Infection Prevention and Control

Operational lead: Dawn Westmoreland, Consultant Nurse, Infection Prevention & Control

> "They have given me lots of information about what will happen and what other support I can get. I am reading through this."

Priorities 4 and 5 for 2012/13

NUTRITION

Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission.

By September 2012 at least 90 per cent of patients will have the risk assessment completed and this will continue for the rest of the year.

HYDRATION

Increase the number of patients who have their fluid balance charts fully completed.

By September 2012 at least 70 per cent of patients will have their fluid balance chart fully completed and this will rise to at least 90 per cent by the end of the year (March 2013).

How we measure and record this priority

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 Malnutrition Universal Screening Tool (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 MUST has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. Locally, 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. In 2012/13 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 of 69 per cent or less. Due to the overall improvement in scores across the board, for 2013/14 a 'Green' will be 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.

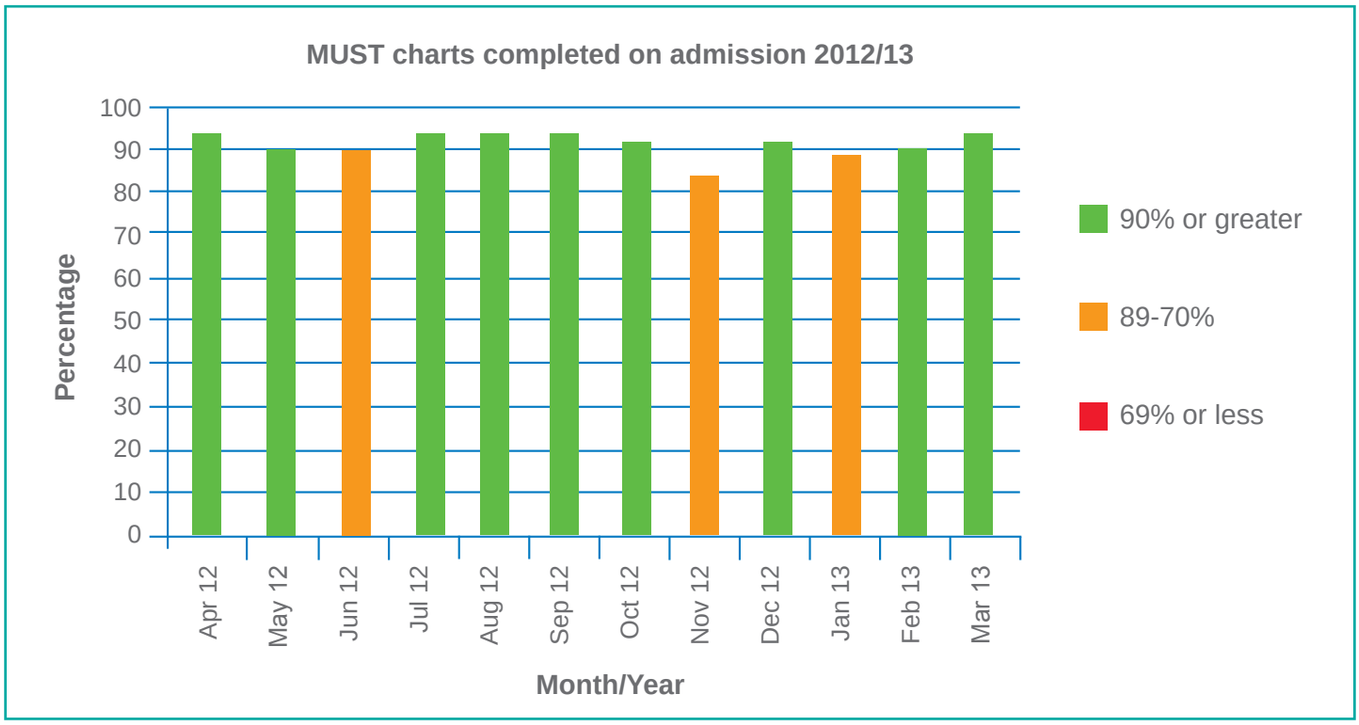
> "I have a physiotherapist who has helped me. I think their kindness and support is brilliant and they've shown me how to change my dressing and everything."

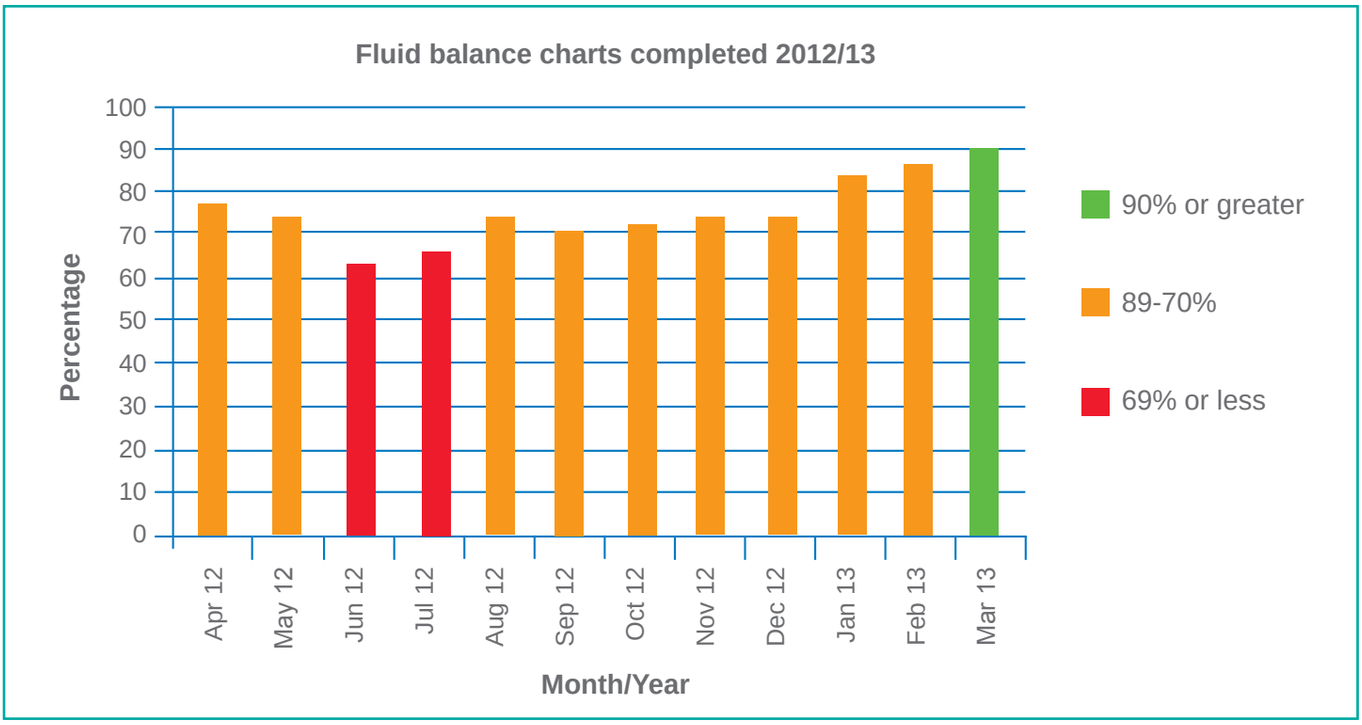
Developments that occurred in 2012/13

- Education sessions on MUST delivered in targeted areas.
- Screensaver developed to promote MUST screening on admission to Trust.
- Essence of Care link nurses re-enlisted.
- Fluid balance charts redesigned and introduced which now include lunch time evaluation requiring a qualified nurse's signature.
- Education package for fluid balance developed and delivered to all ward areas.
- Competency document for fluid balance developed for all staff to sign.
- New fluid balance criteria included in the Nursing Care Indicator (NCI) audit.
- Hand held bells now sounded 15 minutes before each mealtime to indicate the importance of the forthcoming mealtime, the need to get patients ready for the meal and to ensure the feeding of patients is a priority.
- Signs introduced behind every bed to indicate the nutritional needs of patients.
- Introduction of monthly mealtimes audits that include observations and the patient perspective.

Current status

The graphs below show the overall Trust results for 2012/13:





It can be seen that the target of having 90 per cent of patients being risk assessed for their nutritional status was achieved by September 2012. Since that date, there have been two monthly scores (November 2012 and January 2013) that have just dipped below the 90 per cent figure but for the whole of the six months the score has been on average over 90 per cent and so the target was achieved.

With regards to hydration, the 70 per cent completion of fluid balance charts was achieved in September 2012. Following an intensive campaign to improve this figure, it can be seen that the target of 90 per cent was achieved in March 2013.

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 2014).

Increase the number of patients having a food recording chart and a fluid balance chart in place if the MUST score is one or above.

Through the year on average at least 90 per cent of patients will have the charts in place and this will rise to at least 93 per cent by the end of the year (March 2014).

HYDRATION

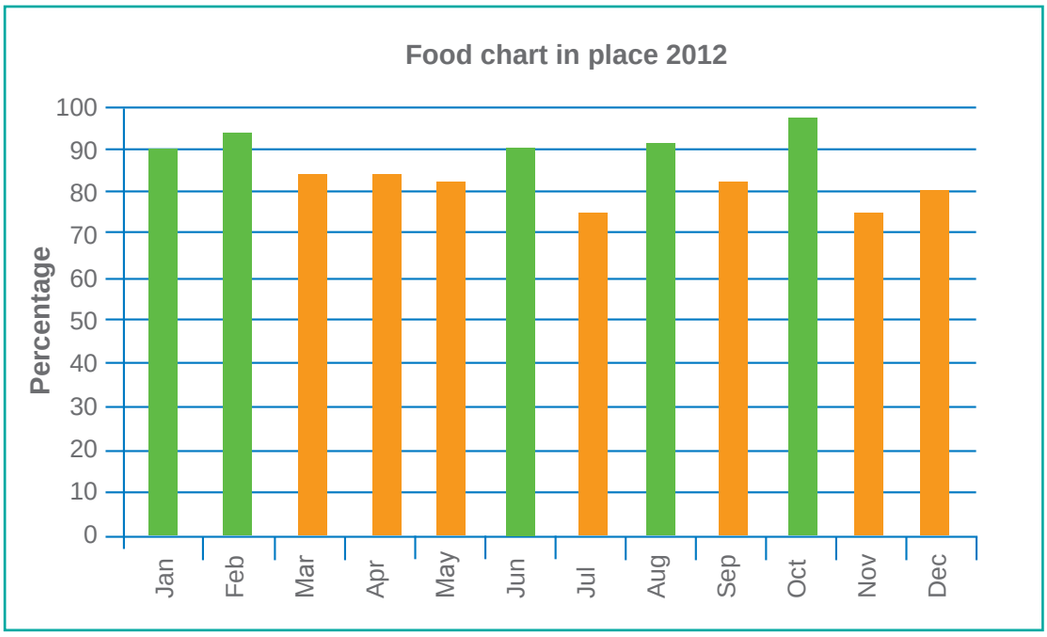
Increase the number of patients who have their fluid balance charts fully completed.

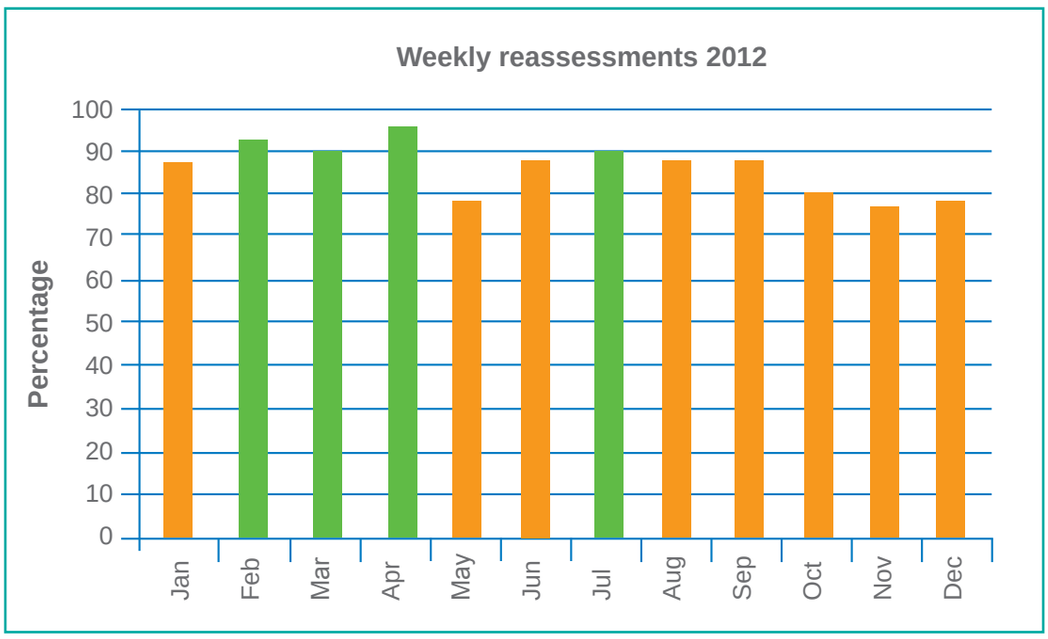
Through the year on average at least 90 per cent of patients will have their charts fully completed and this will rise to at least 93 per cent by the end of the year (March 2014).

Rationale for inclusion

- 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 from Age UK, the CQC etc have questioned the state of practice on these topics across hospitals generally.

In 2012/13 we ensured that generally MUST assessments are completed within 24 hours of admission. This is a good starting point for effective nutritional care. It is important that these assessments are continued on a weekly basis to monitor that if deterioration occurs appropriate action is taken to counteract this when possible. In addition, the purpose of the MUST assessment is that standard actions (e.g. referral to a dietician) occur, dependant on the score obtained from the assessment. One of the standard actions is that food and fluid recording charts are commenced if the score is more than one. It is thought useful therefore to include these targets to ensure that monitoring continues after admission and to ensure that the correct actions are being taken following assessment. It can be seen from the charts below that considerable work is required to match the 90 and 93 per cent targets set for 2013/14.





"The food is OK and I get vegetarian meals as I had requested."

Dehydration has been shown to increase by two-fold the mortality of patients admitted to hospital with a stroke and to increase the length of hospital stay for patients with community acquired pneumonia. Improving hydration brings well-being and better quality of life for patients. It can allow reduced use of medication and can prevent illness. It is not only good healthcare and dietary practice, but also the right thing to do. For optimal hydration of the patient, the need for accurate recording of fluid input and output cannot be underestimated. Although the Trust made great progress in improving the monitoring of fluid balance in 2012/13, it is appreciated that good scores were only achieved at the end of the year and so it has been decided to continue to target a good performance throughout 2013/14.

Developments planned for 2013/14

- System of monthly mealtime audits to be reviewed to have a more robust system of ensuring appropriate action is taken dependent on the audit results.
- Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells.
- Explore the introduction of an e-learning package.
- Develop a strategy for ensuring the importance of nutrition/hydration is a priority issue by such means as further screensavers, articles in newsletters and other appropriate mechanisms.

Board Sponsor: Denise McMahon, Director of Nursing

Operational Leads: Dr S. Cooper, Consultant Gastroenterologist, Sheree Randall, Matron, Karen Broadhouse, Quality Project Lead

> "I have had enough to eat and drink here and they help me when I need it."

2.2 Statements of Assurance from the Trust Board

2.2.1 Review of Services

During 2012/13 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 2012/13 represents 99.4 per cent of the total income generated from the provision of relevant health services by The Dudley Group NHS Foundation Trust for 2012/13.

The above reviews were undertaken in a number of ways. With regards to patient safety, the Trust Executive and Non Executive Directors have been undertaking Patient Safety Leadership Walkrounds (see Section 3.3.2). Also covering patient safety, but including the second element of quality (effectiveness), are the morbidity and mortality reviews undertaken by the Chairman, Chief Executive, Medical Director and the Non Executive Director who is chair of the Audit Committee. External input is provided by the GP Clinical Executive for Quality and Safety from 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 readmission rates, day case rates and standardised mortality rates (see Sections 2.2.7 and 3.3.6 for more detail on our hospital mortality 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 Trust Board monthly by the Director of Nursing.
- 'Productive' series, which is the part of our Transformation programme that looks at 'releasing time to care' by making time and productivity changes in theatres, the wards and the community. It results in clinical staff having more time directly with patients.
- Ongoing patient surveys that give a feel for our patients' experiences in real-time so that we can quickly identify and problems and correct them.
- Every other month, senior medical staff attend the Trust Board to provide a report and presentation on performance and quality issues within their specialty areas.
- Every other month, a matron attends the Trust Board 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 online centre of vital information for staff.
- The Trust works with its local commissioners, scrutinising the Trust's quality of care at joint monthly Clinical Quality Review Meetings.
- The Trust monitors the Midlands and East NHS Acute Trust Quality Dashboard, comparing all the Trusts on a number of quality indicators, some of which are discussed in this report.
- External assessments, which included the following key ones this year:
    - Following a visit on site in June 2012 the Care Quality Commission (CQC) declared the Trust compliant with the regulated activity of terminations of pregnancy. In July 2012, it also reviewed the Trust following a previous inspection to check the progress being made on its cleanliness and infection control standard. It declared the Trust compliant with that standard also. In addition, the CQC undertook a routine unannounced visit in February 2013, and inspectors visited five wards and two departments. The results of that visit were that the Trust is compliant with the following six standards: care and welfare of people who use the services, meeting nutritional needs, management of medicines, supporting workers, assessing and monitoring the quality of service provision and complaints.
    - In July 2012, NHS Dudley undertook an unannounced visit to review our emergency services. An action plan was drawn up which included improving systems of monitoring staffing levels and listening to the concerns of staff, actions which all have been completed.
    - NHS Dudley continued its series of Appreciative Enquiry Visits by reviewing in October 2012 the arrangements for patients who had sustained falls. NHS Dudley staff, which included general practitioners, interviewed staff and visited wards and departments to look at practice and talk with patients. The results of the visit were very positive and an action plan was drawn up for the minor points of concern raised.
    - In addition, Clinical Pathology Accreditation (UK) Ltd, which is the authority which approves laboratories, visited the following departments: Clinical Biochemistry (Nov 2012), Haematology (December 2012) and Microbiology (December 2012). Action plans have been formulated prior to final approval and the Microbiology Department will be inspected further in July 2013. The Human Tissue Authority (HTA) inspected in March 2012 and the Trust was approved for the procurement and distribution of human tissues and cells. A Cancer Services peer review of the Upper Gastro-Intestinal Department was made (March 2012) and the one key recommended action was implemented. Similar reviews of Acute Oncology and Clinical Chemotherapy took place in March 2013 and results are awaited. With regards to education and training, the University of Birmingham College of Medical and Dental Sciences undertook a visit reviewing Foundation Year Training (November 2012) and West Midlands Postgraduate Medical Education and Training Deanery inspected the Ophthalmology (March 2013), Radiology (November 2012), Maxillofacial (November 2012) and Obstetrics/Gynaecology (March 2012) departments. NHS Quality Control North West assessed the Aseptic Preparation of Medicines (April 2012). Where recommendations were made, action plans have been put into place.

2.2.2 Participation in National Clinical Audits and Confidential Enquiries

During 2012/13, 41 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 2012/13, 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 2012/13 and the percentage of the number of registered cases submitted by the terms of the audit

Name of Audit	Type of Care	Audit Participation	Submitted %
ICNARC Case Mix Programme Database	Acute care	Yes	100%
National Joint Registry	Acute care	Yes	95%
CEM Renal Colic Audit 2012	Acute care	Yes	100%
Trauma Audit & Research Network Audit (TARN)	Acute care	Yes	85%
BTS Emergency Use of Oxygen Audit	Acute care	Yes	100%
BTS Community Acquired Pneumonia Audit	Acute care	Yes	In progress - ends 31.5.13
BTS Adult NIV Audit	Acute care	Yes	100%
NHS Blood & Transplant Potential Donor Audit	Blood & Transplant	Yes	100%
National Comparative Audit of Blood Transfusion - Audit of the use of Anti-D	Blood & Transplant	Yes	Delayed nationally
National Lung Cancer Audit (LUCADA)	Cancer	Yes	100%
National Bowel Cancer audit Programme (NBOCAP)	Cancer	Yes	100%
Head & Neck Cancer Audit (DAHNO)	Cancer	Yes	100%
National Oesophago-gastric Cancer Audit	Cancer	Yes	100%
ICNARC National Cardiac Arrest Audit	Heart	Yes	100%
VSSGBI National Vascular Database	Heart	Yes	99%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Heart	Yes	100%
National Heart Failure Audit	Heart	Yes	100%

Name of Audit	Type of Care	Audit Participation	Submitted %
Heart Rhythm Management (pacing/devices)	Heart	Yes	100%
RCPCH National Paediatric Diabetes Audit (NPDA)	Long term conditions	Yes	100%
National Diabetes Inpatient Audit (NaDIA) 2012	Long term conditions	Yes	100%
UK Inflammatory Bowel Disease Audit - biologics	Long term conditions	Yes	Currently 45% running until 2014
National Pain Audit	Long term conditions	Yes	100%
Renal Registry Renal Replacement Therapy Audit	Long term conditions	Yes	100%
BTS Adult Asthma Audit	Long term conditions	Yes	100%
BTS Bronchiectasis Audit	Long term conditions	Yes	100%
National Review of Asthma Deaths (NRAD)	Long term conditions	Yes	100%
National Carotid Interventions Audit	Older people	Yes	97%
National Hip Fracture Database	Older people	Yes	100%
National Parkinson's Audit 2012	Older people	Yes	100%
National Dementia Audit (NAD) 2012	Older people	Yes	100%
CEM Fractured NOF Audit 2012	Older people	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Older people	Yes	In progress – expected 100% May 10th
Hernia/Varicose veins/Hip replacement/Knee replacement	Other	Yes	92% - current published figures
(PICAnet) Paediatric intensive care	Women's & Children's health	Yes	Data collated centrally at BCH
(MBRRACE-UK) Perinatal Mortality	Women's & Children's health	Yes	100%
(NNAP) Neonatal intensive and special care	Women's & Children's health	Yes	100%
BTS Paediatric Pneumonia Audit	Women's & Children's health	Yes	100%
BTS Paediatric Asthma Audit	Women's & Children's health	Yes	100%
RCPCH National Childhood Epilepsy 12 Audit	Women's & Children's health	Yes	Delayed Nationally
RCPCH Child Health (CHR-UK)	Women's & Children's health	Yes	100%
CEM Fever in Children Audit 2012	Women's & Children's health	Yes	100%

Table 2. National confidential enquiries that the Trust was eligible to participate in, actually participated in during 2012/13 and the percentage of the number of registered cases required by the terms of the enquiry.

Name of Enquiry	Type of Care	Audit Participation	Submitted %
Time to Intervene	NCEPOD	Yes	Complete
Bariatric Surgery Study	NCEPOD	Yes	Organisational data only
Alcohol Related Liver Disease Study	NCEPOD	Yes	Complete
Subarachnoid Haemorrhage Study	NCEPOD	Yes	Complete
Tracheostomy Related Complications	NCEPOD	Yes	In progress - Organisational data submitted
Death Following Lower Limb Amputation	NCEPOD	Yes	In progress

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

Table 3. Additional National Clinical Audits that the Trust is participating in during 2012/13.

Name of Audit	Type of Care	Audit Participation	Submitted %
National Audit Project (NAP5) Accidental Awareness During General Anaesthesia	Anaesthetics	Yes	In progress - ends 31.5.13
National Obstetric Anaesthetic Database (NOAD) Anaesthetics	Anaesthetics	Yes	100%
Audit of Blood Sampling and Labelling	Haematology	Yes	Complete
National Insulin Pump Audit	Diabetes & Endocrinology	Yes	100%

"They are very, very good. I get great care 24/7. The nurses are wonderful They showed me how to give myself pain relief and told me all about it. I just have to push the button and I get what I want."

The reports of 10 national clinical audits were reviewed in 2012/13 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

ICNARC Case Mix Programme Audit

The 2011/12 National ICNARC Case Mix programme report was reviewed. No specific actions were identified from this report as the Trust's practice, as captured in the well-validated audit, is shown as very good. Ongoing changes in practice reflect the critical care unit's continued efforts to stay abreast of best practice as recommended from other sources.

ICNARC National Cardiac Arrest (NCAA) Audit

The audit results show the Trust has maintained the level of cardiac arrest calls without any significant increase in the survival to discharge rates. The Trust continually looks at reducing events further.

National Heart Failure Audit

- Introduction of a new Trust Heart Failure Service
- Employment of new senior Heart Failure nurse
- Outreach to all patients with heart failure in the Trust, especially those that are being cared for by general physicians
- Improvement in the number of heart failure patients referred to the Community Heart Failure Team on discharge

National Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) Audit

Prescribing for secondary prevention medication is currently at a high level (less than 90 per cent), but slightly lower than the national average so there is a need for the Trust to see whether there is accurate exclusion of all patients with clinical contra-indications from the analysis. It was also identified that coronary angiography rates appear to be lower than the national average. Actions include:

- To educate nurses regarding appropriate coding of medications
- To discuss coronary angiography rates at future QPDT meeting
- To improve communication of findings

BTS Emergency Oxygen Audit

The audit identified that there needs to be changes in the way oxygen prescriptions are recorded; therefore, commencing in May 2013, there will be a pilot of a new system of oxygen prescribing for all patients on Ward C5.

BTS Community Acquired Pneumonia (CAP) Audit

The audit showed low antibiotic compliance with guidelines; therefore, actions have been implemented to improve adherence to the guidelines.

BTS COPD Discharge Audit

Actions include:

- All patients to be assessed for pulmonary rehabilitation
- All patients to have an emergency pack at discharge

BTS Non Invasive Ventilation (NIV) Audit

Actions include:

- Clear indications for the initiation of NIV have been attached to all portable NIV machines

National Bowel Cancer (NBOCAP) Audit

The National Bowel Cancer (NBOCAP) Audit was reviewed and previous weaknesses in the data collection were highlighted. These are to be addressed by involving clinicians more closely, and quarterly meetings are to be introduced to analyse data prior to submission.

National Diabetes Inpatient Audit (NaDIA)

The audit shows that overall there is evidence of continuing improvements in diabetes care across the Trust and nationally the Trust ranks highly on the majority of outcomes. This can be attributed to the impact of the Front Door Diabetes Team and the protocols developed in the Trust as part of the Think Glucose project. The impact that a new systematic approach to skin assessment and management and the Diabetes Foot Team has had on screening and management of diabetic foot disease is also very dramatic. Further work is required to improve on care planning and choice of meals.

Local Clinical Audit

The reports from 25 completed local clinical audits were reviewed in 2012/13 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- Design and construction of an e-learning module on critical incidents and risk reporting
- Introduction of a more comprehensive discharge plan for older and vulnerable patients following elective orthopaedic procedures
- Introduction of hypo boxes for all diabetic patients
- A change of Trust guidance to the use of Novorapid instead of Actrapid in the management of hyperglycaemia in adults with diabetes mellitus
- All doctors and pharmacists to complete the 'Safe use of Insulin' e-learning training module
- All patients undergoing bowel surgery for malignancy not having anti-thrombotic therapy to receive 28 days of enoxaparin post operatively
- Introduction of a new section in the Surgical Assessment Unit (SAU) clerking sheets to include Best Medical Therapy (BMT) checklist
- Introduction of a standardised format for pre and post operative clinical documentation for Pterygium Surgery
- Further develop the Emergency Department (ED) electronic patient record to promote better use of the electronic sedation record
- Introduction of formal training in sedation technique by anaesthetists
- Refinement of the existing proforma for improved documentation of the Non Invasive Ventilation (NIV) pathway
- Development of a generic PowerPoint presentation on Do Not Attempt Resuscitation (DNAR) and Medical Emergency Team (MET) status for junior doctor induction training
- Deliver supplementary NIV teaching sessions for improved recognition of patients unsuitable for NIV
- Introduction of appointments for investigations (e.g. visual fields tests) before consultation with the doctor
- Follow up appointment dates to be issued on the day of the procedure for Ozurdex Injection in patients with Macular Oedema
- Introduction of a yellow card (for easier recognition) with clinic contact telephone numbers
- Ensure improved pain relief is prescribed 30 minutes before Ozurdex Injection Procedure
- Initiation of testing of Procollegen III for the screening for significant liver disease, as there is good evidence that this substantially reduces the number of patients requiring liver biopsy
- Development of a local guideline and implementation of epilepsy teaching sessions for relevant junior doctors
- Formal CTG training introduced by the obstetrician to anaesthetists
- Sign up to phase two of the Transform Programme developed by the National End of Life Care Programme

> Staff are cheerful and help you if you need it.
> They always check to see if I am okay.

2.2.3 Research and Development

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 2591. We were able to recruit 7.1 per cent to commercial studies. This represents an increase in annual recruitment of over 100 per cent compared to 2011/12.

The Dermatology Department has joined cancer, cardiology and musculoskeletal medicine as a research active specialty by taking part in several large multicentre studies during 2012/13, both academic and commercial studies. This success continues to be due to the services of a research nurse employed by the Birmingham & Black Country Comprehensive Local Research Network (BBC CLRN) and the Clinical Research Unit's laboratory facilities. Diabetes and neurology have also started to recruit to academic clinical studies.

The Trust hosts three research fellows, one funded by Arthritis Research UK, another funded by BBC CLRN and one funded by the Trust. Rheumatology staff have submitted three grant applications.

Some of the improvements in clinical practice brought about by participating in clinical trials and other research studies are:

- Further use of targeted Systemic Anti-Cancer Therapies, which have less associated toxicity and improved efficacy
- Switching of some Systemic Anti-Cancer Therapies, which were previously given intravenously, to being given subcutaneously which leads to swifter administration (an advantage for patients and staff alike) and a lower side-effect profile
- More targeted use of prophylactic medications to prevent infection

Trust publications, including conference posters, increased to 120 during the calendar year 2012, the largest contribution coming from the Rheumatology Department.

2.2.4 Commissioning for Quality and Innovation Payment (CQUIN) Framework

A proportion of the Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they 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 2012/13 and for the following 12 month period are available online at:

https://commissioning.supply2health.nhs.uk/eContracts/Documents/cquin-guidance.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 2012/13 was £6.5m as part of our contracts with PCTs for acute and community services, and with specialised services commissioners. We have not yet agreed the final settlement figure for 2012/13 as some targets are still contingent upon outstanding information. However, for the purpose of the year end accounts, we have assumed 90 per cent achievement of both the PCT and specialised services schemes. This would equate to approx £5.8m. In 2011/12 the payment was £3.56m.

There is one CQUIN scheme per contract, made up of several goals. Goals for venous-thromboembolism, responsiveness to personal needs, dementia and NHS Safety Thermometer are nationally determined, and the remainder are locally agreed. We have rated last year's CQUINS on a red/amber/green basis dependent on achievement to date. We will fall short of meeting the five goals for patient experience, dementia screening, smoking and alcohol, making every contact count and peritoneal dialysis, and we have actions in place to ensure the quality of care in these areas is improved.

Acute

Goal No.	Targets and topics	Quality domain(s) and RAG rating
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Dementia Screening, Risk Assessment and Referral for Specialist Diagnosis	Safety/Effectiveness
4	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
5	Medicines Management – Antimicrobial Stewardship	Safety/Effectiveness
6	Alcohol and Smoking	Effectiveness

Community

Goal No.	Targets and topics	Quality domain(s) and RAG rating
1	Improve responsiveness to personal needs of patients	Patient Experience
2	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
3	Tissue Viability – Pressure Ulcers	Safety/Effectiveness
4	Virtual Ward	Safety/Effectiveness
5	Making Every Contact Count	Effectiveness

Specialist services

Goal No.	Targets and topics	Quality domain(s) and RAG rating
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Dementia Screening, Risk Assessment and Referral for Specialist Diagnosis	Safety/Effectiveness
4	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
5	Clinical Dashboards	Safety/Effectiveness
6	Renal Dialysis – Peritoneal Dialysis Therapyy	Effectiveness Patient/Experience
7	Renal Dialysis – Home Haemodialysis Therapy	Effectiveness Patient/Experience
8	Neonates – Pathway for Therapeutic Hypothermia	Safety/Effectiveness
9	Neonates – Discharge Planning	Effectiveness

> They are very helpful and friendly staff and they make sure my bell is there. I feel respected.

CQUINS report 2013/14

In 2013/14 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 £6.13m. The nationally mandated CQUIN goals for venous-thromboembolism, dementia screening and the NHS Safety Thermometer will continue and in addition there will be three indicators within the Friends and Family Test.

Acute and community

Goal No.	Targets and topics	Quality domain(s)
1	Friends and Family Test (3 parts)	Patient Experience
2	NHS Safety Thermometer – Pressure Ulcers	Patient Experience/Safety/Effectiveness
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	Safety/Effectiveness/Patient Experience
4	VTE Risk Assessment (2 parts)	Safety
5	Safe and Timely Discharge	Effectiveness
6	Patient Safety Culture	Safety
7	Patient Experience for Learning Disability Patients	Patient Experience
8	Reduction in Fractures as a result of falls	Safety
9	Letters returning to the referring clinician	Effectiveness
10	Choose and Book	Effectiveness
11	Senior Clinician Review	Effectiveness

Specialist services

Goal No.	Targets and topics	Quality domain(s)
1	Friends and Family Test (3 parts)	Patient Experience
2	NHS Safety Thermometer – Pressure Ulcers	Patient Experience/Safety/Effectiveness
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	Safety/Effectiveness/Patient Experience
4	VTE Risk Assessment (2 parts)	Safety
5	Quality Dashboards	Safety/Effectiveness/Innovation
6	Renal dialysis – Renal Patient View	Effectiveness/Innovation/Patient Experience
7	HIV – registration and communication with GPs	Safety/Effectiveness
8	Neonatal Intensive Care – Improved access to breast milk; timely discharge; retinopathy of prematurity	Safety/Effectiveness/Patient Experience

2.2.5 Care Quality Commission (CQC) Registration and Reviews (see also Section 2.2.1)

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

The Care Quality Commission has not taken enforcement action against the Trust during 2011/12.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Following the September 2011 visit to review our compliance against the 16 Essential Standards of Quality and Safety set out by the CQC, we submitted an action plan to the CQC for one of the standards. The CQC revisited the Trust in July 2012 to review the progress of the required actions and as these were all complete we were found to be compliant. In addition, the CQC made a further unannounced visit in February 2013 and, again, we were found to be compliant with the standards.

2.2.6 Quality of Data

The Trust submitted records during 2012/13 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 was:

- 99.7 per cent for admitted patient care; national average was 99.1 per cent
- 99.9 per cent for outpatient care; national average was 99.3 per cent
- 99.1 per cent for accident and emergency care; national average was 94.9 per cent

which included the patient's valid General Practitioner Registration Code was:

- 100 per cent for admitted patient care; national average was 99.9 per cent
- 100 per cent for outpatient care; national average was 99.9 per cent
- 100 per cent for accident and emergency care; national average was 99.7 per cent

The Trust's Information Governance Assessment Report overall score for 2012/13 was 78 per cent and was graded 'Green'.

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
Investigations: 8.4 per cent Treatments: 15.9 per cent

Paediatric Emergency
Primary Diagnosis: 10 per cent Secondary Diagnosis: 7.4 per cent Primary Procedure: 0 per cent
Secondary Procedure: 0 per cent

These results should not be extrapolated further than the Accident and Emergency and Paediatric Emergency samples audited.

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

- Crib sheets have been produced to remind reception staff to thoroughly check patient demographic details
- Manual processes have been reviewed and standardised for the input of documents into patient case notes/hand held notes and for ensuring postal addresses are accurate, complete and checked against the hospital main computer system if previously using stand alone systems
- A review of training has taken place so face to face sessions as well as computer based training are now organised

2.2.7 Core Set of Quality Indicators

This is the first year that all Trusts have been mandated to include this section which includes a stipulated number of measures. Due to the time it takes central bodies to collate and publish some of the data, not all of it is up to date and sometimes comparative figures are not available at all (N/A). It should also be appreciated that some of the 'Highest' and 'Lowest' performing trusts on some of the data may not be directly comparable to an acute general hospital e.g. specialist eye or orthopaedic hospitals that have very specific patient groups.

MORTALITY			
Topic and detailed indicators	**Immediate Reporting Period: Oct 2011- Sept 2012**	**Previous Reporting Period: July 2011-June 2012**	**Statements**
Summary Hospital-level Mortality Indicator (SHMI) value and banding	*Value* Trust: 1.042 National Av: 1 Highest: 1.21 Lowest: 0.68 *Banding* Trust: 2 Average: 2 Highest: 1 Lowest: 3	*Value* Trust: 1.036 National Av: 1 Highest: 1.26 Lowest: 0.71 Banding Trust: 2 Average: 2 Highest: 1 Lowest: 3	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges that its SHMI is within the expected range. The Trust has taken the following action to improve this indicator and so the quality of its services by: -Monitoring our hospital deaths in detail and thoroughly investigating each case.
Percentage of admitted patients whose treatment included palliative care	Trust: 1.1% National Av: 1.07% Highest: 3.2% Lowest: 0%	Trust: 0.9% National Av: 1.0% Highest: 3.3% Lowest: 0%	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges that these percentages are within the expected range. The Trust has taken the following actions to improve these percentages, and so the quality of its services by: -Working closely with the specialist palliative care team. -Improving access to the expertise of the palliative care team and recording their input accurately.
Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (Context indicator)	Trust: 25.1% National Av: 19.2% Highest: 43.3% Lowest: 0.2%	Trust: 21.65% National Av: 18.4% Highest: 46.3% Lowest: 0.3%	

PROMS – PATIENT REPORTED OUTCOME MEASURES			
Topic and detailed indicators	**Immediate Reporting Period: 2011/12 Provisional**	**Previous Reporting Period: 2010/11 Finalised**	**Statements**
Groin Hernia Surgery (Adjusted Health Gain)	Trust: 0.046 National Av: 0.087 Highest: 0.143 Lowest: -0.002	Trust: 0.069 National Av: 0.085 Highest: 0.156 Lowest:-0.020	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges the results vary across the four procedures; for Groin Hernia surgery it is below average, for Varicose Vein surgery it is above average and for Hip and Knee replacements it is in the region of the national average. With regards to Groin Hernia we have noted that 94% of patients said that their problems are better now when compared to before the operation and 87% of patients describe the results of their operation as excellent, very good or good. The Trust has taken the following actions to improve these scores, and so the quality of its services by: -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. The health gains that PROMs measure are of a more generic nature and are not exclusively linked to secondary healthcare provision and will need the consideration of a health economy-wide group to influence, comprising GPs, community services, social services, welfare benefit services and Public Health.
Varicose Vein Surgery (Adjusted Health Gain)	Trust: 0.123 National Av: 0.094 Highest: 0.167 Lowest: 0.047	Trust: 0.097 National Av: 0.091 Highest: 0.155 Lowest: -0.007	
Hip Replacement Surgery (Adjusted Health Gain)	Trust: 0.398 National Av: 0.416 Highest: 0.532 Lowest: 0.306	Trust: 0.381 National Av: 0.405 Highest: 0.503 Lowest: 0.264	
Knee Replacement Surgery (Adjusted Health Gain)	Trust: 0.302 National Av: 0.313 Highest: 0.385 Lowest: 0.180	Trust: 0.311 National Av: 0.299 Highest: 0.407 Lowest: 0.176	

READMISSIONS			
Topic and detailed indicators	**Immediate Reporting Period: 2010/11**	**Previous Reporting Period: 2009/10**	**Statements**
Percentage readmitted within 28 days Ages 0-14	Trust: 9.34% National Av: 10.15% Highest: N/A Lowest: N/A	Trust: 8.88% National Av: 10.18% Highest: N/A Lowest: N/A	The Trust considers that this data is as described for the following reasons: -Since the national published figures (across) are considerably historical, we have looked at our recent data and in 2012/13 the overall Trust average for all ages groups is 6.2% which compares to our peer group of similar hospitals of 6% (from CHKS). -The Trust is in the top 10% of Trusts within the Midlands & East SHA cluster for low readmissions to the same specialty. The Trust intends to take the following actions to reduce this percentage, and so the quality of its services by: -Continuing to develop its Paediatric Assessment Unit service. Rapid senior assessment for potential paediatric emergency admissions is undertaken and the principle of more senior and rapid assessment, will reduce admissions and readmissions -Continuing to expand and develop the Acute Medicine and Acute Surgery service by employing more senior decision makers in the initial assessment units, for longer, some unnecessary/avoidable admissions are prevented -Continuing to develop the community virtual ward service. More proactive, risk based management of virtual ward patients is already having an effect on avoidable admission reduction -Working with CCG and primary care practitioners to improve the medical and nursing support to local nursing homes. The Local Enhanced Services for nursing homes and Emergency Nursing Practictioner service will work to appropriately manage “frequent attenders” and avoid hospital admission and readmission -A flag is being developed in our patient administration system to identify patients who are at risk of being readmitted to aid staff decision making about alternative care pathways and care settings
Percentage readmitted within 28 days Ages 15 and over	Trust: 11.55% National Av: 11.42% Highest: N/A Lowest: N/A	Trust: 10.94% National Av: 11.16% Highest: N/A Lowest: N/A	

RESPONSIVENESS TO INPATIENTS' PERSONAL NEEDS			
Topic and detailed indicators	**Immediate Reporting Period: 2012**	**Previous Reporting Period: 2011**	**Statements**
Average score (out of 100) from the five patient experience questions included in the national patient experience CQUIN	Trust: 64.9 National Av: 68.1 Highest: 84.4 Lowest: 57.4	Trust: 63.8 National Av: 67.4 Highest: 85 Lowest: 56.5	The Trust considers that this data is as described for the following reasons: -The Trust notes that is only slightly lower than the national average. The Trust intends to take/has taken the following actions to improve this score, and so the quality of its services by: -Asking these same five questions as part of our real-time surveys to enable results to be attributed to and acted upon at ward level. During 2012/13 more than 3000 patients have given us their feedback via our real-time surveys.

STAFF VIEWS			
Topic and detailed indicators	**Immediate Reporting Period: 2012**	**Previous Reporting Period: 2011**	**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care (Acute Trusts)	Trust: 61% National Av: 60% Highest: 86% Lowest: 35%	Trust: 67% National Av: 62% Highest: 89% Lowest: 33%	The Trust considers that this data is as described for the following reasons: -Whilst there is a small decline compared to the results of the 2011 survey, the latest score of 61% is in line with the national average for Acute Trusts. The Trust intends to take/has taken the following actions to improve this percentage score, and so the quality of its services by: -Commencing focus groups led by Executive Directors following the publication of the staff survey results at which staff are asked about areas of engagement. -Making sure the breakdown of directorate results are made available for directorate leads and line managers. -Involving and communicating with staff through adopting the Listening into Action programme which has covered a wide range of topics.

VENOUS THROMBOEMBOLISM (VTE)			
Topic and detailed indicators	**Immediate Reporting Period: Q3 Oct-Dec 2012**	**Previous Reporting Period: Q2 Jul-Sep 2012**	**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism	Trust: 94.8% National Av: 94.2% Highest: 100% Lowest: 83.3%	Trust: 95.9% National Av: 93.9% Highest: 100% Lowest: 80.9%	The Trust considers that this data is as described for the following reasons: -The Trust is pleased to note that it is above the national average in undertaking these risk assessments due to, in particular, the work of a dedicated specialist nursing team and the promotional work they undertake on this important topic. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: -Continuing the educational sessions with each junior doctor intake -Continuing with a variety of promotional activities to staff and patients -Implementing the use of technology to assist in the recording of the risk assessments

INFECTION CONTROL			
Topic and detailed indicators	**Immediate Reporting Period: 2011/12**	**Previous Reporting Period: 2010/11**	**Statements**
The rate of Clostridium difficile per 100,000 bed days amongst patients aged two or over	Trust: 44.8% National Av: 21.8% Highest: 51.6% Lowest: 0	Trust: 32.1% National Av: 29.6% Highest: 71.8% Lowest: 0	The Trust considers that this data is as described for the following reasons: -The Trust acknowledges it needs to improve its rate and has done so this year (2012/13) (please see Section 2.1.3 which shows a reduction by more than 50% from 2011/12). The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services by: -Reviewing in detail all cases to see what lessons can be learned to prevent further cases -Further promoting effective antimicrobial prescribing -Introducing more intensive cleaning methods and expanding their use -Improving the guidance to clinicians on the prevention and treatment of C.diff

CLINICAL INCIDENTS			
Topic and detailed indicators	**Immediate Reporting Period: Apr 12 – Sep 12**	**Previous Reporting Period: Oct 11 – Mar 12**	**Statements**
Rate of patient safety incidents (incidents reported per 100 admissions compared to 49 medium acute Trusts)	Trust: 7.5 Average: 6.7 Highest: 14.3 Lowest: 3	Trust: 8.1 Average: 6.7 Highest: 10.2 Lowest: 2.1	The Trust considers that this data is as described for the following reasons: -As organisations that report more incidents usually have a better and more effective safety culture, the Trust is pleased to note it has higher than average reporting rates. The Trust has taken the following actions to improve this rate, and so the quality of its services by: -Continual raising of awareness of what constitutes as an incident and how to report. -Continual improvement of quality investigations and learning. -Reviewing the severity coding of all incidents to ensure accuracy and consistency of reporting. -Ensuring actions are taken to reduce any repetition of similar incidents.
Percentage of patient safety incidents resulting in severe harm or death	Trust: 1% National Av: 0.8%	Trust: 1.2% National Av: 0.8%	

Patient safety incidents resulting in severe harm or death

This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to report patient safety incidents under the NRLS's voluntary arrangements.

As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the trusts as this may not be comparable.

"I felt comfortable complaining.
I told them what they did wrong and they got better."

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 A&E, 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.

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. Some senior managers have access to the West Midlands SHA comparative performance tables to enable the Trust to benchmark itself against other trusts.

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 Trust Board 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.

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?

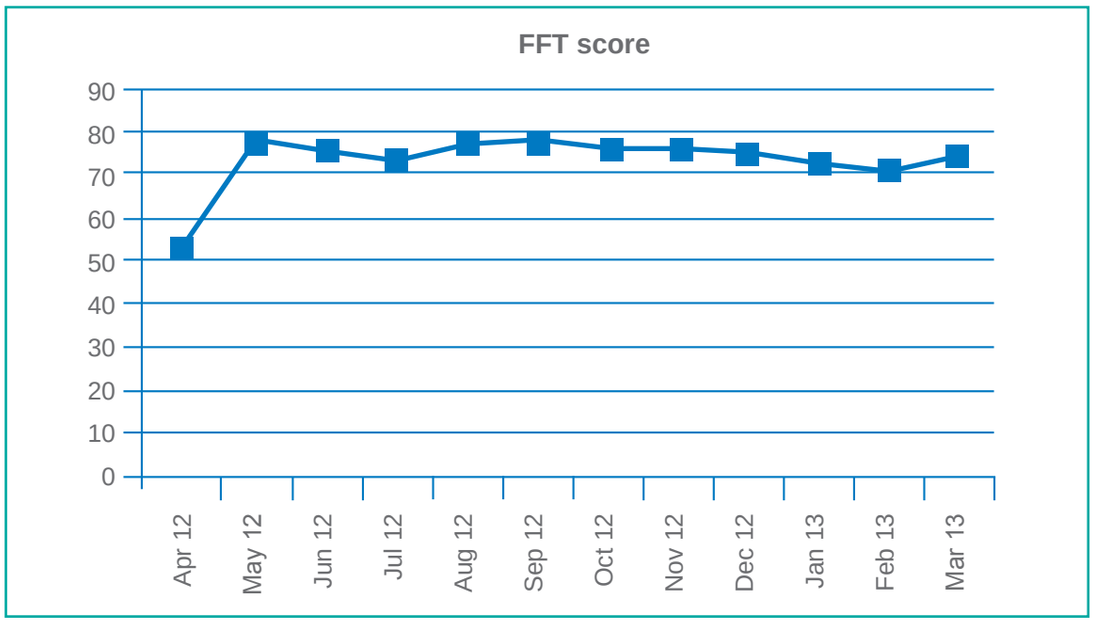
3.2.1 Introduction
This section includes the various methods of gaining a picture of patients' views of the Trust and examples of changes made based on those views.

3.2.2 Trust-wide Initiatives
a) Friends and Family Test
We have been running the Friends and Family Test (FFT) on our wards since April 2012, asking all inpatients when leaving the ward whether they would recommend the service they had received to a friend or family member in their hour of need. Patients were asked to rate us on a scale of 0-10 and offer suggestions where they think improvements could be made.

"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

Average FFT score for 2012/13	Average % of patients completing the FFT
73	21%

Actual monthly FFT score 2012/13

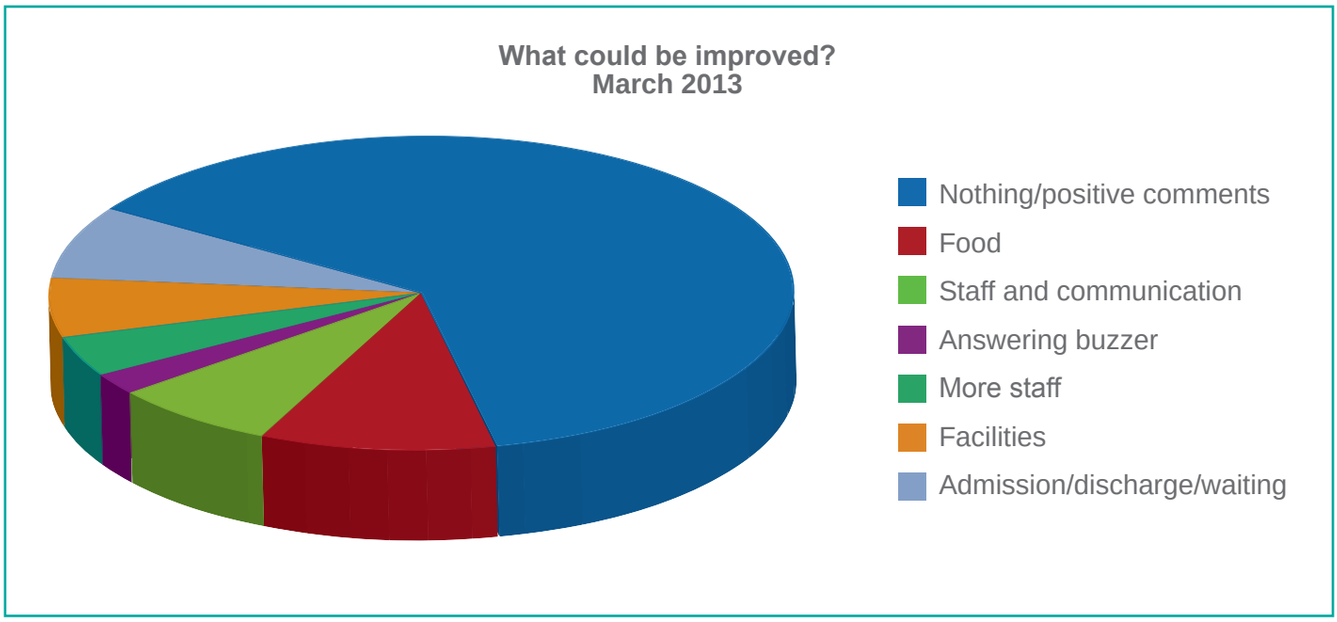


We are pleased that patients have been rating our services highly with scores mainly in the 70s, and we are using their comments to make improvements.

What have patients told us so far?
Around 70 per cent of the comments we have received from patients completing the Friends and Family Test are positive. It is really great for our staff to hear such positive feedback to know that they are providing a good service.

However, there is always room for improvement and the chart below shows the most requested items for improvement during March 2013, food is a common response from an average of 14 per cent of patients during the year (12 per cent in the chart below for March).

All feedback from patients is shared with the wards to help them to make improvements locally, as well as bigger issues being tackled on a Trust-wide basis.



From April 2013 all UK hospitals will be using the Friends and Family Test for inpatients and those patients who have visited A&E as part of a national roll out programme. Patients will be invited to respond to FFT question by choosing one of six options, ranging from 'extremely likely' to 'extremely unlikely' (for 2012/13 we used a 0-10 scale).

The Friends and Family Test is one way we gather patient feedback to help us drive improvements in services.

b) Real-time surveys

During 2012/13 our real-time surveys have gone from strength to strength gaining 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.

An example of surveys undertaken during the year are shown below, these range from large-scale Trust-wide surveys to smaller departmental surveys:

Survey	Responses
Inpatient survey	3069
Discharge survey	780
Outpatient survey	529
Eye Clinic survey	37
Maternity environment survey	67

c) Patient stories

We have continued using patient stories during 2012/13 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.

d) Community volunteers – making our patients smile

During 2012/13 the Trust has worked with the Kissing it Better charity to invite community volunteers and groups into the hospital to entertain our patients. Entertainment has included:

- Gospel singers
- Face painting, hand massage, manicures and make up from Dudley College beauty students
- Regular visits from Buster the dog (and his owner Anthea) from Pets as Therapy

It is a pleasure to see the reaction of patients and staff to these activities; smiles, tears of joy and happiness, laughter and conversation. Priceless! We cannot thank the volunteers enough for their time and effort given to brighten our patients' days.

These activities have been so successful that we plan to develop this initiative during 2013/14.

e) I am the patient experience video

We also wanted to express to staff how each and every one of them contributes to a good experience for our patients. With staff from a variety of roles we produced a motivating and uplifting video to promote good patient experience and raise awareness of the Trust's vision "Where People Matter".

The video can be viewed on our website www.dudleygroup.nhs.uk

Examples of actions taken as a result of patient feedback

Inpatient mealtimes

Following patient feedback from our surveys, patient panel and also our Friends and Family Test, we have been reviewing the way we deliver our inpatient meal service.

In January 2013 we visited the supplier of an alternative food system called 'Steamplicity'. Following this we have run a Steamplicity trial on one of our wards. We have also held taste tests for our Governors, patient panel members and also for staff to sample the food.

We are gathering as much feedback as possible to help us in our decision-making process around how we can improve our mealtime service.

Accessibility

Feedback from patients has also informed us that we could make improvements around accessibility. With patients' help we have drawn up an action plan and have, so far, ordered 30 more wheelchairs for main reception at Russells Hall Hospital and worked on our hearing loops system (including a number of portable hearing loops that departments can access as and when needed).

Information

Patients told us that they didn't always receive enough information about the ward they were staying on. During the year our 'Welcome to the Ward' booklets were launched giving useful information to patients and relatives relating to visiting and meal times, contact numbers and general ward routines.

3.2.3 National Survey Results

In 2012 we took part in two national patient surveys, one for inpatients and one for Accident and Emergency patients. The Trust chose Picker Institute Europe as our independent survey coordinator and participants were selected against the sampling guidance issued. For the national surveys 850 patients were selected to partake in a survey from the sample months indicated in the table below.

A further 1000 participants were selected to partake in the Accident and Emergency survey as part of a national pilot offering the survey in an online format.

Survey	Sample month	Response rate	National average response rate
Inpatient survey	July 2012	51.7%	48%
A&E survey (including online pilot)	March 2012	33%	33.7%

What the results of the surveys told us

Inpatient survey

Things we are good at:

- Having all of the necessary information relating to the patients' condition/illness
- Answering patients' queries about the operation or procedure
- Privacy when being examined or treated
- Availability of hand gel for use by patients and visitors

Areas where improvements could be made:

- Inpatient meals
- Information about condition in A&E
- The wait to get a bed on the ward
- Information about condition or treatment

A&E survey

Things we are good at:

- Staff not talking in front of patients as if they weren't there
- Explaining results of tests in an understandable way
- Advising when normal activities such as driving or working can be resumed

Areas where improvements could be made:

- Length of time to first speak with a nurse or doctor
- Length of time to be examined by a nurse or doctor

Actions plans have been drawn up to make improvements in the areas identified.

> My neighbours speak highly of this hospital.
> It has been as good as I expected.

3.2.4 Examples of Specific Patient Experience Initiatives

a) Kidney dialysis patients access tests online

Patients can now keep track of their treatment and test results from the comfort of their homes, or even while on holiday abroad. A new computer system, called Renal PatientView is more convenient, can save time and will also allow patients to have more control and involvement in their care.

It means they will no longer have to wait for an appointment or travel to hospital to get the latest news about their progress or advice on any worries. Important personal details are easily available to doctors outside the Trust using the patients login details if a patient is taken ill away from home. “Renal PatientView will allow them to see their results as soon as they become available and enable them to monitor their progress,” says Helen Perkins, Renal Unit, Lead Nurse. “It allows them to manage their information, be better informed on their results and medications and attend their appointments armed with more knowledge about their treatment.”

b) Assessment of patients prior to surgery

A number of changes in the surgical pre-assessment process have taken place this year resulting in improvements in the quality of care and patient feedback. Both staff, ensuring that patients are fully assessed for their surgery, and patients themselves, knowing what to expect, have been shown to reduce the risk of complications leading to quicker recovery and a better outcome for the patient.

The depth of the pre-assessment is now based on each patient’s graded risk so ensuring that more time is spent with those at greater risk. Cancellations prior to surgery have also been radically reduced. A survey of 115 patients between September-November 2012, has shown a high satisfaction with the new system with 98 per cent indicating they were as involved as much as they wanted to be in decisions about their care and treatment, 90 per cent definitely happy with the care they received from the pre-assessment service and the same number agreeing that they had received enough information about their operation and anaesthetic.

c) Rheumatology outpatients survey

This year the Rheumatology Department repeated a survey of outpatients it had previously undertaken in 2008. Approximately 550 patients attending the clinic during January 2013 completed the questionnaire. Overall, the majority of patients reported excellent levels in the quality of care received and in their experience of the clinic.

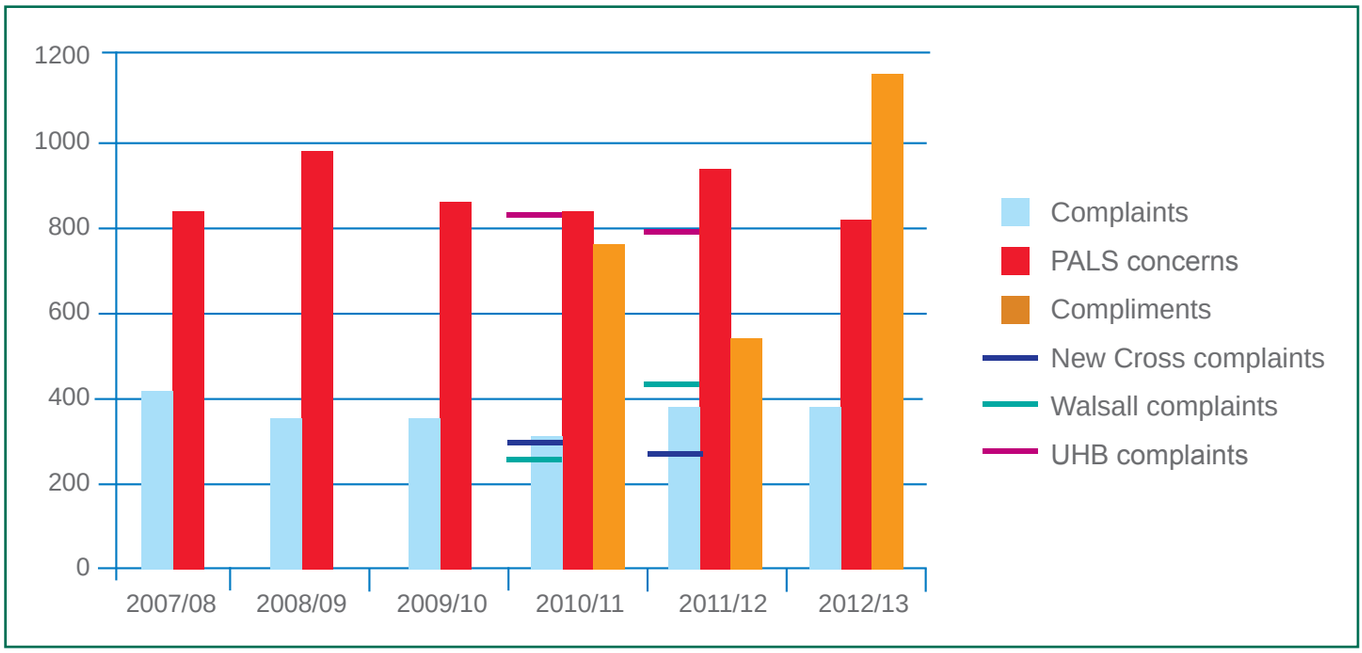
For instance, 89 per cent of patients thought they were definitely involved as much as they wanted to be in the clinical decisions being made (Yes to some extent – 6 per cent, Unanswered – 4 per cent, No – 0 per cent) and 91 per cent had complete confidence and trust in the examining/treating doctor/nurse (Yes to some extent – 3 per cent, Unanswered – 6 per cent, No – 0 per cent). When asked to rate on a scale of 0 – 10 how likely is it that you would recommend this service to family and friends? (10= very likely, 0= not at all) 93 per cent rated the service at ≥ 8 (56 per cent =10; 16 per cent=9; 21 per cent=8) and only one (0.2 per cent) patient rated the service at < 5.

There were areas for improvement: Although 80 per cent of patients were seen within 30 minutes of their appointment (41 per cent on time) and there had been a 50 per cent reduction of patients waiting more than an hour compared to 2008, the department is looking to see how it can increase these numbers as well as reducing rescheduling of appointments which had occurred in 15 per cent of cases.

3.2.5 Complaints and Compliments

This summary contains three tables showing a) the total number of complaints, concerns raised with the patient and liaison service and compliments during the year, compared to both previous years and where possible compared with local trusts b) the total and top five types of complaints this year compared to last year c) the percentage of complaints compared to the total number of patients visiting the Trust and d) some examples of changes in practice made from complaints.

a) Total numbers of complaints (with local trust benchmarks), PALS concerns and compliments



b) Total number and five main types of complaints

Categroy	Year end 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	Year end 2012/13
TOTAL	375	75	101	108	89	373
All aspects of clinical treatment	238 (63%)	51	86	88	74	299 (80%)
Attitude of staff	36 (10%)	8	1	2	4	14 (4%)
Communication /information to patient	26 (7%)	2	4	8	4	18 (5%)
Admission, Discharge & Transfer	19 (5%)	1	1	4	2	8 (2%)
OPD appointment delay/cancellation	29 (8%)	6	5	3	3	17 (5%)

c) Percentage of complaints against activity

ACTIVITY	Total year ending 31/3/11	Total year ending 31/3/12	Total year ending 31/3/13
Total patient activity	714519	753469	735247
% Complaints against activity	0.05%	0.05%	0.05%

d) Examples of changes in practice from complaints

Emergency, Specialty Medicine and Elderly Care

- Medical staff to check if ongoing psychiatric medication is continued to be prescribed during hospital admission.
- Review of mandatory training undertaken relating to care of a vulnerable adult.
- Patients sitting in GP area to be reassessed if their condition deteriorates.
- Information regarding Hickman lines being updated and will be available for patients very soon.
- Aftercare information to be provided on discharge.
- Measures put into place to reduce capacity, with some activity moved outside of the hospital, which has subsequently reduced waiting times within the Oncology unit.
- A record of telephone calls made directly to the district nurse team for those discharges that are complex is now maintained to ensure appropriate information has been communicated in a timely manner.
- The Emergency Assessment Unit (EAU) discharge process is being reviewed to improve communication between staff and family members.
- The EAU is reviewing the availability of senior nursing staff and posters advising patients and relatives to speak to a member of the nursing staff if they have any concerns whilst awaiting assessment and the provision of information booklets explaining the systems in operation within the area.
- Review of seating within the Emergency Department is being undertaken.

Women and Children

- Posters to be developed to inform women of staff to be approached regarding waiting times in the Maternity Outpatients Department.
- Process to be changed so that women are informed of all results, whether normal or abnormal. The leaflet will be changed to reflect this.
- Process for contacting the rapid response team in the event of a child death made available to all staff.
- Additional information added to bereavement box which contains information for the parents of a child who dies on the ward now available to staff.
- In the event of a child death, staff will arrange transport home for relatives and carers, if required.
- All community midwives to ensure women make an appointment at their local community phlebotomy service for their blood sugar tests to prevent any delays occurring.
- Re-develop gastro-oesophageal reflux (GOR) guidelines and design a GOR patient advice leaflet
- Information leaflets to be reviewed and additions made regarding water birth.
- Community midwives are to give advice about age parameters for water in labour/birth.
- Midwives to encourage women to administer their own Enoxoparin whilst an inpatient to build confidence before being discharged.
- A surrogate policy to be produced.

Diagnostics

- MRI scan appointment letter amended to include additional information for patients.
- Senior clinical midwife manager to discuss ethnic origin codes for postnatal newborn screening to avoid any confusion.
- Review of service enabled sonographers to add extra women onto their lists.
- Patients who have common variable immunodeficiency disorders require long-term replacement treatment with immunoglobulins. It is recognised that home therapy minimises hospital attendance for infusions and a business plan was submitted to the PCT in January 2013 and approved by the HENIG (Dudley Health Economy NICE Implementation Group) and forwarded to the commissioning team. Once agreed, the Trust is to start the process of training and transfer to home care.

Surgery and Anaesthetics

- Portering staff to make ad hoc deliveries if urgent notes are required in clinic.
- Staff to offer pain relief medication before commencing mobilisation.
- Review practice of instructing patients to be nil by mouth prior to surgery and divide lists into AM/PM to minimise time patients are without diet and fluids.

Ambulatory Medicine

- An inpatient care plan is currently being developed as well as a dialysis prescription that will help in communication between specialities and subsequently improve the patient journey.

Trauma, Orthopaedics and Plastics

- Patients with metal on metal hips will be monitored and provided with appropriate guidelines regarding their management.

3.2.6 PEAT Scores

Patient Environment Action Team (PEAT) is an annual assessment of inpatient healthcare sites in England. It is carried out in accordance with guidance and the team is made up of Trust staff, PFI partners and an external validator. Patient representatives are also involved in the audit which is carried out on a single day once per year. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care, including environment, food and privacy and dignity. The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

Comparative PEAT assessment results 2009-2012:

Year	Site Name	Environmental Score	Food Score Score	Privacy and Dignity Score
2012	Russells Hall Hospital	Excellent	Good	Good
2011	Russells Hall Hospital	Excellent	Good	Good
2010	Russells Hall Hospital	Excellent	Good	Good
2009	Russells Hall Hospital	Good	Good	Good

> The compassion the ward staff showed to my sister and I during mother's final hours was nothing short of extraordinary.

From 2013 the way the assessment is carried out is changing. The assessments will be patient-led to ensure that the patient voice is given the highest priority and patient assessors will make up at least 50 per cent of the assessment team. Training will be given to the team of volunteer patient assessors who will be made up from members of our local community. The following elements will be assessed:

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

3.2.7 Same 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 no breaches of same sex accommodation. 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 as part of our real-time survey programme. Of the 3069 inpatients asked, the number whose perception was that they shared a room/bay with members of the opposite sex was 73 (2%).

3.2.8 Patient Experience Measures:

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Comparison with other Trusts 2012/13
Patients who agreed that the hospital room or ward was clean	87%	87%	88%	8.7	8.8	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 scale 1-10)					7.6	
Patients who felt they were treated with dignity and respect	89%	86%	86%	8.6	8.7	About the same

Data from national inpatient surveys conducted for CQC – initially scores expressed as percentages but from 2011/12 scores reported out of 10 (previously this table was compiled from raw data scores).

There has been a change to these three measures this year. The first measure above is new this year. Previously we published the score for 'Patients that would recommend the hospital to a relative/friend', in this table, however, due to the introduction of the mandatory 'Friends and Family' test this year (see Section 3.2.2) this would have been a duplication and so it has been removed from here. In addition, the wording of the second question has changed in this year's national survey, hence we are unable to make a direct comparison with previous years' scores.

PATIENT SAFETY
3.3 Are patients safe in our hands?

3.3.1 Introduction

Ensuring patient safety is undertaken in many diverse ways from the quality of the training staff receive to the quality of equipment purchased. This section includes some examples of the ways we try to prevent things going wrong and what we do on those occasions when things unfortunately do not go to plan.

3.3.2 Directors Walkrounds

These Patient Safety Leadership Walkrounds consist of directors hearing first hand the safety concerns of front line staff.

All wards, therapy and community departments are visited throughout the year by an executive team. The team consists of, as a minimum, one Executive Director, one Non Executive Director and a Senior Clinician (i.e. nurse).

The team observes practice by being shown around the ward by a ward representative who also provides a verbal summary of the ward activity, specialty and ways of working. It meets informally with ward/clinical representatives to discuss the staff members' areas of concern related to patient safety issues. In response a report and action plan is produced to address areas of concern identified. Some actions taken from these visits include:

- The purchase of further specialist equipment e.g. medical monitoring equipment, chairs, commodes, wheelchairs for overweight patients.
- Introduction of training of junior doctors in relation to timely prescriptions of medication to take home.
- Completion of minor works for example: blinds, shelving etc.
- Process put in place for volunteers to locate and return wheelchairs to main reception for use by patients.
- Introduction of an additional Oncology outreach service from the Brierley Hill clinic.
- Further development and introduction of training programmes to increase healthcare professionals' knowledge and skills within specialties.
- Review of visiting times to ensure patient safety during drug administration.

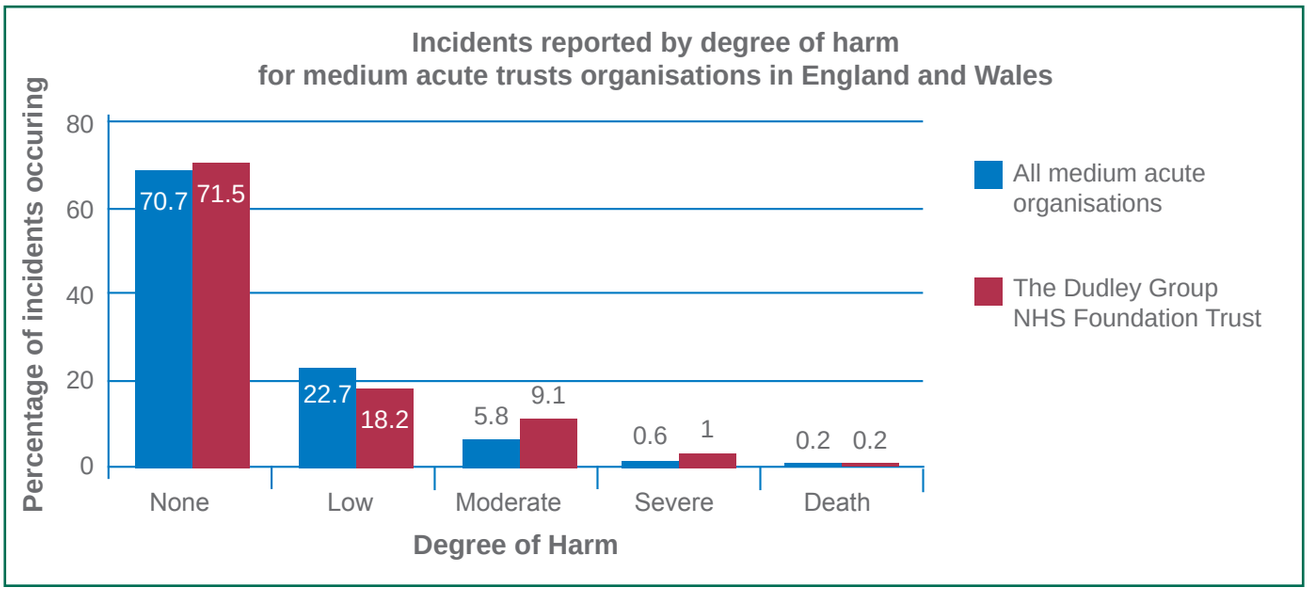
3.3.3 Incident Management

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 1 October 2011 to 31 March 2012. Organisations are compared against others of similar size. The Trust is the twelfth highest reporter of 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 trusts, 68 per cent of incidents are reported as no harm (the Trust 71.5 per cent) and just under 1 per cent as severe harm or death (Trust 1.2 per cent)



During the period April 2012 to the end of March 2013, incidents resulting in severe harm and death have accounted for 0.14 per cent and 0.1 per cent respectively of the total incidents reported. In the same period the Trust has had one 'Never Event' (these are a special class of serious incident that generally are preventable) which resulted in no patient harm. It did have 162 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:

- Development of a new procedure for theatre staff and anaesthetists when throat packs are used
- Implementation of the paediatric Early Warning Score in the Paediatric Department
- Use of fax machines limited to essential use to ensure more robust process to reduce breaches in confidentiality
- Purchase of medical equipment e.g. bed chair alarms and increase the number of patients these are used with
- Development and introduction of a more systematic consistent approach for fluid management and prevention and management of falls
- Implementation of formal Clinician Led Ward Rounds
- Development of care pathways to support clinical practice

> "All involved in looking after me were very sensitive to my situation, very polite, very attentive and above all professional. The ward felt like a well oiled machine, I could not have wished for a better experience."

3.3.4 Nursing Care Indicators

Every month 10 nursing records and other documents are checked at random in all general wards and departments at the hospital and in every nursing team in the community (in effect, approximately 400 records are audited in total per month) to ensure that nurses are undertaking activities that patients require and documenting that activity. The initial themes looked at were: patient observations (temperature, pulse, respirations etc), pain management, manual handling and falls risk assessment, prevention of pressure ulcers, nutrition assessment and monitoring, medications and prevention of infection. Further themes have been added or amended: a) in September 2011, 'ThinkGlucose' programme to monitor diabetes, documentation and bowel function assessments were added and b) in July 2012, fluid balance was added and the infection control section amended.

The completion rates of each ward and team are fed back to the matrons and ward managers for action where necessary. Each ward/team and the whole hospital and community service is RAG (Red/Amber/Green) rated with initially a 'Green' given for a 90 per cent or greater score, an 'Amber/Yellow' 89-70 per cent scores and a 'Red' for scores of 69 per cent or less. Due to overall general improvements in scores, it has recently been agreed to make the criteria stricter in that, for example a 'Green' score will only be given for 93 per cent and above. This change will be adopted into next year's Quality Account results.

Hospital results

The table below shows the end of calendar year position for each of the criteria assessed and changes from year to year. In 2012 we have improvements in seven of the 11 criterion. Infection control figures (*) show a fall, however, the questions for this assessment have been totally changed in July 2012 and so a direct comparison with 2011 is not possible.

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control	Think glucose	Documentation	Bowels	Fluid Balance
2010	77%	70%	71%	86%	68%	92%	95%				
2011	83%	80%	79%	93%	77%	94%	97%	53%	88%	78%	
Difference	↑6%	↑10%	↑8%	↑7%	↑9%	↑2%	↑2%				
2012	86%	88%	85%	95%	82%	94%	91%	79%	88%	81%	77%
Difference	↑3%	↑8%	↑6%	↑2%	↑5%	=	*	↑26%	=	↑3%	

Community results

The table below shows the end of calendar year position and changes from last year for Community Services for each of the criteria assessed. In 2012 we have improved in three of the nine criterion (Manual Handling, Tissue Viability and Infection Control). During October and November 2012 a more systematic approach to assessing skin care and making correct care and treatment decisions was introduced which will have helped increase the score on Tissue Viability. Due to the high levels of compliance the details of all of the indicators are being reviewed to set higher performance targets so ensuring the highest possible standards of care.

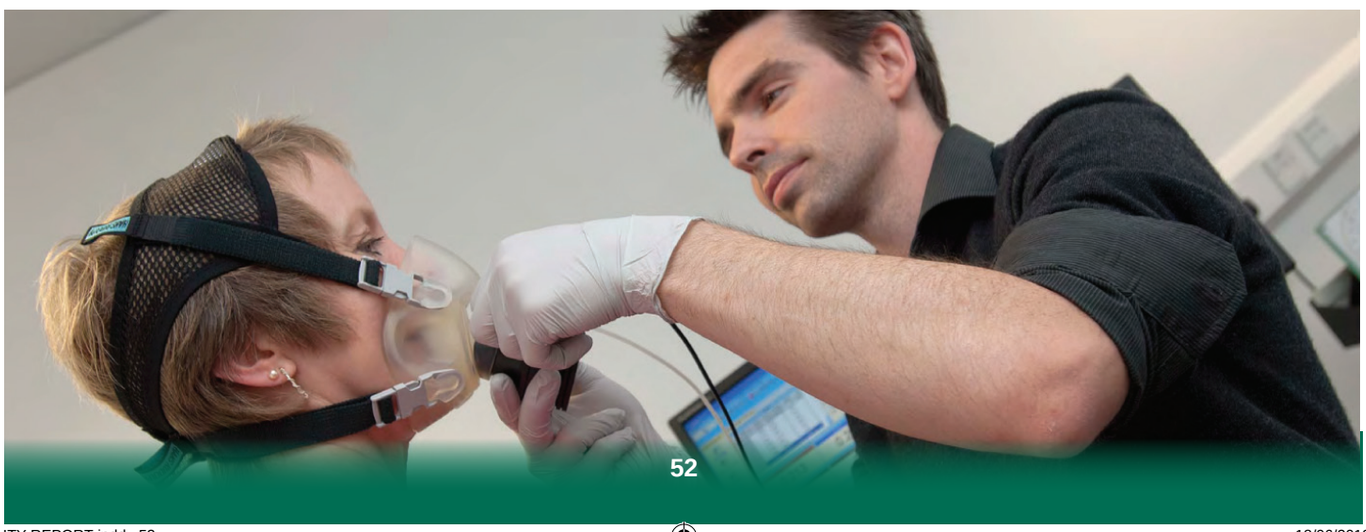
Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control	Documentation	Privacy and Dignity
2011	97%	98%	94%	95%	97%	99%	97%	98%	99%
2012	97%	98%	97%	97%	97%	99%	98%	98%	99%
Difference	=	=	↑3%	↑2%	=	=	↑1%	=	=

3.3.5 'Harm Free' Care and the 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 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 looks to ensure incremental improvements over time.



We aim to reduce these rates to zero per cent. Some examples of actions being taken as a result of the assessments:

- Continue to ensure staff are trained and updated by the Tissue Viability nurse and Link Nurses in the definition and recognition of pressure ulcers
- Enact a verification system to ensure that pressure ulcers are being correctly assessed and recorded
- Adopt a new 'falls bundle' (a clear systematic approach to assessing patients for the risk of falls and putting into place appropriate preventative measures) which is being trialled on a specific ward for later roll out and implementation in all clinical areas
- Ensure staff are aware of the new definition for new VTEs to improve accurate recording

3.3.6 Mortality

The different indices of mortality measure 'excess deaths' in different ways and the Trust now monitors the three most used figures: SHMI (Summary Hospital Mortality Indicator), RAMI (Risk Adjusted Mortality Index) and HSMR (Hospital Standardised Mortality Ratio) via Healthcare Evaluation Data (HED), a system that allows us to monitor, compare and evaluate hospital performance. The Trust is not presently an outlier on the new nationally mandated SHMI (see Section 2.2.7).

To date, all internal investigations of outlier alerts generated from HSMR figures have confirmed no patient care problems and all alerts have been closed by the Care Quality Commission, which oversees these.

Recognising that whatever indices are used nationally, all mortality should be audited, the Trust has a systematic internal mortality monitoring process, which includes monthly presentations to the Chairman, Chief Executive and Medical Director.

The Trust is also part of the West Midlands Mortality Group where knowledge and experience is shared.

3.3.7 Examples of Specific Patient Safety Initiatives

a) Gold standard service to cut infection risk

Upgrade work is now complete on a new suite with four of the latest decontamination machines for cleaning equipment used in the Gastroenterology (GI) Department. It uses advanced technology to clean and disinfect endoscopes used to investigate small and large intestines, take biopsies and even treat some digestive disorders. The cleaning process ensures that dirty and clean scopes are separated at all times and advanced technology speeds up the cleaning process, providing doctors with an almost instant supply of decontaminated instruments. The new facility ensures that the Trust remains fully accredited in terms of quality legislation, both now and for the foreseeable future. "We have a good system for decontaminating GI scopes," says Kerry Castle, GI Lead Nurse, "but the new suite is gold standard. It is a major advance and increases reliability. This will be of significant benefit to the 10,000 patients we see every year." The new suite is part of a project to rebuild the Trust's decontamination facilities and ensures that all flexible endoscopes in the Trust are decontaminated to the same standard.

> "The service received was fantastic.
> I was put at ease and well cared for and well informed."

b) Improved education and working between junior doctors and pharmacists

In August 2012 the Trust became a pilot site for the 'Better Training Better Care' (BTBC) initiative co-ordinated by the country's lead body in training, Health Education England (HEE). There were only 15 Trusts (and only two in the West Midlands) which were successful in getting funds to become a pilot. The purpose of this patient safety initiative at Dudley is improved education and working between pharmacists and junior doctors to ensure that patients, especially those with complex medicine requirements, receive correct medication. Training sessions with pharmacists and juniors together consist of simulated scenarios using dummy drug charts which aim at timely, accurate and effective prescribing so reducing the risk of medication errors and ensuring that patients stay in hospital is not lengthened by inappropriate medication. In a visit to the hospital, Patrick Mitchell, Director of National Programmes for HEE, said, "Post Francis, the need for professional groups, like here in Dudley, to work closer across professional boundaries to promote safe care and share training opportunities is crucial. The behavioural change here is as important, if not more so, than the training itself."

3.3.8 Patient Safety Measures:

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13
Patients with MRSA infection/1,000 bed days*	0.07	0.04	0.01	0.01	0.01
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0	1
Number of cases of deep vein thrombosis (DVT) presenting within three months of hospital admission	48	48	35	143**	117**

*Data source: numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. NB the MRSA figure may differ from data available on Public Health England (PHE) 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 recognized 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.*

There has been a change to these three measures this year. The measure 'Patients with C. diff infection/1,000 bed days' has been removed as it is now part of the mandatory measures that all trusts have to report on (see Section 2.27). The measure on Never Events has been added to replace this as it is an important patient safety issue.

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 where we excel compared to other organisations.

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

a) Nursing Standard Annual Awards 2013 - Ward Sister of the year award

Sara Davis from Ward C8 was presented with the above award in March 2013 for initiating a variety of improvements. These included: increasing staff morale and the scores of the nursing care indicators, reducing the number of complaints, serious incidents and sickness levels, ensuring staff training is up to date and improving working relationships with colleagues in other disciplines. A member of Sara's team said, "Sara has completely altered the ward to make the patient journey the priority here and she cares about her staff just as much."

b) Recognising Excellence in Medical Education (REME) Teaching Award for the academic year 2011-12

At a prize giving ceremony held at the University of Birmingham Medical School in December 2012 the above award was presented to Dr A Whallett, Consultant Rheumatologist. REME is a student-led, medical school endorsed organisation that aims to identify teachers who have contributed significantly toward medical education. All students are invited to provide nominations and feedback, all of which is entirely on a voluntary basis. All nominations are reviewed, and winners chosen on the basis of number of nominations and the comments received. Dr Whallett was one of only 11 individuals given this award.

3.4.3 Examples of Innovation

a) State of the art facilities for interventional radiology and endovascular investigation and treatment

This £1.5m development was opened in March 2012 and allows surgical and radiological teams to perform elective and emergency endovascular aortic aneurysm repairs and in the last 12 months, 68 patients from across the Black Country have benefited from this minimally invasive technique to treat what is a life threatening condition. The suite comprises state of the art equipment enabling real time three dimensional imaging and allows complex vascular and other interventions to be performed to the highest standards of precision and patient safety whilst ensuring the lowest possible patient radiation dose. In addition to the vascular work, the suite is used for conventional interventional radiology techniques and is also now being used to undertake other major interventions such as vertebroplasty, an imaging guided technique that brings together a multidisciplinary team to treat painful spinal collapse of various causes.

b) Community Adult Continence Service

The Community Adult Continence Service has been involved in a number of collaborative partnerships to ensure that the patient is seen speedily by the correct expert as close to home as possible. For instance, a clear process is in place for all male patients with lower urinary tract systems so, dependent on the severity of their symptoms, they are seen and treated by the appropriate experts either in the community or in the hospital. This reduces unnecessary visits to the hospital and allows those with the appropriate symptoms to be seen quicker at the hospital. This has come about due to partnership working between the community clinical nurse specialist, hospital care (Urology service), GPs (Wychbury Medical Centre) and pharmaceutical advisors. Local services from, for example, Wolverhampton and Birmingham have all approached the clinical nurse specialist (CNS) on setting up such a service.

Similar innovative work for those patients with constipation has also been developed. For this service the clinical nurse specialist has worked with the hospital (Gastroenterology) and Worcester St practice. One outcome has been more effective prescribing and the reduction in the use of unnecessary laxatives. Shropshire Trust has approached the CNS for advice in setting up a similar service. The next initiative being developed is looking at more appropriate use of aids for bladder and bowel dysfunction in the hospital.

c) Outpatient Parenteral Antibiotic Team (OPAT)

In the past, patients requiring intravenous antibiotics always had to come into hospital for their therapy but from January 2012 a joint service between the hospital and community commenced. Patients are now assessed in hospital and then discharged for the community nurses to administer the intravenous antibiotics. Patients sometimes return to hospital for a review in a specialist clinic. The service was initially started for patients with cellulitis but then extended to those with complex urinary tract infections, including pyelonephritis. A further service for those with diabetic foot problems was also commenced in October 2012 and there are plans to extend this service. During 2012 over 150 patients were successfully treated in the community setting either in the patient's own home or in the community clinic at Brierley Hill Health and Social Care Centre. This is estimated to have saved over 1,385 bed days, increasing capacity within the hospital for more appropriate patients whilst providing excellent care for patients nearer to home. A survey of the patients treated found they were all satisfied with the service, rating it at 9.2 on a scale of one to 10.

3.4.4 Examples of Specific Clinical Effectiveness Initiatives

a) Abdominal Aortic Aneurysm Screening Service

A new Abdominal Aortic Aneurysm (AAA) Screening Service based at Russells Hall Hospital has screened 4140 men across the Black Country since the programme started in April 2012. The programme is part of a national roll out, which invites all men registered with a GP in the Black Country, who will turn 65 in the financial year. In addition, men over 65 years may self-refer by phoning the office. Posters have been distributed to all GP practices and health centres in the Black Country for display and local newspaper articles on the programme have been published.

Screening takes place five days a week at clinics and GP practices in Walsall, Wolverhampton and Dudley, and all scans are uploaded to our secure picture archive at Russells Hall Hospital. "No individual has to travel more than a few minutes. We've made sure we are screening people on their doorsteps," said Mr Rajiv Pathak, Consultant Vascular Surgeon and Black Country AAA Screening Programme Director. Mr Pathak said the large majority of men (98 per cent) will have a normal result with no aneurysm. A small aneurysm means the aorta is between 3cm and 5.4cm wide and if detected will continue to be monitored with a regular scan. To date, we have detected small aneurysms in 42 men. A large aneurysm is over 5.5cm wide and, if one is detected, the patient will be referred to a consultant for treatment. "Only a few aneurysms will be large enough to require urgent treatment and cause a risk to a person's health," said Mr Pathak. We have detected 12 patients so far who have required referral to a consultant for treatment.

Patient Story:

Roger Davies from Woodsetton says he would not be alive today if he had not attended a routine scan for an abdominal aortic aneurysm as part of the national screening programme. The father of two had no idea he had an aneurysm in his abdomen let alone one measuring 10.5cm, the largest found so far on the programme. “I am so relieved I went for the scan – if it had burst, it would have killed me,” said Mr Davies.

Father of three Tom Walker (pictured left with his wife Sue) from Wednesfield described his 7.5cm aneurysm as a “ticking time bomb”. Following his routine scan, he had a complex four-hour operation at Russells Hall Hospital. Mr Walker said, “I would definitely do the test. It was the best 20 minutes I’ve ever spent. It saved my life.”

b) Hyper Acute Stroke Ward

At Russells Hall Hospital the aim is to get the patient to our specialist acute stroke ward within four hours of arrival at our Emergency Department (ED). This increases the chance of a full recovery. The 12-bedded Hyper Acute Stroke Ward provides continuous monitoring and therapy. Ongoing care is provided at the 28-bedded stroke ward. For patients who arrive at hospital very quickly, and have a certain type of stroke, we provide 24/7 thrombolysis with a clot busting drug to reopen blocked blood vessels. If a stroke is confirmed prior to arrival, the ambulance crew will phone ahead to alert the specialist team who, in turn, pre-warn staff that a scan is required. We have machines that monitor real time blood flow from the heart as 40 per cent of strokes in people under the age of 55 are related to the heart. In addition, we use specialist equipment that goes into the throat to provide images of the heart to help in the diagnosis of the cause of the stroke. Following discharge from hospital, hospital staff work with the community Early Support Discharge team to provide further rehabilitation if needed.

Patient Story:

Stanley Pearce from Kinver received care at Russells Hall Hospital.

He said, “I was in A&E with my daughter when I suddenly felt the room sliding and the feeling had gone out of my left leg. My arm was flinging everywhere. A doctor knew straight away I was having a stroke.”
“It was very frightening and you think the worst, but I was on the ward within two hours of it happening.
“The drugs were given to me really quickly and I got the feeling back in my leg and arm. It was brilliant. I was so frightened but the staff were ace. They saved my life.”

Clifford Palmer (pictured right) was also admitted to the Hyper Acute Stroke Ward. His son Wayne said, “The care at Russells Hall Hospital has been phenomenal, especially how fast he had thrombolysis. I’m over the moon for dad.”

c) Blood Borne Virus Service

From December 2012 the community clinical nurse specialists have introduced a new treatment for patients with hepatitis C, a potentially serious disorder. The drug telaprevir, used in combination with pegylated interferon and ribavirin, has during trials improved the clearance rates of hepatitis C by a further 20 per cent for genotype 1 patients. Currently the first eight patients who require weekly monitoring to detect possible severe side effects have had excellent results and any side effects have been well managed in conjunction with the dermatology team. We have high hopes that those who have previously experienced treatment failures will go on to be successfully treated with this additional therapy. The final results will not be known for 18 months when treatment and follow up are complete. The team of staff have worked closely to involve Pharmacy and Microbiology to ensure safe and efficient patient care is delivered in a timely fashion. It is hoped that once this group of patients has been safely managed through the first few months of treatment, further patients will be able to start on this new therapy.

3.4.5 Clinical Effectiveness Measures:

Categroy	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13
Trust Readmission Rate for Surgery Vs Peer group West Midlands SHA Source: CHKS Insight	4.6% Vs 4.1%	3.9%* Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%	5.6% Vs 5.0%	5.7%^ Vs 5.2%
Number of cardiac arrests Source: logged switchboard calls	397	250	170	145	119	126
% of elective admissions where the planned procedure was not carried out (not patient decision) Vs Peer group West Midlands SHA Source: CHKS Insight	N/A	2.0 Vs 1.6	1.4 Vs 1.6	1.4 Vs 1.3	0.67% Vs 1.1%	0.57%^ Vs 0.86%

*3.8 per cent for 2008/09 in the 2009/10 report was April 2008 to February 2009 only

^To end of January 2013

N/A = Data Not Available

There has been a change to these three measures this year. The measure ‘Never Events’ has now been given its more appropriate categorisation and moved to Patient Safety (see Section 3.3.8) so the Trust has added a new clinical effectiveness measure of when planned procedures are not undertaken. The reduction of cardiac arrests indicates success in identifying patients at risk, monitoring them carefully and escalating the clinical care to appropriate professionals to prevent cardiac arrest.

3.5 Our performance against Key National Priorities across the domains of the NHS Outcomes Framework

National targets and regulatory requirements	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2012/13	Target 2012/13	Trust 2012/13	Target Achieved/ Not Achieved
1. Preventing People from Dying Prematurely								
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	100%	99.3%	99.8%	99.7%	98.3%*	96%	99.5%	☺
All cancers: 31 day wait for second or subsequent treatment: surgery	N/A	N/A	99.6%	99.6%	97.1%*	94%	99.2%	☺
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments	N/A	N/A	100%	100%	99.6%*	98%	100%	☺
A maximum wait of 62 days from urgent referral to treatment of all cancers	99.9%	86.5%	87%	88%	86.3%*	85%	88.7%	☺
All cancers: 62 day wait for first treatment from consultant screening service	N/A	N/A	99.6%	96.6%	94.9%*	90%	99.4%	☺
3. Helping people to recover from episodes of ill health or following injury								
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	92.4%	95.8%	97.03%	95.7%	92.4%	90%	96.1%	☺
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	96.15%	99.1%	99.2%	99.2%	97.6%	95%	99.5%	☺
Maximum time of 18 weeks from point of referral to treatment (incomplete pathways)	N/A	N/A	N/A	N/A	94.2%	92%	98.1%	☺

National targets and regulatory requirements	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2012/13	Target 2012/13	Trust 2012/13	Target Achieved/ Not Achieved
1. Preventing People from Dying Prematurely								
A/E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	95.9%	98.1%	98.8%	97.27%	95.8%	95%	95.4%	☺
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	100%	98%	96.8%	97.2%	95.7%*	93%	96.2%	☺
Two week maximum wait for symptomatic breast patients	N/A	69%	98.2%	99%	95.7%*	93%	98.1%	☺
5. Treating and caring for people in a safe environment and protecting them from avoidable harm								
MRSA – number of post 48hour bacteraemia infections	7	2	3	2	–	No more than 2	1	☺
Data Completeness for community services: Referral to treatment information	N/A	N/A	N/A	N/A	+	50%	97.3%	☺
Data Completeness for community services: Referral information	N/A	N/A	N/A	N/A	+	50%	65.6%	☺
Data Completeness for community services: Treatment activity information	N/A	N/A	N/A	N/A	+	50%	99.1%	☺
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	N/A	N/A	Compliant	–	Compliant	Compliant	☺

N/A applies to targets not in place at that time.

☺ = Achieved target ☹ = Not achieved target

– Applies to National figures not being appropriate

* = Quarter 4 figures as full year figures are not currently available

+ = National figures not available

3.6 Glossary of Terms

AAA	Abdominal Aortic Aneurysm
A & E	Accident and Emergency
ADC	Action for Disabled People and Carers
Bed Days	Unit used to calculate the availability and use of beds over time
BBC CLRN	Birmingham and Black Country Comprehensive Local Research Network
BHF	British Heart Foundation
BTS	British Thoracic Society
CCG	Clinical Commissioning Group
C. diff	Clostridium difficile
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
DAHNO	Data for Head and Neck Oncology
DUBASCO	Dudley Bariatric Surgery Co-morbidity Score
DVD	Optical disc storage format
EAU	Emergency Assessment Unit
ENT	Ear, Nose and Throat
ED	Emergency Department
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
HPA	Health Protection Agency
HQIP	Healthcare Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratios
HTA	Human Tissue Authority
IBD	Irritable Bowel Disease

ICNARC CMPD	Intensive Care National Audit & Research Centre Case Mix Programme Database
LINK	Local Involvement Network
MUST	Malnutrition Universal Screening Tool
MBC	Metropolitan Borough Council
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
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 Clinical Excellence
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
Ofsted	Office for Standards in Education, Children's Services and Skills
PALS	Patient Advice and Liaison Service
PEAT	Patient Environment Action Teams
PFI	Private Finance Initiative
PROMs	Patient Reported Outcome Measures
PCT	Primary Care Trust
RAG	Red/Amber/Green
RCOG	Royal college of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
REME	Recognising Excellence in Medical Education
RAMI	Risk Adjusted Mortality Index
SHMI	Summary Hospital Mortality Indicator
SINAP	Stroke Improvement Audit Programme
SKIN	Surface, Keep Moving, Incontinence and Nutrition
SUS	Secondary Uses Service
SLT	Speech and Language Therapy
VCF	Vertebral Compression Fractures
VSGBI	Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism

ANNEX

Comment from Dudley Clinical Commissioning Group (received 07/05/2013)

Dudley Clinical Commissioning Group acknowledges that this report demonstrates that The Dudley Group NHS Foundation Trust continues to place quality improvement at the forefront of their service delivery. The 2013/14 priorities reflect the continued commitment to patient experience, quality of care, nutrition, hydration, prevention of pressure ulcers, and infection prevention.

The further improvement in healthcare associated infections demonstrates that much has been achieved. The Clinical Commissioning Group continues to encourage the Trust to further reduce and prevent HCAI through implementing improvement plans, and this clearly sets out HCAI as a continued priority.

Mortality remains a focus of the Trust, with monthly meetings attended by the Chief Executive, Chairman, Clinical Director, along with active participation by Board member representatives from the Clinical Commissioning Group. This allows detailed assessment of specialties and identifies any themes or areas for improvement.

The current and planned patient outcome measures of both the Trust and the Clinical Commissioning Group allow assessment, monitoring, and informed judgements and decisions about the quality of healthcare services provided to local patients.

Dudley Clinical Commissioning Group supports the contents and aims of this Quality Account, and looks forward to working closely with The Dudley Group NHS Foundation Trust to ensure that they achieve high quality outcomes and provide a quality experience to their patients.

Comment from the Trust's Council of Governors (received 26/04/2013)

The Trust has presented the Quality Accounts against a challenging background leading up to a major reorganisation of the National Health Service in England on 1st April 2013. The improvements in 2012/13 were achieved against a background of a stringent 4 per cent efficiency target which will continue into the foreseeable future.

Following the Francis Report, there has been an intense focus on the quality of care and safety of patients, both nationally and locally, highlighting the need for caring and compassionate staff.

The Governors fully support the aims and objectives defined in the Statement from the Chief Executive in Part 1 of the report.

There has been an increased pressure on services provided by the Trust particularly in the Emergency Department (in common with many areas of the country) with patients requiring to be admitted as emergencies to Russells Hall Hospital.

The process used to identify the quality priorities was wide ranging and provided a valuable opportunity for Governors, patients, staff, members, and patient representative groups to consider and influence the choices.

Governors recognise and appreciate the significant improvements made by the Trust in many areas in 2012/13, particularly the effective action taken to reduce the incidence of pressure ulcers, post 48 hour MRSA bacteraemia and Clostridium Difficile. Hydration and nutrition are crucial to the health and wellbeing of patients and the Council of Governors notes the systematic processes that have been implemented to ensure that the needs of patients are being met. Further work is required to improve the use of the Single Assessment Process folder.

Trust performance against most national standards has been good and nearly all targets have been met. However, inpatient experience can be improved and remains a priority for further improvement in 2013/14. Whilst the new national Friends and Family Test has resulted in ratings for hospital services of over 70 per cent, there is clearly room for improvement and patients have made many positive suggestions.

Governors have met with many members of the Trust and public, including ex-patients, during the year to gain feedback about the Trust's services and patient experience. This information is fed back into the Trust.

The Trust has informed the Council of Governors that in 2012/13, its Summary Hospital Mortality Indicator is within the expected range and it has monitored hospital deaths in detail and has investigated each case. The Council notes that the Trust also uses the Risk Adjusted Mortality Index and the Hospital Standardised Mortality Ratio, supported by a systematic internal mortality monitoring process.

Governors acknowledge that the Quality Accounts provide a significant quantity of information about the care provided to patients and the range of methods used by the Trust to monitor the safety of patient care, clinical effectiveness and the patient experience. The Council of Governors notes the statements of assurance from the Board which describe an extensive quantity of internal and external practices, audits and assessments which are positive, together with the numerous external assessments that have been undertaken including those carried out

by the Care Quality Commission. Following the inspection by the Care Quality Commission in February 2013, it has stated that the Trust is compliant with the standards inspected.

Governors have been able to question Executive and Non-executive Directors in detail within committee meetings to gain assurance about the quality of services in the Trust, and about patient safety and experience. The outputs from committee meetings are reported to the Council of Governors.

Governors wish to place on record their appreciation of the excellent work done by staff especially on the 'front-line', often in stressful or pressurised circumstances.

It is pleasing to note that there has also been an increase in the membership of the Trust. This has been assisted by holding 'Open Days' for the public and members which have addressed areas of interest such as diabetes. These 'Open Days' have all been well supported.

An enhanced Council of Governors committee structure was implemented in early 2012 in anticipation of the changes being brought forward by the Health and Social Care Act 2012. The effectiveness of the Council and its committee structure is reviewed annually.

An excellent working relationship has been established between the Trust Board (and other staff) and the Council of Governors where there is a full and open sharing of information and co-operation. This has greatly assisted the Council of Governors to fulfil its role within the Trust. The Trust policy of 'full openness and transparency' in all areas, both positive and negative, has also greatly assisted the Council of Governors in its governance role.

While receiving significant assurance about performance and standards from the Board, auditors, together with inspection visits and reviews, Governors will continue to discuss with the Board the need for further direct measures of assurance. From Spring 2013 governors will take part in Director's Patient Safety Walkrounds and have the opportunity to talk to inpatients directly while experiencing services.

Governors are very aware of their increased accountability under the Health and Social Care Act 2012. Governors will continue to seek a full understanding of the information provided by the Board against a background of the changed structure and shape of the NHS, and the number of bodies which will have authority and/or influence in its management, especially in the areas of quality and quality oversight and the influence of the Francis Report.

Comment from Healthwatch Dudley (received 26/04/2013)
Healthwatch Dudley is a new organisation that began operating on 1 April 2013. We acknowledge receipt of The Dudley Group NHS Foundation Trust's annual Quality Report and Account for 2012/13. However, bearing in mind that we are a new organisation and the report covers a period of time when we were not in existence, our ability to comment on its contents in the way that we would like is constrained. Nevertheless, we welcome the improvements that have been made to services cited in the report and are mindful of the need to focus on improvement in services where gaps or weaknesses have been identified. More specifically, with regard to the targets identified for action to improve particular services in 2013/14 we look forward to commenting on the progress made towards achieving them in the annual Quality Report and Account for 2013/14. In future, Healthwatch Dudley will expect to develop a more in-depth response to matters raised in the report and include evidence that draws on our knowledge and understanding of the experiences and views of citizens including patients and carers that are used to support our submission.

Comment from the Dudley MBC Health and Adult Social Care Scrutiny Committee (received 24/04/2013)
Our Committee is responsible for health scrutiny and engages respective Quality Accounts as a useful device for considering operational improvement across the sector. They also present an opportunity to ensure priorities are representative of the quality of services provided; and cover areas of importance across Dudley's communities. We are encouraged to see evidence indicating staff increasingly involved in supporting patients at mealtimes; along with data suggesting patients now having access to more information about services on ward arrival - these are among a number patient experience priorities we have collaborated on arising from our 2011/12 dignity in care review.

The favourable trend in MUST assessments signals improved nutritional practice. On hydration, however, year end compliance for fluid balance disguises a variable performance throughout the year - we will wish to remain watchful on this care issue in 2013/14.

Strengthening the Single Assessment Process across patient pathways will further promote effective monitoring of care needs. This coupled with a greater awareness amongst patients, carers and families on how to raise concerns about care and treatment may also result in even better outcomes and experiences.

We commend the achievement of reducing hospital acquired pressure ulcers by 50 per cent and exceeding quarterly community targets; we will be keen to see this good practice implemented consistently across all services for long-term success.

Practically, in terms of the document's future development, greater use of case studies and stronger performance base-lining would be welcomed with the aim enabling the public and scrutiny bodies to better identify with patterns and trends over time.

The Committee welcomes the opportunity to comment on the Trust's QA; and overall supports the direction of travel endorsed by the Council of Governors for priorities going into 2013/14.

Statement of directors' responsibilities in respect of the quality report

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 foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- 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 2012 to June 2013
- Papers relating to Quality reported to the Board over the period April 2012 to June 2013
- Feedback from the commissioners dated 07/05/2013
- Feedback from Governors dated 26/04/2013
- Feedback from the Local Healthwatch organsation dated 26/04/2013
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 23/04/2013
- The national patient survey June 2012
- The national staff survey conducted between September and December 2012
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 31/03/2013
- CQC quality and risk profiles dated 28/2/2013, 31/1/2013 and 30/11/2012

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
-the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.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

Chairman Date 08/05/2013

Chief Executive Date 08/05/2013

Independent Auditor's Assurance Report to the Council of Governors of the Dudley Group NHS Foundation Trust on the Annual 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 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C. Difficile
- 62 day cancer waits

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 2012 to March 2013;
    - Papers relating to Quality reported to the Board over the period April 2012 to March 2013;
    - Feedback from the Commissioners dated May 2013;
    - Feedback from local Healthwatch organisations dated April 2013;
    - The Trust's 2012/13 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated March 2013;
    - Action Plan and Management Response to 2011/12 recommendations (March 2013);
    - Networking Session Draft Notes (November 2012);
    - Full Council of Governors Final Minutes (November 2012) and Draft Minutes (February 2013);
    - Copy of project plan/ outline of approach to Quality Report Production (November 2012);
    - The national patient survey results 2012;
    - The national staff survey result 2012;
    - Care Quality Commission quality and risk profiles dated December 2012, February 2013 and March 2013; and
    - The Head of Internal Audit's annual opinion over the Trust's control environment for the year ending 31/03/2013.

- 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 considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and considered the implications for our report if we became 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 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.

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 2013, to enable the Council of Governors to demonstrate that it has discharged its 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 save where terms are expressly agreed and with our prior consent in writing.

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;
- Analytical procedures
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact 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 thereof, 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 2013:

- 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 the detailed guidance for external assurance on Quality Reports; 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, United Kingdom
23 May 2013

The Dudley Group NHS
NHS Foundation Trust

Annual Report – glossary of abbreviations:

A&E	Accident and Emergency (often referred to as Emergency Department)
C. diff	*Clostridium difficile* (infection)
CCG	Clinical Commissioning Group
CHP	Combined Heat and Power
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DGH	The Dudley Group NHS Foundation Trust
EBITDA	Earnings Before Interest, Taxation, Depreciation and Amortisation
ED	Emergency Department
ENT	Ear, nose and throat
EPR	Electronic patient record
ERP	Enhanced recovery programme
ERS	Electoral reform service
FT	Foundation Trust
FTE	Full time equivalent
GI	Gastrointestinal
GP	General Practitioner
HR	Human Resources
IT	Information Technology
KF	Key finding
LIA	Listening into Action
LINk	Local Involvement Network
MBC	Metropolitan Borough Council

MDT	Multi-disciplinary team
MRI	Magnetic Resonance Imaging (MRI scan)
MRSA	Methicillin Resistant Staphylococcus Aureus (infection)
NBV	Net Book Value
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
PALS	Patient Advice and Liaison Service
PBL	Prudential Borrowing Limit
PBR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PFI	Private Finance Initiative
QIPP	Quality, Innovation, Productivity and Prevention programme
R&D	Research and Development
SHA	Strategic Health Authority
TIA	Transient Ischemic Attack
WTE	Whole Time Equivalent
VAR	Variance
VAT	Value Added Tax
YTD	Year to Date

A glossary of terms is also available on pages 61 and 62 of the Quality Report.

This leaflet can be made available in large print, audio version and in other languages, please call 0800 0730510

ਜੇਕਰ ਇਹ ਲੀਫ਼ਲੈੱਟ (ਛੋਟਾ ਇਸ਼ਤਿਹਾਰ) ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ (ਪੰਜਾਬੀ) ਵਿੱਚ ਲੈਣਾ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰ ਕੇ ਪੇਸ਼ੰਟ ਇੱਨਫ਼ਰਮੇਸ਼ਨ ਕੋ-ਆੱਰਡੀਨੇਟਰ ਨਾਲ **0800 0730510** ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ ਸੰਪਰਕ ਕਰੋ।

यदि आपको यह दस्तावेज़ अपनी भाषा में चाहिये तो पेशन्ट इनफरमेशन को-आरडीनेटर को टैलीफ़ोन नम्बर **0800 0730510** पर फोन करें।

જો તમને આ પત્રિકા તમારી પોતાની ભાષા (ગુજરાતી)માં જોઈતી હોય, તો કૃપા કરીને પેશન્ટ ઈન્ફોર્મેશન કો-ઓર્ડિનેટરનો **0800 0730510** પર સંપર્ક કરો.

আপনি যদি এই প্রচারপত্রটি আপনার নিজের ভাষায় পেতে চান, তাহলে দয়া করে পেশেন্ট ইনফরমেশন কো-অর্ডিনেটারের সাথে **0800 0730510** এই নম্বরে যোগাযোগ করুন।

أذا كنت ترغب هذه الوريقة مترجمة بلغتك الاصلية (اللغة العربية) , فرجاء ا أتصل بمنسق المعلومات للمريض **Information Co-ordinator** على التلفون **0800 0730510**

حسب ضرورت اس لیف لٹ کو اپنی زبان (اُردو) میں حاصل کرنے کے لئے براہ مہربانی ٹیلیفون نمبر **0800 0730510** پر پیشنٹ انفرمیشن کو-اوارڈینیٹر (مریضوں کے لئے معلومات کی فراہمی کے سلسلے میں افسر) کے ساتھ رابطہ قائم کریں۔

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 4TH July 2013

TITLE:	**Board Assurance Framework – June 2013**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Paula Clark** **Chief Executive**

CORPORATE OBJECTIVES: ALL

SUMMARY OF KEY ISSUES:

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

This report identifies the Trust Assurance Framework and specifically:

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

In addition to the operational risk registers (reported to Risk and Assurance Committee) the Directors are currently managing 27 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (7 risks in total). The report shows the assurance to date of the effectiveness of the management and control of these risks. Action plans are in place, or being developed to address any gaps in control or assurance identified at this time.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD:

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

THE DUDLEY GROUP NHS FOUNDATION TRUST
BOARD ASSURANCE FRAMEWORK – RISKS SCORING 20 AND 25 as at JUNE 2013

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **20** **NEW Lead Director : R Cattell**	Sub optimal management of Diabetes patients	CQC Outcome 4,6,16	1. Diabetes management plans formulated by DOT Team and written in patients notes.	1/2. National external diabetes annual audit.	1.National Diabetes Inpatient Audit 2012 and National external diabetes annual audit results.(March 13) 2) CQPSE Cttee April 13 National Diabetes Inpatient Audit shows overall continuing improvements in diabetes care, Nationally the Trust ranks highly on the majority of outcomes. It is believed to be related to the impact of the Front Door Diabetes Team and the protocols developed in the Trust as part of the Think Glucose project. 2. Audit Committee May 13 - Annual Clinical Audit report 2012/13		1 / 2. Staff do not follow guidelines, surgical pre-assessment do not refer patients in timely manner to enable optimisation of diabetes control pre-theatre.	2. Ensure diabetes assessment is a mandatory part of the new nursing EPR, and monitor Nursing Care Indicators. 2.Ensure all patients have a lab blood glucose on admission

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **20** **NEW Lead Director : R Cattell**	Sub optimal management of Diabetes patients	CQC Outcome 4,6,16	3. Standardised insulin administration and testing equipment within Trust	2/3. National external diabetes annual audit.	As above			
			4. Diabetes protocols and guidance available on Hub for staff to use	4.Policies and guidelines	4. Monthly NCI audits of THINK GLUCOSE		4. Guidelines for surgical management of diabetes, hyperglycaemia and self-administration of insulin are yet to be ratified.	4 Produce urgent Care Bundles for diabetic Ketoacidosis and Hyperkalemia. 4 Produce guidelines and load on Hub for: • Surgical Management of Diabetes • Hyperglycaemia • Self-administration of Insulin
			5. Staff training for diabetes on induction and then 3-yearly updates.	5. Mandatory Training records.	5. Training registers and evaluation sheets 5.Diabetes update sessions records 5. Completed training included in April 2013 mandatory training reports	5. Mandatory Training status for diabetes agreed in November 2012, so poor compliance at this point Trust-wide.	5. Staff do not attend mandatory training	5. Provision of departments/ professional specific training DOT.
			6 Attendance of Diabetes mandatory training included in managers monthly mandatory training reports.	6 Mandatory training reports				
			7. Link Diabetes Nurses on all wards.	7. Champions list	7. Think Glucose Champions on wards.			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **20** **NEW Lead Director : R Cattell**	Sub optimal management of Diabetes patients	CQC Outcome 4,6,16	8. Staff responsible for prescribing, preparing and administering insulin are trained before doing so. (NPSA/2010/RRR013).	8. Mandatory Training Records		.	8. While nursing staff have this as part of Medicines Management Programme, there is no record of medical staff compliance with this control, and no evidence that this staff group have been requested to undertake this training 8. Staff do not attend mandatory training	8. Improve knowledge and training of MAU and ED staff in the management of acute diabetes complications. 8. Ensure all medical staff who prescribe, prepare and administer insulin are trained 8 Improve Medicines Reconciliation Service on EAU.
			9. Datix monitoring for trends.	9. Datix Reports.	9.Quarterly aggregated report of incidents to CQPSE 9.Monthly Serious Incident Reports to CQPSE 9. Monthly Summary of key issues arising from CQPSE to Board	Increase in diabetic related incidents		
			10. Pharmacy Audit for missed doses and insulin errors.	10. Audit reports from Pharmacy	10. Annual Audit Results 10. Nurse Care indicator report to CQPSE (Medication)			10. Inclusion of diabetes care and insulin in Medicines Management mandatory training.
			11. Nursing Care Indicators monitor Trust compliance with diabetes screening for each patient admission, reports sent by Nursing Directorate to Diabetes Team.	11. Nursing Care Indicator Audits	11. Monthly NCI audits of THINK GLUCOSE CQSPE - May 2013 "The greatest improvement has been in the Think Glucose criteria with an increase of 26% on previous year's performance (79% compliance)."			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **20** **NEW Lead Director : R Cattell**	Sub optimal management of Diabetes patients	CQC Outcome 4,6,16	12. ED and EAU undertake routine blood glucose for all new admissions as part of their biochemical test screen.		12. Effective from 13/03/13			
			13. Diabetes Outreach Team available for advice Mon – Fri 9am to 7pm and Saturday 9am to 5pm. Referral process in place.	13 Audit of patient referrals to Diabetes Outreach Team.	13.Audit Results			

Board Strategic Theme: Patient experience	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG02: To provide the best possible patient experience	a) Mobilising the workforce with a passion for getting things right for patients every time	Section C: Clinical and Quality Strategy. Appendix 3E	Outcome 12, 13, 14	CQSPE
		b) Creating an environment that provides the facilities expected in 21st C healthcare and which aids treatment and or/recovery	Appendices 3 C & 3F	Outcome 8 Outcome 10	CQSPE
		c) Providing good clinical outcomes and effective processes so that patients feel involved and informed	Section C: Clinical and Quality Strategy.	Outcome 1,4	CQSPE

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

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

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

Board Strategic Theme: Clinical Partnerships	Strategic Goals		Key Priorities			Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG04: To develop and strengthen strategic clinical partnerships to maintain and protect our key services		a) Demonstrate a distributed leadership model with empowered clinical leaders			Section G: Leadership & organisational Development	Outcome 12, 13, 14	CQSPE
			b) Promoting risk sharing with CCGs			Appendices 3a & 3d	Outcome 6	F&P
			c) Developing clinical links with local GPs and healthcare practitioners			Appendix 3d	Outcome 6	CQSPE
			d) Develop new clinical networks that provide resilience through a more distributed service model			Appendices 3a & 3d	Outcome 6	F&P
Risk Ref	**Risk Description**	**Monitor / CQC / NHSLA ref**	**Current Controls**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**	**Gaps in Control**	**Mitigating Actions**
COR003 (OPO90) **Score 20** **NEW Lead Director : R Cattell**	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	1.Re-designation of surgical beds to medicine has taken place.	1. Board reports include elements of bed capacity etc.	**Reports to Board** April 13 - Transformation Report May 13 Estates Strategy		1. Occasional inability to protect surgical beds. .	1. Admit on the day of surgery to reduce pre-op LOS. 1.Surgery and T&O beds managed as part of whole hospital 1. Implement the 'Enhanced Recovery' programme. (EPR project Timeline)
			2. CD/MSH review of elective admissions to prioritise if cancellations are imminent.	2.Level of cancellations	Finance and Performance Reports		2. MSH/medical staff not consistently engaged in Capacity Management.	2. Empower non-medical staff to improve MDT-led discharge. (Ongoing)
			3. New capacity management system partially deployed.	3. Attended SHA workshops, project group established. 3. Pilot with West Midlands ambulance service will provide additional control.	3. Capacity Team operating training and Capacity HUB area 3. New operating model for capacity meetings		3 Poor attendance at capacity meetings	3 Imperative from Operations Directorate to attend

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR003 (OPO90) **Score 20** **NEW Lead Director : R Cattell**	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	4. Discharge Co-ordinators DISCO.	4.DISCO database	4. Multi agency discharge planning forum meeting minutes. 4. Discharge Process/policy	4 Database only covers Dudley patients		
			5..Escalation Policy and contingency capacity policy reviewed and deployed	5. Discharge Policy available to staff	5."Ready to go " - Information on patient discharge pathways available on the HUB		5 Understanding of policies by all staff	5 Discussion at capacity meetings.
			6. Daily capacity meetings.				6.Bed/Capacity Management approach/systems not aligned to predictive demand management within specialities/wards locally	
			7. Work with primary care and commissioners to curtail urgent care demands, provision of virtual ward etc.	7.Urgent Care Project Steering Group in place, with full and active participation of the CCG Urgent Care Lead GP and Urgent Care Commissioning Managers.	**7.Board April 13** - Transformation Report (including update of Urgent Care Redesign Project). **Board June 13** -Transformation Report (including update of Urgent Care Redesign Report		7. Failure of all parties to contribute. 7. Failure of partners to agree	7. Engagement with all partners of all members of urgent care team from DGH
			8. Directorate SOP					

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR007 (OP080) **Score 20** **NEW Lead Director : R Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	1. Daily monitoring of the delayed discharges via the delayed list, ensuring its accuracy and that challenges by the ward to the patients care is being managed and escalated appropriately.	1. Escalation meeting daily at 9.15am. Information available on the HUB	1.Daily Delays report. 1. Monthly KPI reports to F &P on bed occupancy & medical outliers. 1. ED targets (part of performance information to monthly Board meetings)			
			2. Ward-based Discharge Team support and plan discharge. Use of estimated discharge at ward level. Escalation to Medical Service Head as appropriate.				2.Poor service cover from multi-agency Discharge Teams because of vacancy, sickness, leave etc resulting in further delays. DISCO database. 2. Not ubiquitous cover across hospital	2 .Oversight by capacity team, escalation to Director of Operations.
			3. Lead Nurse meetings with patients and relative to identify needs for discharge.				3. Patient or relative exercising "choice" exacerbates problem.	3 Use of standard “expectations letter” Lead nurse contact

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR007 (OP080) **Score 20** **NEW Lead Director : R Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	4. Early notification to LA via Section 2 to prepare for patients likely needs	4.Section notifications	4. Timeliness of Section Notifications			4.Early understanding of financial constraints from Local Authority and planned use of new re-ablement monies to increase current capacity and response from local authority.
			5. MOA - Local Authority and PCT signed off.	5 MOA	5. Signed MOA 5. Urgent Care Programme Board Minutes and actions April 2013		5 DMBC overseeing a higher than agreed number of patients.	5 Escalation of issue to Director level.
			6. Agreed health economy escalation plan. Provision of training on compliance with the escalation plan. Issue of letter to prepare patients and family for discharge arrangements	6.Escalation Plan 6.Training Records 6.Letters to Patients	6. Compliance with Escalation Plan 6..Training undertaken May 2012			
			7. Utilisation of independent company Care Home Select (CHS) to support patients/relatives in identifying suitable 24-hour care placement. Matron/Lead Nurse ensure that understanding of discharge processes is provided by all nurses/carers.	7. Integrated Care Group Minutes and actions.				
			8. Daily multi-agency teleconference at Level 2 or above.		8. Notes of meeting			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR007 (OP080) **Score 20** **NEW Lead Director : R Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	9. Directorate solutions to manage delayed discharge.	9.Acute Medical Unit 9. Provision of non acute care	**Acute Medical Unit Business Case - Board 6th Oct** **Acute Medical Unit Business Case - F&P 25 Oct** **Additional Board** - July 12 Provision of Non Acute Care report – exploration of Trust options. None recurrent winter pressure monies secured on LHE initiatives, into all of 2013/14	9.Funding for 13/14 can only be provisionally agreed as it is unclear what elements of the reablement money will be available.		Working with CCG and LA to manage delayed discharge database, improve admission prevention SW input.

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR026 **Score 20** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	1. Ward staffing levels have been reviewed with Matrons and presented to the Board. .	1.Staff Survey Results	Workforce KPIs reported to F&P monthly. **CQSPE Committee** – May 2013 National Staff Survey - Update on Activity	1/3.Nursing skill mix review for specialist departments will conclude in April. Further investment is likely.	1 Staffing levels fall below acceptable safe levels.	1 / 3 .Explore investment opportunities. 1. Use of AUKUH/Safer Nursing Care tool
			2. Rosters managed and monitored. Matrons and Lead Nurses, midwives & AHP Leads identify shortfalls in staff levels and rectify	2 / 4 Datix Incident Reporting captures shifts with staffing concerns reported to CQPSE Committee	CQSPE - May 2013 Aggregated Report of incidents			
			3. Significant investment in the workforce. Mass recruitment undertaken.	3. Financial investment made in high risk wards in medical directorate.	**Board May 13 -** F&P Report **Income & Expenditure Position – Year to 31:03:13 (Appendix 5) and investment in front line staff.**	1/3.Nursing skill mix review for specialist departments will conclude in April. Further investment is likely.		1 / 3 .Explore investment opportunities.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR026 **Score 20** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	4. Nurse bank established.	2 / 4 Datix Incident Reporting captures shifts with staffing concerns reported to CQPSE Committee				4 / 5 Use of Bank Staff to cover shortfalls.
			5. Continue to use bank staff to cover vacancies. Move staff to under resourced areas.	5. Agency expenditure remains low. (Reports on agency staffing at F&P Committee).	Reports on agency staffing at F&P Committee.	**F&P Committee – May 2013 - Income & Expenditure Summary April 2013 Agency (medics, qualified and unqualified and others) spending and trends reported. Upward trend in all but Medics.**		4 / 5Use of Bank Staff to cover shortfalls.
			6. Accredited training programme established for novices and new graduates.	6 Training Records				6 Continue with pro-active vacancy management for both graduate posts and novice programme.
			7. Actions plans developed.					
			8. Matrons report to Board and Nursing Care Indicators to CQPSE.	8. Nursing Care Indicators reported at least quarterly to CQPSE. 8.Monthly Matrons presentation to Board	**6.CQPSE** NCI reports – Aug, Nov 12, Mar 13, May 13 - 12 wards on level 1 escalation, 4 wards on level 2 escalation. 6.Matrons report to Board (monthly)			

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR 034 **Score 25** **Lead Director: P Assinder**	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £15.7m (5.5% of budget). A Transformation, IT and Traditional CIP combined Programme of £15.3m, 5.9% of budget has been developed. This has a very high risk of failure.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1. The Board has approved a programme of CIP savings proposals.	1. Board and Board Committee Reports. Monthly CIP updates to F&P Committee	**1. F&P Committee** -Jan 13 - Financial projections 2013/14 onwards -Feb13- Report on IT CIP) -March 13 – Financial Plan March 13 - Financial Budget Package 2013/14 April 13 - Income & Expenditure Summary Draft Outturn 2012/13 May 13 - Income & Expenditure Summary April	1 Future years CIP schemes require further development to enable them to be brought forward. 1 Absence of a clear understanding of Commissioner's roles in CIP quality assurance	1. Although the Trust has identified sufficient savings schemes it has not yet fully developed these schemes to achieve the required financial contribution of £15.7m for 2013/14. The Trust has made a poor start to the years CIP programme (£0.8 off plan at Month 2)	1. Traditional and service re-design and drive towards Lean. Support on longer term CIP opportunities by the Transformation Programme. 1. CIP discussions continuing with each Directorate and form part of business plans 1. As part of the new contracting round agree a protocol with Commissioners
			2. A Programme Management Office (PMO) capability is established and has been operating effectively for some months.	2. PRINCE level project management of individual schemes.	2. Transformation & CIP PMO established and resourced.	2. Full alignment of Commissioner's QIPP and Trust CIP schemes. 2.Delays in agreement of schemes & delivery by PFI Contract Efficiency Group	2. Some schemes remain to be fully developed and implemented. Some schemes will deliver benefits that are unlikely to yield cash savings in 2013/14.	2. Detailed monthly progress reports prepared. 2. The Trust is seeking transitional funding support from the local CCG.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont .. **COR 034** **Score 25** **Lead Director: P Assinder**	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £15.7m (5.5% of budget). A Transformation, IT and Traditional CIP combined Programme of £15.3m, 5.9% of budget has been developed. This has a very high risk of failure.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	3. Regular reports are made to the Board's Finance & Performance Committee, Directors and TME.	3 Detailed scrutiny of Directorate and Corporate CIP Schemes at Directorate Performance Review Meetings and weekly Directors Meetings. 3 Reports to TME	3.**F&P Committee** 2013/14 Financial Efficiency paper 29th Nov 2012 3. Financial efficiency process and plans (Jan 13)		3.Many schemes are not recurrent creating pressure in future years. 3. The efforts of managers and Trust staff is diverted on the management of day-to-day operational pressures rather than the achievement of efficiency savings.	
			4. All CIP proposals are risk-assessed for impact upon clinical standards and signed off by the Medical Director and Nursing Director.	4.CIP Risk assessments	4 CIP risk assessments (2013/14) **4.F&P Committee** Financial projections 2013/14 onwards (Jan 13) IT CIP update (Feb 13) Financial Plan (March 13) March 13 - Financial Budget Package 2013/14	4.Completion of quality risk assessments		
			5. Monitor approval of plan.	5. Monitor approval of plan.	5 Monitor Finance and Governance Risk Ratings			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR 42 **Score 25** **Lead Director:** **P Assinder**	Failure to deliver financial balance in 2013/14as a result of further efficiency abatement to NHS Tariff and clinical cost pressures, the Trust is required to deliver unprecedentedly high cash releasing Cost Improvement s in 2013-14. A Transformation, IT and Traditional CIP combined Programme of £15.3m, 5.9% of budget has been developed. This has a very high risk of failure.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1. CIP in place.	1. Monthly Progress reports	1 F&P Committee – May 2013 Income & Expenditure Summary April 2013	Audit Committee May – Deloitte Report		
			2. Transformation Programme Board established.	2. Minutes of Transformation Project Board	**2/3 Board – 1st Nov** Transformation programme Structure Report and 4th April 13 Transformation Programme Board 2/3 Board – 6th June 2013 Transformation Programme update			
			3. CIP Transformation Team in place. 4. Traditional and service redesign and drive towards LEAN.	3/4.Transformation & CIP PMO established and resourced.	3/4Transformation Project Board inaugural meeting January 2013.	3. /4Delivering widespread clinical change will be a cultural 'hearts and minds' issue that is notoriously difficult to measure.	3 / 4 Given the transformational nature of savings schemes in 2013-14 the increased participation of clinicians in promoting clinical practice changes is essential. Whilst the vast majority of clinicians are on board the pressure from increased activity and maintaining high clinical quality standards may impact on their ability to be fully involved in the process.	3. Directors to take personal responsibility for the delivery of individual CIP projects.
			5. Detailed monthly progress reports.	5.Monthly Progress reports	5. F&P Committee – May 2013 Income & Expenditure Summary April 2013		5. The controls have delivered effective CIP savings schemes in previous years but size of the savings target is greater and the need is for greater transformational change to deliver sig financial benefit.	

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
NEW COR043 Score 20 Lead Director: Paul Assinder	The Trust will be working to a much more onerous NHS Standard Acute Contract in 2013-14 than hitherto. The DoH and NHSCB have already declared that CCGs MUST invoke financial penalties for non-compliance issues	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1 Detailed monthly monitoring of exposure to penalties by Directorates and Corporate Information Teams.	1. Independent audit scrutiny of data capture and reporting. 1. Monthly discussions with Commissioners.		1. In the absence of clear targets and definitions, data capture and reporting processes may be inadequate. 1. The Commissioners have initiated penalties in the first 2 months of the year for A&E and Ambulance breaches		1 We are currently (June 2013) seeking to negotiate with Commissioners deployment of any funds recovered through the imposition of fines / penalties (Concludes April 2013).
			2 Escalation procedure of risk issues to Directors.	2. Directorate Performance Review Meetings			2 Continuous increases in emergency activity compromise effective risk management processes.	2 Undertake detailed assessment of exposure for each potential penalty and develop agreed escalation and mitigation strategies (May 2013).
			3 Regular performance reports to Directors/F&P Committee and Board	3. Detailed monitoring by commissioners and strict escalation and investigation of breaches regime in place.			3 Clinical Departments are not sufficiently sighted on such performance risks and target achievement is always subservient to safety and quality concerns	

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
			4 Corporate and departmental dashboards in place for monitoring.				Poor / inadequate IT solutions in place to provide constant monitoring of target achievement in certain instances.	
			5.Breach analysis and reporting regime in place					

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
NEW COR046 **Score 20:** **Lead Director:** **P Clark**	Reputational risk associated with the Keogh mortality review.	NHS England	1.Project lead identified to collate supporting evidence		**1.Board** Meeting held on Thursday, 7th March, 2013,		1 Full scope of review and process unknown	
			2.Board briefings and review process	2. Board and Council of Governors presentations.	2.Chief Executives Update March 13 2.Francis Inquiry Update report (Board April 13)			
			3. Council of Governors briefing and review process.	3.Medical Director and Director of Nursing briefing to Board, Council of Governors, Dudley Health and Adult Social Care Committee and patient panels.	**3. CoG Feb 13 –** Chief Exec update and Mortality Update by Dr Harrison. **3.Extra –Ord CoG Mar 13** Update on Trust response to Francis) and Mortality Update by Dr Harrison 3.Dr Harrison presentation to Dudley Health & Adult Social Care on 27th Mar13			
			4. Staff advised of requirements and impact on clinical areas.	4.Staff Briefings	4. C Executive Video to all staff supported by open sessions February 2013. 4.Message from Chief Exec 6th Feb 13 and HUB story 12th Feb 13 4. Your Trust Issue 19 to all staff and Trust members. 4.GP brief (issue 12)			

The Dudley Group NHS Foundation Trust

Enclosure 9

Paper for submission to the Trust Board on 4th July 2013

TITLE:	Safeguarding Report to Trust Board – June 2013		
AUTHOR:	Pam Smith Matron Lead Safeguarding Children and Adults	**PRESENTER:**	Denise McMahon Nursing Director

CORPORATE OBJECTIVE:
SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2: Patient experience - To provide the best possible patient experience
SGO6: Enabling Objectives - To deliver an infrastructure that supports delivery

SUMMARY OF KEY ISSUES:

1. EXTERNAL REVIEWS

CQC/OFSTED ASSESSMENT

Evidence of assurance for completed actions have been submitted to the Clinical Commissioning Group. An evidence log of completed actions for the Trust is being developed. This will be monitored by the CCG at the Children's Health Safeguarding Forum.

SECTION 11 AUDIT

Dudley Safeguarding Children's Board no longer require confirmation of compliance from the self assessment. The board are confident that required action has been implemented. The audit is due to be repeated this year.

2. LEARNING DISABILITY

The Learning Disability Liaison Nurse post has been recruited. The Winterbourne View Key Findings report has been reviewed and an action plan is being developed for presentation at the Internal Safeguarding Board.

A number of incidents identifying poor compliance with the management of patients with Learning Disabilities and failure to undertaken appropriate mental capacity assessment are being investigated. A series of specific training sessions for medical staff have been implemented to raise awareness and knowledge.

Dudley Safeguarding Adults Board have requested an independent review of one case in collaboration with Changing Our Lives. Key professionals have met and a report will be presented to the Dudley Safeguarding Adults Board in August 2013.

3. TRAINING

Safeguarding Children compliance:
Foundation level is at 78.8%.
Intermediate level is at 50.1%. A review of the staff requiring this level of training is in progress and is likely to result in an increase in the % compliance.

Safeguarding Adults compliance
Training is at 75% across the Trust.

Private Finance Initiative partners Safeguarding compliance
On line training is 100%.
Face to face training for porters and security staff is at 60% and 50% respectively. This has been discussed with the Director of Operations, Head of Estates and FM.

Mental Health compliance
This has increased from 37% to 48% across the Trust against a target of 38% for the year.

4. SAFEGUARDING ADULTS – MULTI AGENCY POLICY AND PROCEDURES

Multi agency policies and procedures for the West Midlands have been launched. The Internal Safeguarding Board have expressed concerns at the complexity and process for the written referral process for safeguarding adults; as there is a requirement for duplication of documentation with an external referral form and an internal incident referral form using the Datix system.

5. DEPARTMENT OF HEALTH LETTER RE: JIMMY SAVILE ALLEGATION (Gateway Ref. 18350)

Guidelines for the 'Wishing Well' charity have been developed and are being submitted for ratification. The Volunteer Policy has also been reviewed. There is still a requirement to provide guidance for visiting celebrities visiting any patient area of the Trust. The Named Nurse for Safeguarding is liaising with the Communications Manager.

6. WORKING TOGETHER

A review of this document has now been published. This is due to be reviewed at the Internal Safeguarding Board on 27th June 2013.

IMPLICATIONS OF PAPER:			
Risk Management	**Risk Register:** Y		Review of safeguarding practices in light of Savile allegations
	Risk Register: Y		**CSO11 Score 6 -** Lack of Safeguarding Children Intermediate Training **NEW Score 12 -** Lack of Learning Disabilities Role Trust wide
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Compliance with Care Quality Standards Outcome 7
	NHSLA	Y	**Details:** CNST Maternity standards
	Monitor	Y	**Details:** Ability to maintain at least level 1 NHSLA
	Equality Assured	Y	**Details:** Better Health outcomes Improved Patient access and Experience
	Other	N	**Details:** Safeguarding

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
		✓	

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

The Dudley Group NHS
NHS Foundation Trust

SAFEGUARDING REPORT TO TRUST BOARD
JUNE 2013

1. EXTERNAL REVIEWS

(i) CQC/OFSTED ASSESSMENT

The Trust continues working with collaboratively with other health partners to implement an action plan following the Care Quality Commission/Ofsted inspection in November 2011. The Matron Lead for Safeguarding has submitted evidence of assurance for completed actions to the Clinical Commissioning Group safeguarding admin support and following a request from the CCG is in the process of developing an evidence log of completed actions for the Trust. This will be monitored at the Health Safeguarding Forum.

(i) CQC/OFSTED THEMATIC INSPECTION FOR MENTAL HEALTH AND SUBSTANCE MISUSE

Maternity has shared policies and procedures and are attending further meetings with key professionals from other agencies. No further progress to report.

(ii) SECTION 11 AUDIT

Dudley Safeguarding Children's Board no longer require confirmation of compliance from the self assessment. The board are confident that required action has been implemented. The audit is due to be repeated this year.

2. LEARNING DISABILITY

(i) Learning Disability Liaison Nurse

The post has been recruited to. Jackie Howells is due to commence post on 29th July 2013.

(ii) Winterbourne view – Key Findings

The report has been reviewed and an action plan is being developed for presentation at the Internal Safeguarding Board.

(iii) Incidents

It was reported at the April 2013 Internal Safeguarding Board that a number of incidents identifying poor compliance with the management of patients with Learning Disabilities and failure to undertaken appropriate mental capacity assessment had been noted. These are being investigated. A series of specific training sessions for medical staff have been implemented to raise awareness and knowledge.

An independent review of one case is being undertaken in collaboration with Changing Our Lives at the request of Dudley Safeguarding Adults Board. This is due to presented at the DSAB in August 2013.

3. TRAINING

(i) Safeguarding Children compliance

Compliance with the Foundation level is at 78.8%.
Compliance with the Intermediate level is at 50.1%, however, a review of the staff requiring this level of training is in progress and is likely to result in an increase in the % compliance.

(ii) Safeguarding Adults compliance

Compliance for this training is at 75% across the Trust.

(iii) Private Finance Initiative partners Safeguarding compliance
Compliance of PFI partners undertaking the on line training is 100%.
Face to face training for porters and security staff is at 60% and 50% respectively. This has been discussed with the Director of Operations, Head of Estates and FM.

(iv) Mental Health compliance
Compliance for this training has increased from 37% to 48% across the Trust against a target of 38% for the year.

4. RESTRAINT POLICY AND RESTRAINT TRAINING

The Restraint Policy has been submitted to the Policy Group for review prior to ratification. This has been tabled for the July Policy Group meeting.

5. GUIDELINES FOR UNDER 16's WHO ARE PREGNANT

The Named Nurse for Safeguarding Children is working with staff in the Emergency Department and the Gynae ward to develop a risk assessment and guidelines are being developed.

6. COMMON ASSESSMENT FRAMEWORK POLICY

This is being reviewed. There is a push from Dudley Safeguarding Children's Board to improve the number of CAF assessments completed, including the use of CAF for teenagers identified as having problems with substance and/or alcohol misuse.

7. DEPARTMENT OF HEALTH LETTER RE: JIMMY SAVILE ALLEGATION (Gateway Ref. 18350)

The report was reviewed at the Internal Safeguarding Board in April 2013. Guidelines for the 'Wishing Well' charity have been developed and are being submitted for ratification. The Volunteer Policy has also been reviewed. There is still a requirement to provide guidance for visiting celebrities visiting any patient area of the Trust. The Named Nurse for Safeguarding is liaising with the Communications Manager.

8. DEPRIVATION OF LIBERTY SAFEGUARDS AUTHORISATION

The Internal Safeguarding Board has agreed that they will undertake DoLs assessments during office hours with the site coordinators undertaking this out of hours.

9. SAFEGUARDING ADULTS – MULTI AGENCY POLICY AND PROCEDURES

Multi agency policies and procedures for the West Midlands have been launched. These were circulated in January 2013. The Internal Safeguarding Board have expressed concerns at the complexity and process for the written referral process for safeguarding adults; as there is a requirement for duplication of documentation with an external referral form and an internal incident referral form using the Datix system.

10. WORKING TOGETHER

A review of this document has now been published. This is due to be reviewed at the Internal Safeguarding Board on 27th June 2013.

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meeting held on 27th June 2013**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**

CORPORATE OBJECTIVE:

SO 10 Enabling Objective

SUMMARY OF KEY ISSUES:

- **The Trust has generally continued to perform well against the long list of access and waiting target set by the NHS nationally and locally. The notable exception to this is the key 4 hours access target for A&E, which has now been missed for the second successive quarter.**
- **Financially the Trust has performed well in the first weeks of the year and at the end of May, recorded a small surplus of £0.8m.**
- **However the Committee noted with some concern some early slippage on CIP schemes.**

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in Q1 forecast**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **Monitor has rated Trust at 'Amber/Red' for Governance & '3' (good) for Finance at Q4. The Trust remains on quarterly monitoring by Monitor.**
	Other	**N**	**Details:** **Some exposure to performance fines by commissioners**

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
			X

NB: Board members have been provided with a complete copy of agenda and papers for this meeting.

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to:

1. **Note the report.**

The Dudley Group NHS
NHS Foundation Trust

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

Finance and Performance Committee Meeting held on 27th June 2013

1. Background

The Finance & Performance Committee of the Board met on 27th June 2013. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports. The Committee noted in particular the following matters:

2. The Allocate workforce rostering system

The Committee received a progress report from the Director of Nursing on the rollout of a replacement nurse rostering system, 'Allocate'. The system will be configured to centralise the daily clerical tasks of staff rostering and sickness management from ward based nurses and is estimated to release significant nursing hours for direct patient care.

3. Business case to extend staff counselling services

The Committee has closely monitored trends in workforce absenteeism and sickness over the past year and has invited Directors to develop a detailed strategy to respond to a deteriorating trend in some departments within the Trust. This Business case is a response to an increasing wait for access to specialist counselling services through Occupational Health professionals within the Trust. The Committee were pleased to support the case for additional counselling resources to meet the growing demand.
In future, the Committee will be invited to consider a comprehensive strategy for addressing staff sickness within the Trust.

4. Workforce KPIs

a. Absence
The Trust absence rate for the month of April is 4.35% (4.32% in April) and was 4.02% in 2012. The 2013-14 target is 3.50%.

b. Turnover
Turnover continues to remain consistent and within target at 7.76% (7.94% in April)

c. Pre-employment Checks
Pre-employment checks managed through the Centralised Recruitment Department perform at 100%, together with 100% for Medical Workforce recruitment. Staff bank also performed at 100%.

d. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small decrease on previous months. However in part this is the result of adding Diabetes Management training to this portfolio (27.9% compliance).

Appraisals have increased again this month to 82.3% (81.8% in April).

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

f. Vacancies
The current live vacancy rate has increased slightly to 238 FTE.

g. Employment Tribunal Summary
The Committee noted that the Trust had 11 ET cases submitted during 2012-13. Of these 7 have been closed, with 4 currently ongoing or awaiting scheduling. The Committee noted that the Trust has been extremely successful in defending claims against it with minimal awards in claimants favour.

5. Training Programme for Junior and middle-grade doctors

The Board will recall that the Trust has recently launched an innovative scheme for the direct recruitment and training of junior and middle grade doctors in hard pressed specialties. The Committee noted the first round of recruitment had gone well with 8 posts (of 26) now recruited to. This is estimated to reduce medical agency locum costs by £81,000 in 2013-14.

6. Financial Performance for Month 2 - May 2013 (Appendix 1)

The Trust made a small trading surplus of £1.1m in May (deficit of £297,000 in April). Although forecast, this surplus was significantly ahead of Plan, due to receiving slightly higher levels of income from CCGs for additional elective activity in the month. This reflects a determined effort to recover some of the planned cases that were delayed during the winter months when emergency admissions were much higher than planned.

However, in common with some other areas of the local NHS, pressures on emergency and unplanned care in the first quarter of the year has resulted in some ambulance turnaround delays and excessive patient waits in the Russells Hall A&E Department and under the new NHS operating regime, it is possible that local commissioners may levy performance fines. The Committee further considered a detailed report on the various performance contracts in place in 2013-14 across the NHS and to which the Trust is now subject. The significant increased exposure to financial penalties (and the absolute absence of financial incentives) was noted.

Once again, the Committee noted with concern slippage on some CIP schemes, with £3.8m (£3.5min April) now achieved to date against a 2013-14 savings plan of £12.5m. This is £850k behind the phased plan for May and will thus require closer scrutiny by the Committee over the next couple of months.

At this stage of the year, the Trust forecast outturn is a £600k surplus, in line with the approved plan.

The Trust's balance sheet and liquidity position remains strong.

Capital spending is generally in line with phased plans and the Committee further received a progress report on works associated with the operation of Dudley Clinical Services.

7. Performance Targets and Standards (Appendices 2 & 3)

The Committee noted the following matters:

a) A&E 4 Hour Waits (Q1 failure to hit the target)

The percentage of patients who waited under 4 hours within A&E for May was 96.6% However April was 90.1% and the recovered performance in May did not continue sufficiently in June for the overall Quarter 1 performance target of 95% compliance (a key Monitor target) to be met. Given that this is the second consecutive Quarter that this target has been missed, it is likely that the Regulator will rate the Trust 'red' in its public governance rating and require the submission of a detailed recovery plan and monitoring regime. Clearly, Russells Hall is not a-typical of other local providers in failing this target and is indicative of well-publicised pressures upon the emergency care systems across the Country over the past 12 months.

b) Cancer 14 days GP referral for urgent breast care

The Trust has achieved this performance target in Quarter 1 but the Committee noted the risk associated with staff sickness in this Department. It considered a report from the Cancer Services Department to ensure continued rapid access to care at Russells Hall.

c) Never Events

The Trust had no 'never events' in May.

d) Mortality Indices

The Committee noted that all current reported mortality indices are within expected ranges:

Standardised Hospital Mortality Indicator (Dept of Health)	1.04
Hospital Standardised Mortality Ratio (Dr Foster/HED)	99
CHKS Risk Adjusted Mortality Index (CHKS)	96

8. Monitor Quarter 4 assessment

The Committee noted the confirmation of Monitor of the Board of Directors' Quarter 4 financial risk rating of '3' and governance rating of 'amber/red'.

9. Approval of 2012-13 reference costs process

The Committee approved the Director of Finance's costing approach and process plan for completion of the 20012-13 reference costing set for Monitor.

10. Matters for the attention of the Board of Directors

The Board is asked to note the report and in particular actions taken under delegated authority in Paragraph 9, above

PA Assinder
Director of Finance & Information
Secretary to the Board

APPENDIX 1

THE DUDLEY GROUP NHS FOUNDATION TRUST

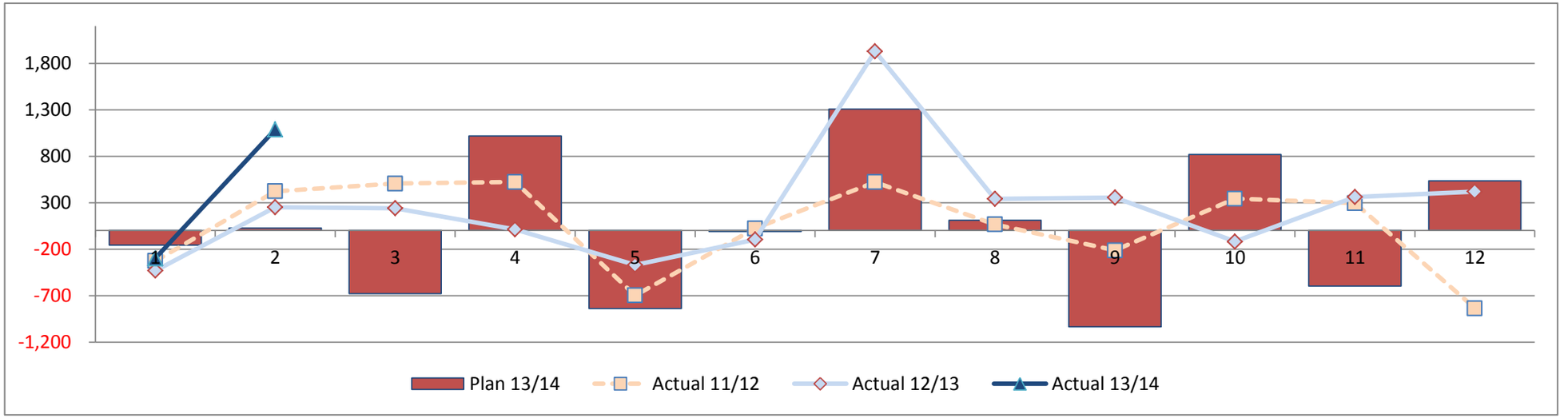
FINANCIAL SUMMARY **MAY 2013**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£25,429	£26,583	£1,154
PAY	-£15,153	-£15,094	£58
CIP	£397	£0	-£397
NON PAY	-£8,738	-£8,480	£257
EBITDA	**£1,936**	**£3,008**	**£1,072**
OTHER	-£1,909	-£1,919	-£10
NET	**£26**	**£1,088**	**£1,062**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£50,706	£51,033	£327
PAY	-£30,432	-£29,785	£646
CIP	£850	£0	-£850
NON PAY	-£17,449	-£16,639	£810
EBITDA	**£3,675**	**£4,609**	**£933**
OTHER	-£3,805	-£3,817	-£13
NET	**-£129**	**£791**	**£921**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£301,041	£304,769	£3,728
PAY	-£182,727	-£179,617	£3,110
CIP	£8,679	£0	-£8,679
NON PAY	-£103,645	-£101,663	£1,982
EBITDA	**£23,348**	**£23,489**	**£141**
OTHER	-£22,848	-£22,848	£0
NET	**£500**	**£641**	**£141**

NET SURPLUS/(DEFICIT) 12/13 PLAN & ACTUAL **MAY 2013**



Key Comments

£1.088m surplus in May (£1.062m ahead of planned surplus of £26k). Cumulatively this gives a £791k surplus (£921k ahead of planned deficit of £129k).
The income position to May is £327k ahead of plan. This includes an assumption of transitional support of £500k from the CCG and a risk reserve of £886k.
Pay costs are slightly below budget in May and cumulatively under by £646k
Similarly, the non pay spend in May is £257k lower than budget resulting in a cumulative underspend of £810k.
However, CIP achievement is below the May plan by £397k resulting in a cumulative shortfall of £850k.
Other "below the line" items are consistent with plan.
The forecast assumes growth in income offset by increased pressures on expenditure giving rise to an overall suplus of £641k (£141k ahead of plan).

2013/14 EXPECTED RIGHTS AND PLEDGES FROM THE NHS CONSITUTION 2013/14

The Dudley Group NHS Foundation Trust

APPENDIX 2

Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	A&E	2% of revenue derived from the provision of the locally defined service line in the month of the under - achievement	A&E 4 hour wait	96.6%	95%	↑	●
5	Cancer		14 Day – Urgent GP Referral to Date First Seen	96.2%	93%	↓	●
5	Cancer		14 Day – Urgent GP Breast Symptom Referral	91.7%	93%	↓	●
5	Cancer		31 Day – Diagnosis to Treatment for All Cancers	100%	96%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs	100%	98%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Radiotherapy	-	-	-	-
6	Cancer		31 Day – 2nd/Subsequent Treatment – Surgery	100%	94%	→	●
6	Cancer		62 Day – Referral to Treatment after a Consultant upgrade	97.9%	85%	↓	●
6	Cancer		62 Day – Referral to Treatment following National Screening	100%	90%	→	●
6	Cancer		62 Day – Urgent GP Referral to Treatment for All Cancers	89.3%	85%	↑	●
8-9	Diagnostics		Percentage of diagnostic waits less than 6 weeks	99.9%	99%	→	●
-	MSA	Retention of £250 per day the patient affected	Mixed Sex Sleeping Accommodation Breaches	0	0	→	●
7	RTT	Deduction of 0.5% for each 1% under-achievement, to a max of 5%*	Admitted % Treated within 18 Weeks	95.9%	90%	↑	●
7	RTT		Non-Admitted % Treated within 18 Weeks	99.4%	95%	↓	●
7	RTT		Incomplete % waiting less than 18 Weeks	98.1%	92%	↑	●
	RTT	£5,000 per patient	Zero tolerance RTT waits over 52 weeks	1	0	↓	●
	A&E	£1,000 per breach	Trolley Waits in A&E >12 hours	0	0	→	●
-	Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payments*)	Failure to publish a Declaration of Compliance of Non-Compliance pursuant to clause 4.24. *Retention of monthly sums will continue for each month or part month until either a Declaration of Compliance or Declaration of Non-Compliance is published.*	Annual – Trust Compliant			●
-	Compliance		Publishing a Declaration of Non-Compliance pursuant to clause 4.26.				●
4	HCAI	Lesser of 1.5% of inpatient revenue or £50,000 per case above 38 threshold.	C Diff – Post 72 hours *(77 breaches allowed)*	4	3	↓	●
4	HCAI	Non-Payment of inpatient episode	Zero Tolerance for MRSA	0	0	→	●
10	Never Events - Recovery of costs of procedure and no charge to the commissioner for any corrective procedure.			0			
11-12	Monitor Summary Report		Governance Risk Rating	1			
13-14	Mortality Reports		2012/13 Qtr 2 SHMI	1.04			

One month behind

⇩ Position Deteriorating ⇧ Position Improving ⇨ Position Unchanged

⇧ Within Target ⇧ Outside Target ⇧ Position Unconfirmed

Dudley Group FT MORTALITY - SHMI
Quarterly KPI Report

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR

Source: NHS Choices

The Full SHMI is only issued by the NHS Information Centre on a quarterly basis. The SHMI intends to compare the number of deaths that actually occur against a statistical estimate of the number of deaths that might have been expected, based on the national average death rate and the particular characteristics of patients treated. The SHMI covers deaths relating to all admitted patients that occur in all settings including those occurring in hospital and those occurring within 30 days post-discharge. The In-hospital SHMI excludes the influence that the deaths that occur within 30 days post-discharge and therefore, only represents the deaths that occur within the Trust.

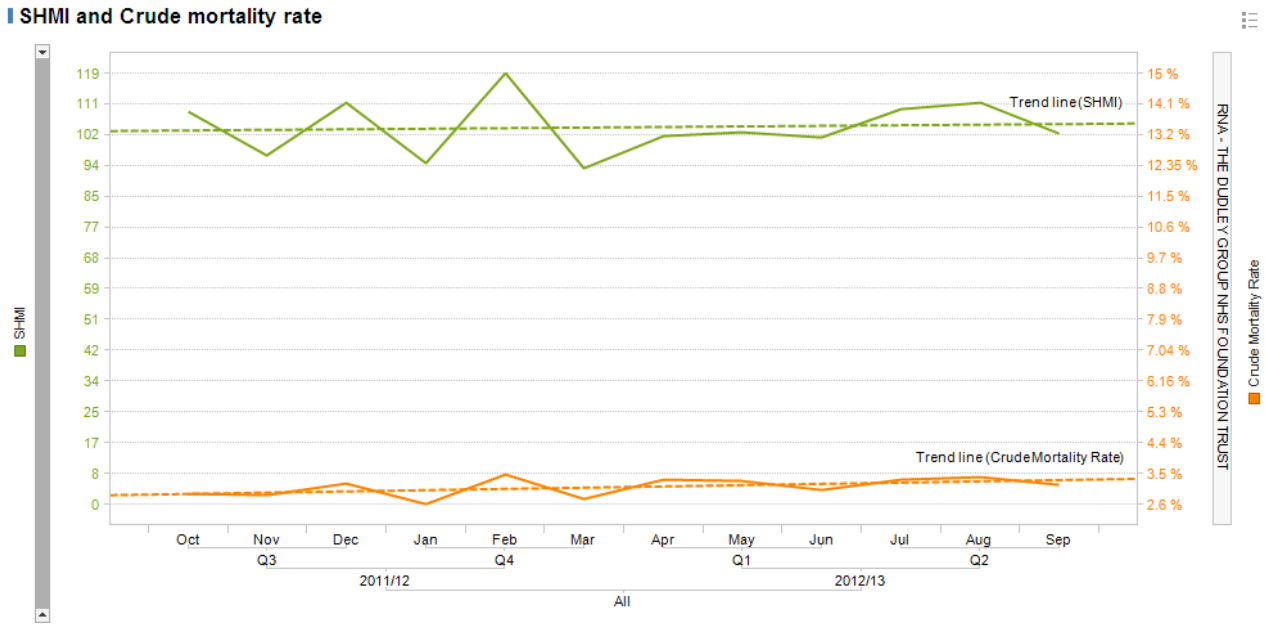
SHMI	Source	2011/12 Q4		2012/13 Q1		2012/13 Q2	
Full SHMI	**NHS Choices**	1.07		1.04		1.04	

Within over dispersion range

Within both Poisson and over dispersion range

In Hospital SHMI trend line against the Trust's crude mortality rate.

Source: HED



Enclosure 11

The Dudley
NHS Foundation Trust

Paper for submission to the Board of Directors
On Thursday 4th July 2013

TITLE:	Patient Catering Improvements – update report		
AUTHOR:	**Head of Facilities Management** **Deputy Director of Operations (Facilities & Estates)**	**PRESENTER**	**Director of Strategy, Performance & Transformation**
CORPORATE OBJECTIVE: SGO2 Patient Experience			

SUMMARY OF KEY ISSUES:

At the May Board of Directors meeting, it was agreed that the twin objectives of significant CIP savings and quality/experience improvements from patient catering would not be pursued. The Facilities & Estates team were instead requested to establish what improvements in patient food provision could be made from within current resources. This exercise was to be carried out using the Trust's Nutrition Steering Group as its expert reference point and in the context of the planned market test process within the next 12-18 months.

The Facilities & Estates team has undertaken two elements of work since this request was made. Firstly, to oversee and evaluate the introduction of a pilot of a new method of patient food provision, in partnership with Interserve FM. Secondly, to seek outside advice on what marginal improvements or changes to patient catering we could make with our FM provider in advance of the market test exercise.

This report provides an update to the Board of Directors on both actions. In addition, it proposes that the September Board of Directors meeting be the date at which the final decision is made on patient catering improvements in advance of the market test timetable.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Poor perception of food quality and choice can affect the patient's experience and in turn, local and national patient experience survey scores can be adversely effected
	Risk Register: **N**		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N/A**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

The Board of Directors is requested to note the report which provides an update on both the Steamplicity pilot and also advice received from Amadeus Catering.

The Board is also requested to agree to receive a report at its September meeting, where final agreement about interim actions to improve patient catering, in advance of the market test exercise, can be made.

Operations Directorate

Progress Report to Board of Directors

Patient catering improvements

1. Background

At the May Board of Directors meeting, it was agreed that the twin objectives of significant CIP savings and quality/experience improvements from patient catering would not be pursued. The Facilities & Estates team were instead requested to establish what improvements in patient food provision could be made from within current resources. This exercise was to be carried out using the Trust's Nutrition Steering Group as its expert reference point and in the context of the planned market test process within the next 12-18 months.
The F&E team has undertaken two elements of work since this request was made. Firstly, to oversee and evaluate the introduction of a pilot of a new method of patient food provision, in partnership with Interserve FM. Secondly, to seek outside advice on what marginal improvements or changes to patient catering we could make with our FM provider in advance of the market test exercise.

2. Alternative method of patient food provision – "Steamplicity"

Steamplicity is a method where both raw and partially cooked food is "plated" off site in a central production unit, where it is placed within a sealed pack incorporating a valve, which is then chilled down to below 5°C. As required, meals are heated/cooked individually in a microwave to above 75°C.
This allows patient choice at short notice and provides better quality food as the regeneration process includes moist heat thus avoiding drying out and maintaining texture. This method reduces the potential of nutrition degradation and can also result in lower levels of wastage, which may result in marginal savings.

2.1 Progress to Date

Regular project team meetings are now ongoing with Summit, Interserve and the Trust. The Project Team is steering the project with a view to a final costed proposal being received from Interserve by 31st May 2013. The proposal has only just been received in the last few working days. The current initial views on the proposal received are as follows:

2.1.1 "Steamplicity" Business Case

The proposal from Interserve is very limited in useful information though in runs to the best part of 200 pages. The financial summary identifies an annual £22, 700 saving however the actual cost of delivering the existing service is not identified and information on the Steamplicity system does not identify a detailed breakdown of cost. The main body of the report is made up of related information though there is not clear structure to the report. It is a collection of data, however it does not tell a story so that the cost of both the existing service and the cost of the proposed Steamplicity is not clear. The data appears to be a patchwork quilt of differing sources and is not a bespoke tailored piece of research that focuses on building a useful and comparative picture of existing and proposed patient catering. Overall it is not a business case but a collection of data on which it is not possible for the Trust to make any objective assessment on. Formal comments on the proposal have been sent to Interserve and Summit by the Deputy Director of Operations.

It had been agreed that the proposal would include both financial and non financial information including costs/savings for the implementation of different delivery models, proposals and costs for a free patient snack service, as well as proposals for a potential patient high quality snack and beverage service, which patients would pay for on wards.

2.1.2 Site Visit Steamplicity Manufacturing Plant

On 28th January 2013, the Trust Project Team, along with representatives from Interserve and Summit, visited the Steamplicity Manufacturing plant in St Albans. During the visit, contingency plans, statutory compliance and production processes were reviewed, all of which were proven acceptable to all parties. In

addition, all stakeholders took part in a food tasting session where the majority of feedback was very positive. Some negative aspects of the process were identified, including the systems unsuitability for providing certain food types e.g. pastry items etc., not being able to adjust portion size etc. However, it was felt the advantages from the perspective of quality, nutritional content and the wide range of available options, outweighed these negative points.

2.1.3 Site Visit to Peterborough City Hospital

On 21st March 2013, the Trust Project Team along with representatives from Interserve and Summit attended a site visit to the Peterborough City Hospital to view a mature steamplicity solution. Project team members visited wards within the site and spoke to nursing and housekeeping staff about their experience with the product. Generally feedback was very good, however, it became evident that Ward staffing levels associated with food delivery, were probably greater than those currently deployed at Russells Hall Hospital.

2.1.4 Trial of Steamplicity Product at Russells Hall Hospital

Between 3rd March 2013 and 19th May 2013 a trial of the Steamplicity solution was implemented on Ward C5 at Russells Hall Hospital. During the trial two staff delivery models were implemented as follows:-

1. Menu Completion - Trust Nursing Staff
   Meal Preparation (Picking and reheating) – Interserve Staff
   Meal Delivery to Patient – Trust Nursing Staff

2. Menu Completion - Trust Nursing Staff
   Meal Preparation (Picking and reheating) – Interserve Staff
   Meal Delivery to Patient – Interserve Staff

A number of studies were undertaken before, during and after the trial as follows:-

1. Patient Experience
2. Staff Experience
3. Process / Time and Motion
4. Waste

Although the final analysis of the data collected has not been completed, early indications are that both patient and staff experiences improve with the Steamplicity Model. It is evident that the optimum model of Steamplicity delivery occurs when Interserve staff both prepare and deliver the meals to patients.

3. Site Visit by Amadeus Catering

To help get an objective external view on the issue of patient catering, the Trust Chairman set up a site visit and discussions between the Trust and Amadeus Catering. Amadeus are part of the ICC group and are wholly owned by Birmingham City Council. On 20th May 2013 three senior representatives from Amadeus visited Russells Hall Hospital and met with Richard Beeken- Director of Strategy & Transformation, Robert Graves – Deputy Director of Operations and Andrew Rigby – Head of Facilities Management.

Amadeus are a well established catering organisation, who provide catering services to a wide range of clients and events, including the NEC, Crufts, Hampton Court Palace Food Show, The Conservative Party Conference, The Scottish Open, BBC Sports Personality of the Year, The Ryder Cup at the Belfry etc.

The purpose of the visit was to share experiences and ideas on mass catering services and how Amadeus would advise we improve the current service provided. During the discussions, the proposal for Steamplicity was mentioned which was complemented on as a quality product by a member of the Amadeus Team.

A short written report from Amadeus Catering was received on 21/6/13. Interestingly, one of their main observations made on the day of their visit, was that that any consumer's perception of the quality of the food can be significantly enhanced, if the food is served by staff who have an exceptional attitude to customer experience and take pride in their work. We may well need to reflect on this advice as we make any proposed changes to our food provision for patients. Immediate observations on their report are as follows:

The report concentrates on a number of options that focus on patient and staff experience and establishing a more consistent feedback loop to continually improve standards, on establishing product awareness, service standards and customer care.

Reference is also made to improving the environment and on increasing the retail opportunities. It is focused very much on retail opportunity and improving a number of supporting business strands to give an overall better patient/user experience. The report does not go into any detail on the how, other than outlining the need to engage professional expertise if we are to tackle this systematically.

4. Next steps

It is proposed to bring a report to the September Board of Directors, with final proposals on patient catering improvements, which will have allowed the F&E team to reflect any consensus on the Steamplicity proposal as well as the advice from Amadeus Catering. The F&E team will agree these proposals with both the Nutrition Steering Group as well as the Executive Team in advance.

Andrew Rigby
Head of Facilities Management

Robert Graves
Deputy Director of Operations (F&E)

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors on 4th July 2013

TITLE:	**Schwartz Rounds/Intelligent Kindness**		
AUTHOR:	**Mark Stobert**	**PRESENTER**	**Paul Harrison**
CORPORATE OBJECTIVE: SG06			

SUMMARY OF KEY ISSUES:

- Report is an update following the presentation given to Board in November 2012.
- Intelligent Kindness Think Tank (IKTT) established.
- Schwartz Centre Rounds began In March 2013 and are now part of the Grand Round lunchtime programme.
- IKTT continues to work on developments and should be more formally integrated into the Trust reporting structure.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Outcome 1**	**Details:**
	NHSLA		**Details:**
	Monitor		**Details:**
	Equality Assured		**Details:**
	Other		**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
✓	✓		

RECOMMENDATIONS FOR THE BOARD

To note content of the report and support continual development of Schwartz Centre Rounds and the Intelligent Kindness agenda.

To agree the reporting structure for the Intelligent Kindness Think Tank.

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

The Dudley Group NHS
NHS Foundation Trust

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS
4TH JULY 2013

INTELLIGENT KINDNESS AND SCHWARTZ CENTRE ROUNDS UPDATE

Background and Summary

In November 2012, it was reported to the Trust that a small group had gathered to discuss what responses could be made to a number of issues that had been observed, namely:

- Requests for consultation to resolve conflict and recognition that some conflicts were acting out of complex tensions
- Providing psychotherapeutic support to staff members whose issues arise out of, or are exacerbated by, tension in teams
- Recognising teams that are under stress and are displaying clear signs of distress and conflict.

Also the recognition that, in normal circumstances, there is an "Unconscious at Work" where:

- Individuals, teams and organisations behave similarly in response to pain, anxiety and stress and exhibit patterns of behaviour to defend against such feelings.
- Pain may be anxiety arising from the pressures of work and "rubbing shoulders" with the flux of life and death.

The group came up with several responses that could be made:

- MDT development as a starting point to introduce more emotional intelligence
- Reflective practice as a concurrent paradigm to Evidence Based Practice
- Reflective consultation forum of 'wise heads' to reflectively support managers and directors in conflict resolution
- Schwartz Rounds on a monthly basis in place of the Grand Round session

The Trust Board enthusiastically supported this initiative.

Developments

A Steering Group was established and a fact-finding visit was made to Royal Free Hospital to witness a Schwartz Round in action. A business case was presented to a Trust Management Executive meeting and Schwartz Rounds were established within the Trust.

The Intelligent Kindness Think Tank (IKTT) was established to develop the Intelligent Kindness agenda with a membership of: Lucy Chatwin, Paul Harrison, Graeme Johnston, Denise McMahon, Helen Shilvock, Mark Stobert and Paul Stonelake.

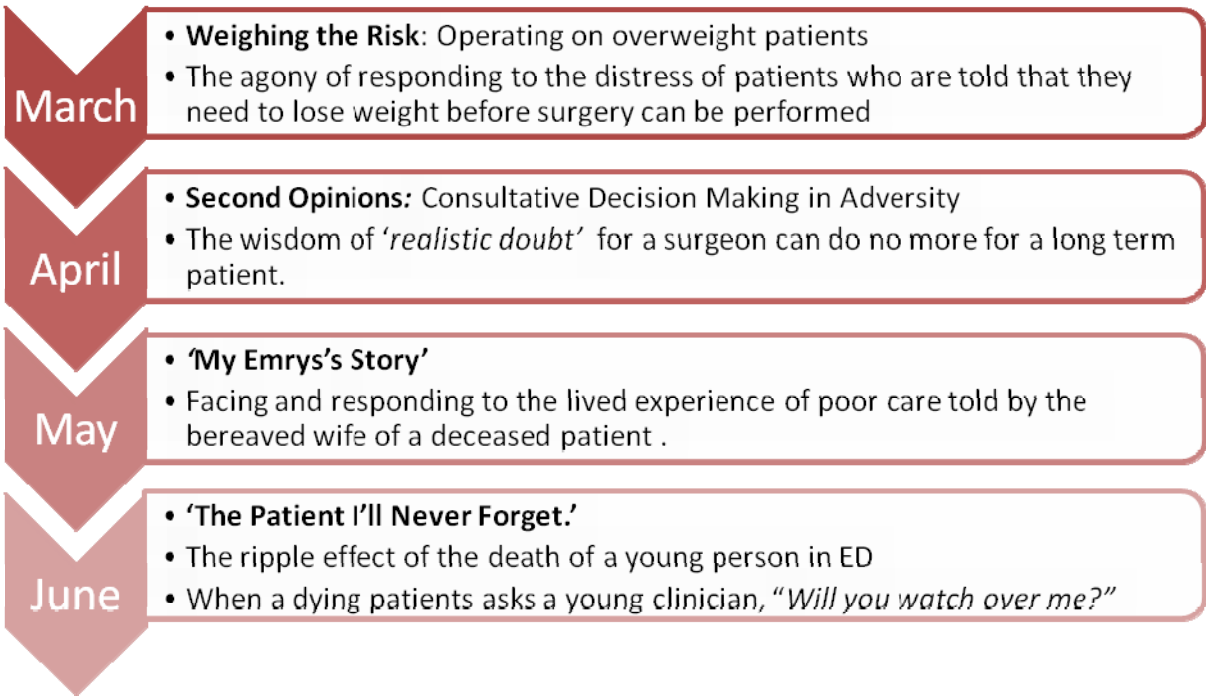
Schwartz Centre Rounds began In March 2013 and are now part of the Grand Round lunchtime program.

Schwartz Centre Rounds

- Four Schwartz Rounds to date (see below)
- Attendance of approximately 30 people per round
- Regulars and newcomers attending
- Evaluation positive so far
- Lots of chatter
- External enquiries received
- Enlightenment for the Keogh Review Team

Future dates for Rounds in 2013: 26th September
24th October
21st November
19th December

2014 dates: 3rd Thursday in the month.



Future Plans and Developments

In the short term, the IKTT are to further develop and launch an Intelligent Kindness Forum in late 2013/early 2014, and will develop and implement a business case to include:

- Resourced co-ordinator
- Link to developing the culture of compassionate care
- Working in parallel with staff engagement processes and the Nursing Strategy

In the medium/longer term to:

- Develop and cascade Reflective Practice.
- Develop a Listening for Kindness programme
- Develop multi-disciplinary team emotional development strategy
- Develop reflective conflict consultation
- Focus on clinical benefits and patient experience outcomes

Recommendations/Actions:

To note content of the report and support the continual development of Schwartz Centre Rounds and the Intelligent Kindness agenda, as outlined above.

To agree a reporting structure for the Intelligent Kindness Think Tank. It would seem appropriate in the first instance if this were via the Clinical Quality, Safety and Patient Experience Committee.

Board of Directors Members Profile.

Paula Clark – Chief Executive

As the Chief Executive, Paula leads the Executive Team to ensure that effective management systems are in place and that Directors and Senior Managers have clear objectives and are assigned well-defined responsibilities in line with the Trust's strategy and organisational objectives.

As a leader Paula provides visible examples of a positive culture for the Trust and drives the Trust Management executive to reflect a positive culture in their behaviour and decision making to continuously improve the Patient Experience within the Trust.

John Edwards – Chairman

Johns responsibility is to ensure that the Board and committee assignments are done in the most efficient and effective way. John assigns the appropriate committee's to deal with certain roles of running the Trust and ensures the Committee chairs report the issues to the Board regularly. John is also Chair of the Council of Governors and Chair for the IT Project Board.

Paul Assinder – Director of Finance and Information

Paul provides strategic financial and business advice to the Board of Directors. He has lead responsibility for statutory accounts and audit as well as informatics, information technology, contracting, procurement and supplies. Paul is also Secretary to the Board of Directors and key liaison director for the FT regulator, Monitor.

Richard Beeken – Director Strategy, Performance and Transformation

Richard is responsible for developing the Trusts Long Term Strategy and for driving transformational change programmes within the organisation and local health economy. He provides leadership of the facilities and estates function via the PFI contract, in addition to security and health and safety management. In his role he also leads Emergency Planning and Business Continuity Planning for the Trust.

Denise McMahon – Director of Nursing

Denise provides professional leadership, management and direction for: Nursing and Midwifery Strategy, Education and Professional Conduct; Infection Prevention and Control and Integrated Governance. Denise also has collective corporate responsibility for strategic and operational performance as an Executive Director and member of the Trust Board.

Paul Harrison – Medical Director

Paul provides professional medical leadership for the organisation, including the role of Responsible Officer for revalidation. He contributes to the Boards strategic discussions by bringing perspective on clinical issues as a practising clinician. He is responsible for medical education, research and development and medical workforce issues. Paul and is also lead on Mortality and Morbidity issues.

Richard Cattell – Director of Operations

Richard is Executive Lead for operational management and delivery in clinical services on a day to day basis. He is responsible for the successful delivery of all national and local performance targets and quality standards, via each of the organisation's clinical directorates. Negotiation of and adherence to the contract the Trust has with our CCG commissioners is a vital part of his role.

Annette Reeves – Associate Director of Human Resources

Annette provides leadership and strategic management for the Human Rescources Directorate and gives advice to the Board on issues relating to functions under her control and their impact on the wider service issues to the Trust. She is responsible for developing strategies which meet NHS/legislative/best practise requirements and the needs of the Trust. She participates in the corporate management of the Trust, ensuring the Trust's strategic and operational objectives are met to facilitate the highest quality of services for patients.

David Badger – Non Executive Director, Deputy Chairman and Chair of the Finance and Performance Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act. David is Deputy Chair of the Trust and also Chair's the Finance and Performance Committee.

David is also responsible for the following:
Member - Clinical Quality Safety and Patient Experience Committee
Member - Risk and Assurance Committee
Member - Remuneration Committee
Member - Nominations Committee
Member - Transformation Programme Board
Member and link to Trust Board - Organ Donation Committee
NED liaison - Council of Governors
Assigned - Governor Development Group
Assigned - Governor Membership Engagement Committee
Attendee - Governor Appointments Committee
Board representative - Contract Efficiency Group

David Bland – Non Executive Director and Chair of the Clinical Quality, Safety and Patient Experience Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

David is also responsible for the following:
Chair of the Clinical Quality, Safety and Patient Experience Committee
Non Executive Director Lead for Patient Experience
Non Executive Director Lead for Patient Safety
Member of Risk and Assurance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Member of Charitable Funds Committee
Member of Council of Governors Committee
Member of the Dudley Clinical Services Limited (subsidiary of the Trust

Jonathan Fellows - Non Executive Director and Chair of the Audit Committee

As a Non Executive Director it is Jonathans responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Jonathan is also responsible for the following:
Chair of Audit Committee
Member of Finance and Performance Committee
Member of Charitable Funds Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Assigned to the Governors Governance Committee
Board representative - Contract Efficiency Group

Richard Miner – Non Executive Director and Chair of the Charitable Funds Comittee

As a Non Executive Director it is Richard's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Richard is also responsible for the following:
Chair of the Charitable Funds Committee
Non Executive Director Lead for Security Management
Member of Finance and Performance
Member of Audit Committee
Assigned to the Governors Governance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Chair of the Dudley Clinical Services Limited (subsidiary of the Trust)

Ann Becke – Non Executive Director and Chair of the Risk and Assurance Committee

As a Non Executive Director it is Ann's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Ann is also responsible for the following:
Chair - Risk and Assurance Committee
Member – Audit Committee
Member – Clinical Quality, Safety and Patient Experience Committee
NED Lead for Safeguarding
Board Representative – Dudley Children's Partnership
Non Executive Director Liaison for West Midlands Ambulance Service
Member – Remuneration Committee
Member – Nominations Committee
Member – Arts and the Environment Panel
Assigned – Governor Sub Committee Membership Engagement
Assigned – Governor Sub Committee Strategy
Member – Dudley Clinical Education Centre Charity