The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 5th September 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 – D. McMahon**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 4th July 2013	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 4th July 2013	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Video	M Green	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	L Rees	To Note	10.30
	7.4 Risk and Assurance Committee Exception Report	Enclosure 7	A Becke	To Note	10.40
	7.5 Audit Committee Exception Report and Annual Report	Enclosure 8	J Fellows	To Note	10.50
	7.6 Corporate Risk Register	Enclosure 9	P Clark	To Note	11.00
	7.7 Keogh Review Progress Update	Enclosure 10	P Clark	To Note & Discuss	11.10
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 11	D Badger	To Note & Discuss	11.20
9.	**Date of Next Board of Directors Meeting** 9.30am 3rd October, 2013, Clinical Education Centre		J Edwards		11.30

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

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 4th July 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
Paula Clark, Chief Executive
Paul Harrison, Medical Director
Denise McMahon, Nursing Director

In Attendance:
Helen Forrester, PA
Liz Abbiss, Head of Customer Relations & Communications
Richard Cattell, Director of Operations
Richard Price, Deputy Director of Finance
Robert Graves, Deputy Director of Operations (Estates and Facilities) (item 9.1)

13/031 Note of Apologies and Welcome

Apologies were received from Paul Assinder and Annette Reeves.

13/032 Declarations of Interest

There were no declarations of interest.

13/033 Announcements

The Chairman reminded that Board that they were not quorate for the last meeting and any decisions were to be taken under delegated powers. Board members noted that there were no items for ratification at this meeting.

13/034 Minutes of the previous meeting on 6th June, 2013 (Enclosure 1)

David Bland, Non Executive Director, asked that the minutes were amended at page 4, item 13/026.1 Clinical Quality, Safety and Patient Experience Committee, to read “NICE Guidance: David Bland confirmed that a lot of work had been undertaken in this area and the numbers of guidelines awaiting action have reduced considerably”.

With this amendment the minutes of the previous meeting were agreed as a correct record of the meeting and signed by the Chairman.

13/035 Action Sheet 6th June, 2013 (Enclosure 2)

Board members noted that all items were for future action.

13/036Patient Story

The Nursing Director presented the Patient Story. Board members noted that this was an extract from a communication sheet provided on clipboards at the bottom of a patients bed on ward C7. The Nursing Director confirmed that these clipboards are checked for actions each morning. The Nursing Director read the extract aloud to Board members. Board members noted the positive story.

Richard Miner, Non Executive Director, asked if it was possible to display the feedback on the internet. The Chief Executive confirmed that the Trust is giving patients cards about how to get comments onto NHS Choices.

David Badger, Non Executive Director, confirmed that his daughter had been an inpatient at the Trust that week and she had added her own positive comments to the NHS Choices website including good food, spotless conditions and comfortable bed. David commented that she had not received a Friends and Family or NHS Choices card and he would advise Liz Abbiss which ward this relates to. David also stated that more prominence should be given to the poor manner in which some patients speak to the staff.

The Chairman noted the Nursing Directors report and David's personal experience and commented that it was important to capture experiences at Board and through other media.

Ann Becke, Non Executive Director, confirmed that the communication sheet is a very good initiative and asked if it would be rolled out across the Trust. The Nursing Director confirmed that Matrons are rolling the initiative out across other wards.

The Chairman enquired if patient stories were still being videoed. The Nursing Director confirmed that they are but different formats were being used for reporting to Board.

13/037 Chief Executive's Report (Enclosure 3)

The Chief Executive presented her report given as Enclosure 3, including the following items:

- Friends and Family Test: Board members noted that the test in its current format was not working within the A&E environment and this was a problem across the country and had been criticised in the health press. It was noted that we would not hit the CQUIN target for quarter one. It had been agreed by the Clinical Quality, Safety and Patient Experience Committee to use a token system from 1st August and that had been more helpful.

- Keogh Review/Risk Summit: Board members noted the publication date for final reports of 16th July, 2013. Staff briefing sessions will be held during that morning and Governors will be invited to attend. It was noted that Ruth May would be supporting Bruce Keogh during the announcement of the reports all information will be embargoed until the 16th. The Trust had completed an urgent action plan and this had been provided to Ruth May and PwC.

The Trust was currently working on medium term actions to be completed by the end of July. The Chairman confirmed that he had attended a lunch with Lord Hunt the previous Tuesday and had shared experiences of the review. Chris Hopson at the Foundation Trust Network had confirmed that David Behan and Mike Richards will be meeting with the 14 Trusts to look at the review process. The Chief Executive confirmed that the Review Team will be visiting the Trust again in the Autumn.

- NHS Constitution 2013: Board members noted that renewed document. A link was provided in the Chief Executive's Report.

- NHS Leadership Academy: Board members noted that the Academy had undertaken a refresh of the Healthy Board Guidance and the Trust will look at this as part of its own Board development programme.

- Consultant Level Outcomes: The Medical Director confirmed that this was part of the NHS commitment to openness and clarity. Board members noted that this is very different data to the mortality data collected for SHMI or HSMR, it is a clinical data collection and should give a better picture on performance. There had been a few initial problems and not all areas had yet been published. Board members noted that all Trust Consultants are within the required parameters. The Medical Director commented that it was expected that the data would form part of the appraisal/revalidation process. Ann Becke, Non Executive Director, asked how results would be moderated for complex cases. The Medical Director confirmed that the difficulty of surgery and complexity of cases and health of patients will be taken into account. The outcome will be provided initially for ten areas and will then be rolled out to other areas including GPs and Primary Care. David Badger, Non Executive Director, suggested that the Trust should start pushing back on consistency and value. The Chairman agreed to raise with the Foundation Trust Network.

13/038 Quality

13/038.1 Clinical Quality, Safety and Patient Experience Committee (Enclosure 4)

David Bland, Committee Chair, presented the Exception Report given as Enclosure 4. The Board noted the following key issues:

- Update on the Management of Falls: Jenny Bree had attended the meeting and a very comprehensive report had been presented and assurance provided.

- Mortality Report: An update had been received from Roger Callender. It was pleasing to note that SHMI now stood at 1.04.

- Patient Safety Group: A report had been received from the Red Incident Assurance and Learning Group. The Committee noted that some incidents had not been completed within the required timeframe and Julie Cotterill was following these up although this was an onerous piece of work.

The Chairman asked about the management of falls and commented that there had been some negative press on this in relation to another hospital and enquired if the Trust had picked up any learning from elsewhere. The Nursing Director confirmed that she had met with Jenny Bree to ensure the Trust was performing as it should be. The falls bundle is being rolled out across wards and audits will be undertaken. Board members noted that this area will continue to be maintained as a priority. Ann Becke, Non Executive Director, confirmed that this had been picked up by the Risk and Assurance Committee and the use of Charitable Fund monies had been agreed to purchase alarms for chairs.

The Chief Executive commented on Resus Trolley checks as this had been highlighted by the review. Board members noted that the Trust now has a process in place to ensure we achieve 100%.

The Board noted the report and issues arising.

13/038.2 Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Enclosure 5)

The Chief Executive presented the report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, given as Enclosure 5.

Board members noted that this had been discussed by the Executive Directors and an exception report will now start to be provided. Reporting may also be moved to a quarterly basis. Board members noted that outstanding areas were highlighted in yellow on the report.

The Chief Executive asked Board members how they would like the information presented. The Chairman suggested that the report should continue to be presented monthly until October and then bi-monthly thereafter.

Ann Becke, Non Executive Director, confirmed that the highlighted areas make the report easier to read.

The Chief Executive asked if Non Executive Directors would still like to be presented with the whole report. The Chairman confirmed that the full report with highlighted changes should be presented.

The Chairman confirmed that at his meeting on Tuesday, other Trust Chairs felt the first Francis report was a better document for Acute Trusts and he asked if we had managed to capture Francis one and two in the report. The Chief Executive confirmed that the Board could reconsider the first Francis Report at its October meeting.

The Chief Executive reported that Executive Directors had expressed the view that it was not helpful to the Trust to have so many action plans and it now needs to draw the various stands of work together.

The Chairman confirmed that the Board would continue to receive an exception report monthly until October and then bi-monthly thereafter. The Board would reconsider the first Francis Report at its meeting in October and also how the Trust can link its action plans together.

Board to continue to receive a monthly exception report until October and then bi-monthly thereafter.

Board to reconsider the first Francis Report at its meeting in October and also how the Trust can link its action plans together.

13/038.3 Infection Prevention and Control Exception Report (Enclosure 6)

The Nursing Director presented the Infection Prevention and Control Report Exception Report given as Enclosure 6**.** Board members noted that following areas:

C.Diff: The Trust had experienced the lowest quarter ever in relation to the incidence of C.Diff with ten cases. The Trust was one over trajectory for the quarter. The Infection Control Team had been working seven days a week and also hydrogen peroxide fogging was now available seven days a week.

Board members noted that Dr Liz Rees was taking on the role of Director of Infection Prevention and Control (DIPC) and will maintain the focus on Root Cause Analysis (RCA).

MRSA: No confirmed cases.

Norovirus: No confirmed cases.

TB: One patient confirmed. An RCA had been undertaken and Board members noted that the case had been impossible to diagnose. Contact tracing was being undertaken. The Nursing Director confirmed that an increase in TB had been seen nationally and the Trust needs to be mindful of patients with chest conditions. The Chief Executive asked how easy the infection is to catch. The Medical Director confirmed that it was not easy and only the immuno-supressed were at real risk.

Ecoli: One case in June.

The Chairman asked about the small increase of C.Diff cases in June. The Nursing Director confirmed that there was no clear reason and the Trust continues to investigate all cases. No cases had been experienced to date for July. The Medical Director confirmed that the Trust needs to maintain its focus on antibiotic prescribing.

The Chairman asked about the DIPC and her access to the Board. The Nursing Director confirmed that the Infection Prevention and Control Board report is produced in conjunction with herself and the DIPC and the DIPC can attend Board meetings as required/requested.

The Chairman noted the good progress and the comments relating to maintaining the focus on C.Diff.

13/026.4 Trust Annual Report (Enclosure 7)

The Nursing Director presented the Trust Annual Report, given as Enclosure 7, for noting and approval

The Chief Executive confirmed that the Trust no longer prints multiple copies of its Annual Report and this was now available to download from the Trust's website.

Board members noted that both of the Trust's auditors had quoted favourably on the quality of the Trust's information.

Jonathan Fellows, Non Executive Director, confirmed that it was a very comprehensive document which had been produced in a timely manner.

13/038.5 Board Assurance Framework (Enclosure 8)

The Chief Executive presented the Board Assurance Framework, given as Enclosure 8, for information.

The Chairman confirmed that the Chief Executive signs off the Annual Governance Statement.

Board members noted the report.

13/038.6 Quarterly Safeguarding Report (Enclosure 9)

The Nursing Director presented the Quarterly Safeguarding report given as Enclosure 9.

Board members noted that the report gave a summary of issues from the Safeguarding Board, including the following items:

- Appointment of a Learning and Disability Liaison Nurse.
- The Winterbourne View Report had been reviewed by the Safeguarding Board. Key findings to be reported to Board as an exception report. The Chief Executive confirmed that this was particularly important for services that we commission in the Community.
- Training Compliance – The Trust is still working on enhanced safeguarding training. There is still a small issue with our PFI partners for face to face training.
- Jimmy Saville Enquiry – Concern had been noted around Wishing Well and the policy had now been strengthened. Work still need to be undertaken on visiting celebrities to the Trust.

Ann Becke, Non Executive Director, confirmed that she had attended the Dudley Children's Board and the Trust had been asked for its involvement in early interventions. Details had been passed to Carol Weston.

The Board noted the report and progress made and the Chairman confirmed that the Winterbourne Report findings will be reported back to a future Board meeting.

Report on the Winterbourne View Report findings to be presented at a future Board meeting.

13/039 Finance

13/039.1 Finance and Performance Report (Enclosure 10)

David Badger, Chair of the Finance and Performance Committee presented the summary of papers received by the Finance and Performance Committee given as Enclosure 10, including:

- Financial Performance: Good performance noted for May with significant surplus to report. Board members were pleased to receive the healthy report although noted that there were a number of financial warnings and risks in particular around CIP and fines/penalties. There is a revised projected surplus for the year end of £600k. David confirmed that there was a real concern over the achievement of CIP as the Trust is not making the progress it had hoped to. There was also concern around corporate and major schemes and this is an area on which the Committee will maintain focus. The Committee had received a report on fines and penalties for 2013/14 that had been produced by the Local Area Team. There is a new system of fines and penalties and Board members noted that some fines appear to be out of proportion. The Committee had noted the new system and its short comings and voiced its disappointment that the CCG had little discretion available. Richard Price commented that if was a positive financial performance for the time of year and confirmed that the surplus was due to the amount of income. He urged that the Trust be mindful about around whether the CCG could afford to pay for the overperformance but summarised that overall it was a very positive position.

- Performance: Board members noted that the Trust had failed to meet the A&E target for the second consecutive quarter and this would result in a red governance rating from Monitor. The Chief Executive confirmed that this was as a result of a couple of poor spells in June and voiced her huge disappointment that the target had been lost over three very difficult days towards the end of the quarter. She confirmed that the Trust needs to learn lessons for the future around how to prevent this from happening again and she had met with the Clinical Director and the Executive Team had met with the ED team to discuss how to ensure this does not happen again. The Chief Executive stated that the Trust needs to ensure it has a consistent approach to flow in the Department, 24hours a day, 7 days a week. She confirmed that Monitor will expect the Trust to produce an action plan.

- Mortality: All three indices within the expected range.

- Quarter 4 Monitor Feedback: Concern had been raised with Monitor over their use of Dr Foster data and their failure to use other recognised indices. It had also been noted since the Committee that the data was also inaccurate. Monitor had confirmed that the information will be amended and a revised report sent.

Richard Miner, Non Executive Director, commented that it was a good month for income but the Trust cannot let up on cost control and in particular absenteeism and the Trust was looking at using Charitable Funds to provide support. The Chief Executive confirmed that the Associate Director for Human Resources had produced the Health and Wellbeing Strategy.

The Medical Director confirmed that Mike Farrar from the NHS Confederation had commented that it nonsensical to fine Trusts for not meeting targets when they should be helped to achieve them.

Richard Price, Deputy Director of Finance, confirmed that there was no scope to negotiate fines and the Trust had already received a letter of intent against April performance.

Jonathan Fellows, Non Executive Director, asked about SHMI and if there was any likelihood that information will become more up to date. The Medical Director confirmed that the suspected the Trust had now plateaued for SHMI.

Ann Becke, Non Executive Director, asked about the CCGs attitude towards the fines. Richard Price confirmed that the CCG had always taken a reasonable stance and would have been prepared to negotiate.

The Chairman commented that it would be helpful at the September or October Board meeting to see the list of potential fines.

The Chairman noted the report and item 9 in relation to the approval of the 2012-13 reference costs process.

List of potential fines to be presented to the September of October Board.

13/040 Corporate and Strategic

13/040.1 Food and Nutrition Report (Enclosure 14)

Robert Graves, Deputy Director of Operations (Estates and Facilities) presented the Food and Nutrition Report given as Enclosure 14.

Robert confirmed that he had been set a task by the Board in May 2013 to improve the quality, presentation and perception of food provision at the Trust but within current budgets. The report is a position statement and included the following key elements:

- Amadeus Catering: Advice had been taken from Amadeus (NEC catering group) and their helpful assistance was noted in the report.

- Steamplicity: An evaluation had been undertaken of the Steamplicity pilot and final recommendations on Steamplicity will be presented to the September Board meeting. Robert confirmed that his recommendation to the Board would be that the Trust needs to make a change to provision. A trial had been undertaken on C5 and a gap had been noted in staff and patient perceptions.

For patient experience Steamplicity had scored well and Board members noted that the system would result in a £22k saving as well as gaining on nursing time. The Chief Executive confirmed that she felt strongly that Steamplicity was the way forward for the Trust, it is viewed positively by patients and also releases nursing time. Amadeus had agreed that it was a good system although it was cost neutral or only offered a small saving.

The Director of Strategy, Performance and Transformation confirmed that he agreed with the Chief Executive that as a product it is what the Trust would wish to use.

The Chief Executive confirmed that there was also the option of staff being able to purchase Steamplicity meals and the Trust was also investigating facilities for staff use.

The Chairman asked the Nursing Director if it was her understanding that the system would save nursing time. She confirmed that it was.

David Badger, Non Executive Director, confirmed that he would still like to explore medium to longer term options.

The Chairman had discussed Steamplicity with Nick Pew, who had been recommended by Roy Savin. Nick had confirmed that it is a good product but the quality of presentation of the food is very important.

The Chairman noted the current position and that there will be a more detailed presentation to the September Board.

The Chief Executive confirmed that market testing will be discussed further at Executive Directors meeting.

The Chairman suggested that the report is delayed until the October Board it that helps provide a more complete paper including market testing options.

Complete Food and Nutrition Report including market testing options to be presented to the October Board.

13/040.2 Schwartz Rounds/Intelligent Kindness Report (Enclosure 12)

The Medical Director presented the report on Schwartz Rounds and Intelligent Kindness given as Enclosure 12.

Board members noted that Mark Stobert, Hospital Chaplain, had previously presented to the Board in November 2012, when they had endorsed the proposal of Schwartz Rounds and intelligent kindness.

Board members noted that the Rounds had seen a reasonable attendance and the Intelligent Kindness Think Tank (IKTT) had been established with a list of planned developments and actions.

The Medical Director confirmed that Schwartz Rounds were now much more on the national agenda and these are being rolled out across the country.

Reporting needs to be incorporated into the Committee structure and a lot of the outcomes fit with the Clinical Quality, Safety and Patient Experience Committee.

The Director of Strategy, Performance and Transformation confirmed that he would encourage all Board members to attend the Rounds. The Chairman confirmed that he attended the first Round and he found it fascinating to listen to the issues raised and would also encourage colleagues to attend.

The Chairman passed on his thanks to Mark Stobert for his efforts.

Schwartz Rounds/Intelligent Kindness to be incorporated into the Committee reporting structure.
All Board members are encouraged to attend the Schwartz Rounds whenever convenient.

13/041 Any Other Business

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

13/042 Date of Next Meeting

The next Board meeting will be held on Thursday, 5th September, 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 5 September 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	Jules Perks appointed as staff engagement lead working with Jackie Dietrich on LiA
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	Positive feedback being collected through friends & family. Arranging forum for sharing best practice. Done
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	Done Done
13/026.4	Audit Committee Exception Report	Audit Committee Annual Report to July Audit Committee and September Board.	JF	5/9/13	On Agenda
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	Done
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	

13/038.2	Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry	Board to continue to receive a monthly exception report until October and then bi-monthly thereafter. Board to reconsider the first Francis Report at its meeting in October and also how the Trust can link its action plans together.	DM DM	5/9/13 3/10/13	On Agenda
13/039.1	Finance and Performance Report	List of potential fines to be presented to the September or October Board.	DB	3/10/13	
13/038.6	Quarterly Safeguarding Report	Report on the Winterbourne Report findings to be presented at a future Board meeting.	DM	3/10/13	
13/040.1	Food and Nutrition Report	Complete Food and Nutrition Report including market testing options to be presented to the October Board.	RB	3/10/13	
13/040.2	Schwartz Rounds/Intelligent Kindness Report	Schwartz Rounds/Intelligent Kindness to be incorporated into the Committee reporting structure. All Board members are encouraged to attend the Schwartz Rounds whenever convenient.	PH All		Now incorporated into the Clinical Quality, Safety, Patient Experience Committee Reporting Structure

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 5th September 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Patient Food (Media Report)
- ED Performance Q2
- Deloitte Governance Review
- Advancing Quality Alliance Update
- Friends and Family Test Report

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
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Chief Executive Update – September 2013

Patient Food (Media Report):
The Trust unfortunately hit the headlines last week as one of the worst rated hospitals for patient food. This is very disappointing but underlines the number of complaints we receive about this and the dissatisfaction our patients have with the inpatient food service on offer in the hospital, despite being one of the hospitals trusts whose spend on patient food is amongst those at the higher end. Inpatient catering is provided under our Private Finance Initiative (PFI) contract by Interserve. A review has been ongoing for some months, including the possibility of a switch to the Steamplicity system which was successfully trialled on several wards, but as yet we are still waiting for Interserve to come back to us with costed proposals. I hope a way forward can be presented to the Board by the end of October to address this major patient experience issue.

ED Performance – Q2 to date:
We are currently performing at 96.4% for the quarter to date and optimistic that we will achieve the Q2 target of a minimum of 95% if current performance continues.

Deloitte Governance Review:
In response to the Keogh Review this is now well underway. Board members are being surveyed, with their responses required by 6th September, and information requested by the Deloitte team has now been forwarded to them. The report will be with the Board in October.

Advancing Quality Alliance (AQuA):
As another response to the Keogh Review we are working with the AQuA team from the north west on quality and patient safety. A meeting is being held with their team on 6th September with myself and the Medical Director to scope the work programme.

Friends and Family Test Report:

	April 13 Overall	May 13 overall	June 13 overall	April to June cumulative	July 13 overall	Aug 13 Wk 1	Aug 13 Wk 2	Aug 13 Wk 3
	01.04.13	01.05.13	01.06.13	**01.04.13**	01.07.13	05.08.13	08/01/1900	19.08.13
Date range	30.04.13	31.05.13	30.06.13	**30.06.13**	31.07.13	11.08.13	18.08.13	25.08.13
Number of eligible inpatients	*1930*	*1962*	*1929*	***5821***	*1987*	*413*	*441*	*477*
Number of respondents	*408*	*573*	*505*	***1487***	*500*	*150*	*111*	*128*
Ward FFT score	66	75	74	**72**	71	69	68	76
Ward footfall (min'm 15% required)	21%	29%	26%	**26%**	25%	36%	25%	27%
Number of eligible A&E patients	*4206*	4380	*4194*	***12800***	*4652*	*1018*	*1017*	*989*
Number of respondents	*17*	62	*353*	***432***	*265*	*41*	*21*	*28*
A&E FFT Score	53	71	59	**60**	55	70	29	39
A&E footfall (min'm 15% required)	0%	1%	8%	**3%**	6%	4%	2%	3%
TRUST FFT Score	65	74	68	**70**	65	70	62	69
TRUST footfall	7%	10%	14%	**10%**	12%	13%	9%	**11%**

Inpatient scores saw a drop in August week one and two, but week three saw an increase in score up to 76. However, the A&E score and data collection continue to struggle.

CQUIN
We were previously informed that the FFT CQUIN could only be achieved if we met the requirement to reach 15 per cent response rate overall in Quarter one and then increase this to 20 per cent by the end of Quarter four. This meant that the Trust would lose out on this particular CQUIN in its entirety as we did not reach the required 15%. However, guidance has now been updated to clarify that it is possible to earn 50 per cent of the CQUIN funding if the quarter four target is met.

With this in mind, the token system for A&E has now been delivered. Uptake will be closely monitored to ensure we reach the Trust-wide 20% response rate target. Inpatient response rate continues to run at around 26 per cent.

National publication update
On 30th July NHS England published for the first time all FFT results for all Trusts inpatients, accident and emergency and then a combined score. The table below shows Dudley Group scores against the national ones. For the first quarter the Trust has scored higher than the national average scores in all three categories. Results were published in full by month and ward/ category on NHS England website and June only figures are on NHS Choices. On NHS Choices there is a rating system with the top 10 per cent of Trusts getting a green tick, bottom 10 per cent a red exclamation mark and those in the 'normal' range a blue ok. DGNHSFT were in the 'ok' range.

Trust scores				
	April	May	June	**Quarter**
A&E	53	71	59	**61**
Inpatients	66	75	74	**71**
Combined	65	74	68	**69**
National scores				
	April	May	June	**Quarter**
A&E	49	55	54	**53**
Inpatients	70	70	71	**70**
Combined	62	64	63	**63**

In June 36 wards out of 4,500 across the country scored an overall negative figure, down from 66 in April. Unfortunately A2 was one of these wards for the first time in the 15 months we have been collecting data. (-6 in June).

The Care Quality Commission will use the data as part of its new surveillance system when assessing risks at hospitals, together with other data such as mortality rates and never events.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th September 2013

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 11th July 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:

Quality Dashboard Report for Month 2 (May 2013/14) - the following issues were discussed:

- **C Diff** - CDiff numbers for the first quarter did not exceed the projected numbers when the report was completed. However, the preliminary figure for June was 5 incidents which meant that the Trust was over its trajectory for Quarter 1.
- **Maternity Smoking in Pregnancy -** there had been little change in the smoking in pregnancy indicator which was below the target at 17.6% for the fourth month in a row.
- **TAL Appointment booking within 4 days -** the Trust had started a review of its demand and capacity which would last for 3 months with Ophthalmology, Dermatology and Respiratory being the first three areas to look at how they manage their specialties more effectively. Reporting to the Outpatient Steering Group, one of the expected outcomes was an improvement in the TAL Key Performance Indicator.
- **NHS Choices -** the Trust was within the acceptable range for all NHS Choices clinical indicators.

Compliance with NPSA Safety Alerts - there was one outstanding NPSA Safety Alert: **Safer Spinal (intrathecal), Epidural and Regional Devices Part B - NPSA/004B 2009 NPSA/2011/PSA001** - Part B remains active with a closure date of 1st April 2013. Trials of the new equipment remained problematic due to a shortage of companies producing suitable non-luer products.

Serious Incident Monitoring Report - 9 new incidents were reported in June (8 general serious incidents and 1 pressure ulcer). There were 40 open general SI's (19 under investigation, 11 awaiting assurance that all actions identified from the RCA investigation had been completed, 1 extension requested from the CCG and 9 recommended for closure). The concerns highlighted from the general SI's were Falls Resulting in a Fracture. There were no breaches in the 2 day reporting from date of identification, but 1 breach in the completion of the RCA within the agreed time scales. Work was continuing with regard to Patient Falls.
The Committee **noted** the current position and supported the closure of the 9 SI's recommended: 2013/11017, 2013/11569, 2013/721505, 2013/11951, 2013/7586, 2013/5140, 2013/12292, 2013/7572 and 2013/10156.

Patient Safety Group - the following issues were discussed:

- **Feedback from the Red Incident Assurance and Learning Group Meeting on 24th April 2013 -** There were 65 incidents on the red matrix (excluding SI's) of which 25 had breached the timescales for completion of the RCA or to provide assurance that actions identified had been taken.
- **Aggregated Quarterly Incidents, Complaints and Claims Report (January- March 2013)-** The total number of incidents reported showed a quarter on quarter increase. There was an upward trend/monitoring of incidents in the sub-categories of Clinical Care Assessment Monitoring; Infection Control - Hospital Acquired Infections; Patient Falls; Injuries and Accidents.

- **Community Services and Integrated Care (30 April 2013) -** There were 111 incidents relating to CSIC in March which demonstrated a strong reporting culture. Severity of incidents had been noted with only one 'major' and 23 'moderate' severity.
- **Ambulatory Medicine (12 February 2013 and 26 April 2013) -** Diabetes incidents were increasing; a Task and Finish Group was set up to deal with these and would cease in the autumn. There was a noted trend in the Renal Unit of the reporting of workforce issues, caused by high sickness levels and number of patients above capacity that were treated out-of-hours. This had settled and the management of change had taken place to move to three shifts.

Maternity and Children's (8 April 2013) - The minutes of the meeting highlighted the following:

- **Speech and Language Therapist Service -** The service was only available part time and incidents were occurring when the therapist was unavailable. The Service Level agreement with the Black Country Partnership NHS FT had been reviewed and a Risk Assessment was being completed.
- **Paediatric Dietician -** Delays had occurred with dietician assessments. This had been escalated to the Dietetic Manager and a business case developed. Staff had been appointed but were not yet in post.
- **Sub-optimal Care of Diabetic Women -**This related to the glucose tolerance test and the monitoring and reporting of this.
- **Flushing of Lines -** this was being reviewed in the Children's Ward following feedback at a mock Deanery Visit and guidelines and training were being developed for ward staff.

Surgery/T&O and Critical Care (22 April 2013) - The group had reviewed their arrangements and reinforced links with various forums. The timing of the meeting would move to 6 weekly to provide sufficient time to progress actions. Terms of reference were being reviewed and core members identified.

Patient Safety Leadership Walk rounds - There had been 4 Patient Safety Leadership Walk rounds since April. Action plans had been developed for each. 9 actions from 2012/13 had breached their completion dates and were outstanding. Of these, 7 had no updates and 2 had been updated but the patient safety issue remained unchanged.

Safeguarding Group (27th June) - the group discussed the compliance levels associated with the staff receipt of the **Safeguarding Staff Leaflet.** Signatures were received from 76% of staff. The process for collecting information from wards and departments was under review.

LET Working Group (20th June) - A number of Quality Assurance Visits had taken place:

- Anaesthetics (20th June) was successful with no concerns.
- SAS doctors visit was successful with no concerns.
- Ophthalmology visit - some issues to be managed by the Clinical Tutor locally. No concerns.
- Elderly Care visit highlighted some departmental issues that the Clinical Tutor was dealing with locally. No concerns.
- Paediatric revisit in April was successful and no concerns were highlighted. In preparation for the revisit in November 2013, which would check the progress of the action plan implementation, a mock visit was planned in September.

The Group also discussed the establishment of a task and finish group to consider the future of Physicians Assistants and Advanced Nurse Practitioner roles in the Trust. This would report any future training needs back to the LETG. The two roles fell between medicine and nursing.

Nursing Strategy Update - a quarterly report would be presented to the Committee and annually to the Board of Directors. This was the first quarterly update since the strategy's development. Leads had been identified and a new matrix and data set had been completed. The audit for the End of Life Care had already changed. The quarter 2 data would be presented to the Committee in October 2013.

Friends and Family Survey Results - June 2013 highlighted the following key points:

- The response rate Trust wide was 14% and the target was 15%. The comments received

provided really useful information which the wards were using to make improvements and were mainly positive. Food still remained the highest concern for patients.

- The A&E response rate continues to be low at 8%. A token system, similar to those in Supermarkets would be introduced from the 1st August 2013 to help improve the response rates.
- CQUIN cannot now be achieved
- Data would be published nationally by the end of July 2013
- An audit of noise at night on wards was being undertaken by the site coordinators

KEOGH Patient Experience Strategy Event - the Trust had held a Patient Experience Public Event where 97 people registered and 60 people attended. Many good points and comments were made about the Trust. The findings would be documented and shared. The Trust was considering having other events for Maternity and Paediatrics to appeal to a younger audience.

***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 11th July 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 Group NHS
NHS Foundation Trust

Paper for submission to the Board on September 5th 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:

The attached report confirms the progress made against the local actions arising from the recommendations of the Francis Inquiry Report.

Updates provided are shaded in yellow. Completed and closed actions are shown in bold.

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

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

Report to Board September 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.**	**Closed** **Closed**
	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.	**Open**

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. **The Trust has invested in new technology 'The Hub' to manage policies and procedures, including their regular review and update. Staff have improved search facilities and will be automatically informed when relevant policies and procedures are updated.**	**Closed**
		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**	**Closed**
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**.	**Transferred to the Keogh Action Plan**

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**	**Closed**
		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. Governors have committed to evaluate their current role in the monitoring of clinical quality within the Trust and strengthen this where necessary. This report will be produced by the Governor Development Group for consideration by the full Council in November 2013.	**Continue to Monitor and progress**

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. Governors now attend patient safety walkabouts in ward areas to meet patients.	**Continue to Monitor and progress**
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. The Department of Health has announced that it is currently developing an NHS wide assessment model for application in 2014.	**Open**
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		**Open**
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 Director of HR would make the necessary referrals. The Department of Health has announced that it is currently developing an NHS wide assessment model for application in 2014.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
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.**	**Closed**
	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.	**Open**
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.	**Open**
	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.**	**Closed**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	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	**Transfer to Keogh Action Plan**
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.**	**Closed**
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 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.	**Transfer to Keogh Action Plan**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
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	**Transfer to Keogh Action Plan**
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	**Transfer to Keogh Action Plan**
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.	**Transfer to Keogh Action Plan**
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.	**Transfer to Keogh Action Plan**
		• 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 & 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	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
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**	**Transfer to Keogh Action Plan**
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.**	
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.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	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.** **The Trust has initiated a revised model of directorate performance review that embraces increased qualitative KPIs.**	**Closed**
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.**	**Closed**
	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**	**Closed**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
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.	**Open**
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		
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**	**Closed**
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		

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
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 compromise agreements that have been obtained from the Trusts Solicitors and do not include gagging orders**	**Closed**
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.**	**Closed**
	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.	**Open**
					Interviews for novice programme – entirely on values.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		– 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.	**Open**
		– 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.	**Open**
		– 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.**	**Closed**
		• 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 CDs, MSHs 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.	**Open**
		• 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.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• 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	**Open**
		– Regular, comprehensive feedback on performance and concerns;			Nurses referred to NMC report to be taken to the Board.	**Open**
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'**	**Closed**
		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.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		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.**	**Closed**
		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.**	**Closed**

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)	**Transfer to Keogh Action Plan**
					Datix to be completed when ward nurse managers are not supernumerary.	**Transfer to Keogh Action Plan**
					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.**	**Closed**
					Wards round bundle is being rolled out.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	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.	**Open**
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:	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.	**Open**
		• 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	**Open**
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.**	**Closed**
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.**	**Closed**

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**	**Closed**
	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.	**Open**
					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.	**Open**

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**	**Closed**
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**	**Closed**
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**	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
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**	**Closed**
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.	**Open**
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	**Open**
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.	26	Director of Finance and Information	The Trust had adopted robust manual information sharing arrangements. At present real time information is not available	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		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				

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th September 2013 - PUBLIC

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Infection Prevention and Control	
	Risk Register: Y		**Risk Score:**	IC010 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	June '13	July '13	As of 28th August '13	Totals so far 13/14
A1	2	0	0	0	0	0	0
A2	12	0	1	0	1	0	2
A4	0	0	0	0	0	0	0
B1	0	0	0	0	0	0	0
B2	1	0	1	0	0	0	1
B3	4	0	0	0	0	0	0
B4	3	0	0	0	0	0	0
B5	0	0	0	0	0	0	0
B6	2	0	0	0	0	0	0
C1	7	1	1	0	0	0	2
C3	6	0	1	1	1	0	3
C4	4	0	0	0	0	0	0
C5	1	0	0	2	0	0	2
C6	3	0	0	0	0	0	0
C7	7	0	0	0	0	0	0
C8	2	0	0	0	0	1	1
MHDU	0	0	0	1	1	0	2
CCU/PCCU	0	0	0	1	0	0	1
Critical Care	0	0	0	0	0	0	0
EAU	1	0	0	0	0	0	0
SHDU	1	0	0	0	0	0	0
Total	**56**	**1**	**4**	**5**	**3**	**1**	**14**

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 have been no confirmed cases of Norovirus in the Trust.

C. difficile – We reported 10 post 48 hr cases against a target of 9 for the first quarter; 3 cases in July on target and as of 28th August there has been one case in August.

Pseudomonas aeruginosa (non-reportable organism) – In the Neonatal Unit, as part of ongoing surveillance a baby transferred from a neighbouring Trust was identified as being colonised as was another baby on our own unit. Neither of the babies were clinically affected by their carriage and typing confirmed that these organisms were different strains.

Other matters – Dr E Rees has taken the role of DIPC (Director of Infection Prevention and Control) as of June 2013 with Mrs McMahon remaining as Board lead for Infection Control. Mrs D Westmoreland has resigned from her post as Consultant Nurse in Infection Control. The Infection Prevention and Control Team is currently being reviewed with the intention to replace the lead nurse role.

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

Monthly number of C.diff cases

(N13) Clostridium difficile infections

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	-33.3%	2	3	-33.3%	5	7
May-13	4	3	33.3%	6	6	0.0%	10	11
Jun-13	5	3	66.7%	11	9	22.2%	6	6
Jul-13	3	3	0.0%	14	12	16.7%	9	11
Aug-13	1	3	-66.7%	15	15	0.0%	7	10
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	14	38	-60.5%				37	45

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.

Monthly number of MRSA cases

(N1) MRSA infections

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	0.0%	-	0	0.0%	-
Aug-13	-	0	0.0%	-	0	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) has established a national zero tolerance approach regarding MRSA bacteraemia for 2013/14 onwards.

Monthly number of MSSA cases

MSSA infections		
Month / Year	**Total**	**Cumulative**
Apr-13	6	6
May-13	6	12
Jun-13	-	12
Jul-13	6	18
Aug-13	3	21
Sep-13		
Oct-13		
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	21	

Monthly number of E.coli cases

E.coli infections		
Month / Year	**Total**	**Cumulative**
Apr-13	25	25
May-13	13	38
Jun-13	14	52
Jul-13	22	74
Aug-13	2	76
Sep-13		
Oct-13		
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	76	

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th September 2013

TITLE:	**Summary of Key issues from the Risk & Assurance Committee held on 23rd July 2013**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Ann Becke (NED)** **CQSPE Committee Chair**

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

SUMMARY OF KEY ISSUES:

Matters arising from the Risk and Assurance Committee held on 23rd April 2013 - The Committee confirmed progress against outstanding actions and received updates on:

- Recruitment and Retention of Accredited Clinical Coders
- Out of hours medical cover - risk assessment
- Failure to control Directorate Overspend – risk assessment.
- National Cardiac Arrest Audit Report - Update paper

Diagnostics Risk Register – The Clinical Director and General Manager presented the Diagnostic Directorate Risk Register and top 5 risks. They felt that their processes could be improved to embed the risk management systems fully and hoped to have revised procedures in place by the Autumn. Risks are reviewed at the Directorate meeting but these are not all aligned to the risk register. Some risks include actions that are outside of the directorates control which will be re-directed or escalated to the appropriate directorate or Lead Director. The Committee received assurance that a process would be established by the end of August. The current position in terms of mitigating actions and revisions in progress were discussed and the Committee requested further reviews in some areas and additional information for future reports. Some risks would be escalated to the corporate risk register

Corporate Risk Register - Directors were currently managing 25 corporate risks, 9 of which scored 20 or above. All risks were Director led. The Committee discussed the progress against mitigating actions and further actions required.

Operations Directorate Risk Register - In the absence of the Director of Operations, the Committee reviewed the Risk Register and discussed some of the risks identified as the top 5 for each individual Directorate. The Committee noted that following the drafting of the Keogh review action plan, the Trust Governance team, Director of Operations and the directorate managements teams would be establishing greater consistency and robustness in the governance arrangements in each directorate.

Transformation and Estates Risk Register – The Deputy Director of Operations (Estates and Facilities) presented the Transformation and Estates Risk Register. He updated the Committee on the progress with the directorate top risks and provided assurance on the actions to date.

Nursing Directorate Risk Register – The Director of Nursing presented the report for the Nursing Directorate confirming the current position with regard to the risk of infection outbreak and incidents of pressure ulcers.

Finance, Information and IT Directorate Risk Report – The Director of Finance outlined the current position and confirmed that there were 5 risks on the Finance, Information and IT risk register of which 1 scored 16. Two risks were closed in the last quarter – Recruitment and Retention of Coders and Loss of income re Soarian, which were successfully mitigated.

Human Resources Risk Register - The Associate Director of Human Resources presented the Risk Register and confirmed that there were 5 risks on the register. 3 had been carried over, 2 closed and 2 new risks added. The Committee discussed the progress against actions to mitigate risks.

Compliance with NPSA Safety Alerts - the report confirmed the Trust position with regard to compliance with NPSA alerts.Currently there is only one provider producing non luer needles which had delayed trials of the new equipment. This problem was shared with many organisations. A risk assessment was completed on the 04/03/2013 and an update on 26th June 2013 confirmed that difficulties in obtaining equipment from other companies remained a problem and was continuing to delay progress in identifying a suitable product. Progress would continue to be tracked.

CQC Quality Risk Profile Exceptions Report - this report detailed the areas where the CQC had estimated the Trusts risks as "worse than expected", "much worse than expected" and "tending toward worse than expected". The Committee **noted** the Trust's position with regard to compliance with the CQC and **received** the CQC Quality Risk Profile Exceptions Report.

Policy Group Recommendations - The Policy Group recommended 45 policies/guidelines for formal ratification. The full documents were available for review on the Directors shared drive prior to the meeting. The Committee **reviewed** the schedule of Policies and Guidelines and **ratified** all 45 documents listed.

Diversity Management Group 9th April 2013 - The Diversity Management Group minutes were received. There were no major issues to report. Diversity training for staff remained green and the training had been updated to include the 9 protected characteristics. There were no concerns reported from procurement with contractors not complying with the public sector equality legislation.

Research and Development Directorate Report - The Committee was advised of new studies taking place within the Dudley Group and the risk levels of these. There was nothing of great concern relating to the adverse studies and the group were requesting approval of the terms of reference for the Protocol Review Group.

***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
		Y	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Risk & Assurance Committee held on 23rd July 2013 and refer to the full minutes for further details.

The Risk and Assurance Committee has overarching responsibility for risk and ensures that the Trust has appropriate and effective systems and processes in place to identify, record, manage and mitigate all risks (clinical and non clinical) to the provision of high quality, safe, patient centred care. The duties of the Committee include the assessment of the Trust risk portfolio and the provision of assurance to the Board of Directors on the adequacy and effectiveness of the risk management arrangements across the Trust and in the Community.

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5 September 2013

TITLE:	**Audit Committee Exception Report**		
AUTHOR:	**Jonathan Fellows**	**PRESENTER**	**Jonathan Fellows**
CORPORATE OBJECTIVE: Quality			

SUMMARY OF KEY ISSUES:

The Trust Audit Committee met on 23rd July 2013 and considered:

- The results of the Board risk assurance self assessment;
- Progress reports from Internal Audit and the Local Counter Fraud Service (LCFS);
- An update from Deloitte on the external audit and on the audit of charitable funds;
- Compliance with governance changes required by the Monitor licence;
- A Clinical Audit progress report;
- Results of the Payment by Results (PbR) data assurance audit for 2012/13;
- Results of an audit of sickness absence;
- The annual report of the Audit Committee.

Results of board risk assurance self assessment: As part of its commitment to continuously reviewing systems of assurance and arrangements for governance, all board members had completed a risk assurance self assessment questionnaire. The results showed that there was general satisfaction with the current arrangements, although a few actions will be followed up as a result of the responses, including:

- Ensuring discussions on risk management form part of all clinical directorate performance review meetings;
- Including updates on risk management processes and outputs in all matrons and clinical directors presentations to board.

In addition, the Governance Manager will work with each clinical directorate to ensure consistency of risk management across directorates.

Internal Audit Progress Report: Since the last Committee meeting 4 reports had been finalised, with a further 23 reviews in progress or scheduled to be undertaken. The 4 completed reports were:

- Validation of high and medium priority recommendations reported as actioned and closed : Good progress
- Review of business planning : Advisory
- Distribution of payslips : Advisory
- Governance arrangements for design and implementation of Transformation Programme board and ICT Services Project board : GREEN opinion

RED opinion	The Board CANNOT take assurance that controls are suitably

	designed, consistently applied or effective
AMBER/RED opinion	The Board can take SOME assurance that controls are suitably designed, consistently applied or effective
AMBER/GREEN opinion	The Board can take REASONABLE assurance that controls are suitably designed, consistently applied or effective
GREEN opinion	The Board can take SUBSTANTIAL assurance that controls are suitably designed, consistently applied or effective

LCFS progress report: the LCFS confirmed that the work undertaken to date was on track to deliver the full year plan. Two new referrals had been received, one relating to mobile phone use and one to working whilst off sick. The latter referral had arisen from the Trust participation in the National Fraud Initiative (NFI), a bi-annual data matching exercise carried out in conjunction with the Audit Commission across public sector organisations including Local Authority, NHS and Emergency Services.

The referral relating to mobile phone use has been investigated and the case closed. The working whilst sick referral has been passed to HR to take appropriate action.

Deloitte update on external audit and charitable funds audit: Deloitte confirmed that all matters relating to the audit of the Trust 2012/13 Annual Report & Accounts and Quality Report had been completed and the accounts submitted on time. Audit work on the Charitable Funds accounts for the year ended 31st March 2013 had also been completed. Subject to receiving the signed letter of representation, Deloitte anticipated issuing an unmodified opinion on the truth and fairness of the Charitable Funds financial statements.

The Audit Committee considered the representations contained in the draft letter of representation and approved its signature. Under delegated authority, the Audit Committee also approved the Charitable Funds Accounts for 2012/13. The accounts showed fund balances carried forward of £2.789 million at 31st March 2013 compared with £2.476 million at the same point in 2012.

Ensuring compliance with governance changes required by Monitor licence: following on from a previous briefing by RSM Tenon on the changes to the governance of Foundation Trusts resulting from the 2012 Health and Social Care Act, the Trust had prepared an action plan to ensure compliance with the new legislation and with the terms of the licence issued by Monitor. The key areas of the action plan and the lead director for each are:

KEY REQUIREMENT	RESPONSIBILITY
Fit and Proper person test for governors and directors	Director of HR
Right of patient to make choices	Nursing Director
Provision of integrated care	Director of Finance
Restrictions on asset disposals	Director of Strategy & Transformation
Compliance with licence obligations and provision of information to Monitor	Director of Finance
Governance arrangements including good corporate governance, effective board and committee structures, effective leadership, accountability and comprehensive, timely and up to date information	Deloitte board effectiveness review Data quality reviews by Audit Committee Bi-annual Quality Governance review

Clinical audit progress report: there were a further 29 additional clinical audits assessed as having met the set criteria and thus recommended for inclusion in the plan for 2013/14. Overall the standard of audit proposals is high and there has been an increase in clear measurable standards.

There are currently 143 audits in the plan, with National & Royal College, Quality Account, Service Evaluation and NICE Guidance related audits comprising 69% of the total. Of the 47 clinical audits carried over from the 2012/13 plan, 8 are now complete with the remainder continuing to be progressed.

Results of the PbR data assurance audit: for the 2012/13 PbR data assurance audit, the two areas chosen by the local PCT were Emergency Paediatric admitted patient care and Accident & Emergency (A&E) attendances.

The incidence of clinical coding errors affecting either the Healthcare Resource Group (HRG) or a data error or both was 10% for Emergency Paediatrics and 10.7% for A&E. These include all errors, whether they resulted in commissioners being over or undercharged. The financial values associated with the level of errors were quite low.

Whilst still below the national error rate of 11% on average, the above rates represented an increase for the Trust. One factor appeared to be the transfer to the Sorian system in the Emergency department, which had led to problems being encountered with coding and necessitated some manual processing whilst these were resolved. A further factor affecting Paediatrics was incorrect patient discharge date information on the PAS system.

An action plan to address the issues arising from the audit was in place and the Audit Committee recognised the importance of putting appropriate resources into the coding service, as well as making improvements to the IT systems as rapidly as possible.

Audit of sickness absence: a sickness absence audit was carried out by the Trust in February 2013. Whilst the audit found a reduction in the number of files with missing paperwork, plus an increase in the number of files containing all relevant absence paperwork, there were still a number of issues arising, including missing notifications of absence; incomplete self certification forms; and lack of evidence of return to work meetings.

The findings were not dissimilar from those of an Internal Audit review undertaken in 2012. It was agreed that managers needed to be held accountable for the problems of sickness absence reporting, as left unresolved this could reduce the reliability of the sickness absence reporting and monitoring data presented to the Finance and Performance Committee.

The next audit will be undertaken in August 2013 and the Audit Committee recommended that the results of this audit be considered in depth by the Finance and Performance Committee.

Audit Committee annual report: the committee agreed the annual report of its activities which has been forwarded to the board under separate cover.

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
	CQC	**No**	**Details:**

COMPLIANCE and/or LEGAL REQUIREMENTS	**NHSLA**	**No**	**Details:**
	Monitor	**Yes**	**Details: Licence Compliance**
	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

To note the report and in particular that :

a) **under delegated authority the Audit Committee approved the Charitable Funds representation letter and adopted the 2012/13 Charitable Funds accounts;**
b) **the sickness absence audit was referred to the Finance and Performance Committee to follow up the issues arising from the audit;**
c) **the Audit Committee annual report has been presented separately to the board of directors for approval.**

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 Audit Committee was established to provide assurance to the Board that there is an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities (both clinical and non clinical), that supports the achievement of the organisation’s objectives and that this system is established and maintained In particular the Committee reviews the adequacy and effectiveness of all risk and control related disclosure statements including the Annual Report, Quality Report and Annual Governance Statement, underlying assurance processes and policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification. In addition the Committee reviews the findings, implications and management responses to the work of the External Auditors, ensures there is an effective Internal Audit function and that the organisation has adequate arrangements in place for countering fraud

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th September 2013

TITLE:	**Audit Committee Annual Report 2012-13**		
AUTHOR:	**Jonathan Fellows**	**PRESENTER**	**Jonathan Fellows**

CORPORATE OBJECTIVE: Quality

SUMMARY OF KEY ISSUES:

Audit Committee annual report and opinion for presentation to Trust Board

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**No**	**Details:**
	NHSLA	**No**	**Details:**
	Monitor	**No**	**Details:**
	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

The attached report details the activities undertaken by the Audit Committee in 2012/13 together with the opinion of the Committee as to whether the Trust's risk management, control and governance processes are adequate and effective and may be relied upon. The Board is asked to note the report.

STRATEGIC OBJECTIVES : *(Please select for inclusion on front sheet)*		
SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
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The Dudley Group NHS
NHS Foundation Trust

ANNUAL REPORT OF THE AUDIT COMMITTEE FOR THE YEAR 2012/13

1. Introduction

The Audit Committee was established to provide assurance to the Board that there is an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non clinical), that supports the achievement of the organisation's objectives and that this system is established and maintained.

The purpose of this report is for the Audit Committee to account to the Board of Directors on its activities relating to the financial year 2012/13. In practice this covers the period up to the approval and sign off of the Trust's Annual Report and Accounts, which took place in May 2013.

The Audit Committee provides a report to the board of the matters discussed after each of its meetings during the year, so this annual report draws on the information contained in these regular reports.

The Committee's chief functions are to support the Board by critically reviewing:

a) the governance and assurance processes on which the Board places reliance, including the risk and performance management systems and the Assurance Framework; and

b) all risk and control related disclosure statements, including the Annual Report and Accounts, Quality Report and Annual Governance Statement, underlying assurance processes and policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; and

c) the findings, implications and management responses to the work of the External Auditors, together with ensuring there is an effective Internal Audit function and that the organisation has adequate arrangements in place for countering fraud.

Although financial scrutiny remains vitally important, Audit Committees have long recognized that there is a widening range of activities which require comprehensive and effective controls. For the NHS, this includes clinical governance issues, such as the collection and reporting of performance and quality data and the preparation of annual clinical audit plans and processes, together with the measures taken to combat fraud.

In order to discharge its key functions, the Audit Committee prepares an Annual Report for the Board and the Accounting Officer (Chief Executive) and expresses a considered opinion based upon the evidence placed before it.

2. Audit Committee's Responsibilities

During the year, the Audit Committee operated in accordance with its responsibilities as set out in its Terms of Reference, which were:

a) To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical, that supported the achievement of the organisation's objectives;

b) To ensure that there was an effective Internal Audit function that met Government Internal Audit Standards and that provided appropriate independent assurance to the Audit Committee, Chief Executive and Board;

c) To review the work and findings of the External Auditors and consider the implications of and management's responses to their work;

d) To review the findings of other significant assurance functions, both internal and external to the Trust and including in particular local and national clinical audit activity and outcomes and consider the implications for the governance of the organisation;

e) To satisfy itself that the organisation had adequate arrangements in place for countering fraud and to review the outcomes of counter fraud work;

f) To receive and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee also requested specific reports from individual functions within the organisation (for example, clinical audit) where these were appropriate to the overall arrangements;

g) To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance;

h) To ensure that the systems for financial reporting to the Board, including those of budgetary control, were subject to review in order to establish the completeness and accuracy of the information provided to the Board;

i) To review the Annual Report, Quality Report and financial statements before submission to the Board focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in and compliance with accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgments used in the preparation of the financial statements
- Significant adjustments resulting from the audit
- Letter of representation
- Qualitative aspects of financial reporting
- Contents of Quality Report

3. Audit Committee Membership

The Audit Committee is constituted as a sub-committee of the Trust Board with approved terms of reference that are aligned with the *Audit Committee Handbook 2005* published by the HFMA and Department of Health. The required quorum for meetings is two Non-Executive Directors.

It is recommended that the Chair of the committee is a suitably (CCAB) qualified accountant and as a Fellow of the Association of Chartered Certified Accountants, the current Chair meets this requirement.

Certain individuals were required to attend Audit Committee meetings. These included the Trust Director of Finance & Information, senior representatives of the External Auditors of the Trust, senior representatives of the Internal Auditors of the Trust and the Local Counter Fraud Specialist (LCFS).

The table below records attendance at each meeting during the 2012/13 cycle:

Date of Meeting	Audit Chair	Other NEDs	Finance Director	External Auditors	Internal Auditors	LCFS
17th July 2012	Yes	2	Yes	Yes	Yes	Yes
16th October 2012	Yes	1	Yes	Yes	Yes	Yes
15th January 2013	Yes	2	Yes	Yes	Yes	Yes
14th May 2013	Yes	2	Yes	Yes	Yes	Yes

In March 2012, the Terms of Reference for the Audit Committee were reviewed by the Trust Board. In addition to the Chair of the Committee, two specific Non-Executive Directors were appointed to serve on the Committee although all Non-Executive Directors could attend meetings if they wished to do so.

Other individuals from the Trust were invited to attend meetings. The Director of Nursing, the Trust Director responsible for Risk and Governance, attended four meetings during the year, while the Chief Executive attended three meetings. In addition, the Governance Manager, Clinical Coding manager and Head of Information each attended one meeting.

The Committee was able to draw on the independent advice of the Trust's auditors and any other officers or outside agencies it considered necessary. The Committee met with both the External and Internal auditors in private during the year in order to ensure that they had the freedom to raise any issues of concern. There were no matters to report as a result of these meetings.

4. Internal Audit

Internal Audit services for the 2012/13 year were provided by RSM Tenon. Internal Audit supports the work of the Audit Committee in two key areas:

a) by providing an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's strategic objectives; and

b) by providing an independent and objective service to help improve risk management, control and governance.

As is normal, a risk based approach was taken to establish the internal audit plan for 2012/13. This took account of the strategic and operational risks relating to quality and safety issues; service delivery standards and targets; workforce; finance and business, as identified by both management and the Committee, as well as the need to review key financial systems to ensure that External Audit could continue to place reliance on the work of Internal Audit.

Internal Audit issue assurance ratings for audits as follows:

GREEN	the Board can take significant assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective
AMBER	the Board can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective
RED	the Board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective

A total of 30 internal audit reviews were undertaken in the year. Of these:

- 7 were advisory reviews;
- 4 were follow up audits which all found reasonable/good progress in implementing recommendations with the exception of delayed discharges where a shared database still needed to be developed;
- 9 resulted in **GREEN** opinions
- 9 resulted in **AMBER**/**GREEN** opinions
- 1 resulted in a **RED** opinion.

The **RED** opinion related to data quality for 18 week waits in Community Services. Overall the Trust was achieving 97.25% compliance with the 18 week wait target, well above the 92% required threshold; however there were a small number of errors noted in the Community Services data, particularly in the two specialities Dermatology and ENT. Whilst RSM Tenon considered that errors in Community Services pathways would be highly unlikely to risk taking the overall Trust performance below the 92% threshold, nonetheless it was important to improve training and to reduce coding errors.

A follow up review of this area found reasonable progress although the recommendations cannot be fully implemented until a single PAS is in operation across both the hospital and Community Services. Work is ongoing to achieve this.

Of the 6 audits undertaken by Internal Audit on the key financial systems, 5 received **GREEN** assurance ratings. The sixth related to Payroll, which received an **AMBER/GREEN** rating as budget holders were not required to confirm establishment information plus information was sometimes submitted late increasing the risk of overpayments. Recommendations to resolve these issues have been accepted and are being actioned.

In total there were 71 recommendations issued by Internal Audit across all of the reviews, all of which were accepted by management with plans agreed for implementation.

Internal Audit operated a recommendation tracking system which identified any recommendations made which had not been actioned by their due date, or where recommendations were considered to have received inadequate management attention. Regular reports were provided to the Audit Committee. There were no outstanding recommendations which the Trust should have implemented and Internal Audit confirmed to the Committee that there were no recommendations which had received inadequate management attention.

The Audit Committee was pleased to note that Internal Audit issued positive opinions in respect of the majority of the work undertaken in 2012/13 and, in particular, found that a consistently high level of sound internal control was demonstrated within the operation of the Trust's key financial systems.

The Audit Committee received progress reports from the Internal Auditors throughout the year and a final report in May 2013 that provided the Head of Internal Audit Opinion. This opinion is based on:

a) an assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

b) an assessment of the range of individual opinions arising from the risk based audit assignments reported throughout the year. This assessment takes account of the relative materiality of these areas and management's progress in addressing control weaknesses;

c) an assessment of any reliance placed upon third party assurances.

The full Head of Internal Audit opinion is as follows:

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.

In May 2013, RSM Tenon presented to the Audit Committee the internal audit strategy for 2012/13 to 2014/15, including the annual plan for 2013/14. The strategy and plan had been updated after detailed discussions with the Trust executive management team, plus consideration of the Trust's Assurance Framework and how other emerging issues that affect the Trust may impact on the internal audit assurances required.

The key areas discussed with management for inclusion in the 2013/14 plan were:

- Nurse Care Indicators/Safety Thermometer
- Data Centre
- Community Focus
- Francis Report implementation of recommendations
- Business Planning priorities.

Other areas for audit included claims and complaints, commissioning arrangements, appraisals, doctor revalidation, PFI monitoring, pressure ulcers and on call payments.

The Audit Committee agreed to move away from annual audits of some core financial systems. These consistently achieved **GREEN** opinions so it was considered more appropriate to direct resource to other areas of specific risk, or where assurance was needed. RSM Tenon had met with the Trusts external auditors to confirm that the scope of work in the area of internal financial control and core financial systems would still allow the external auditors to continue to place the planned level of reliance on the work undertaken by internal audit in 2013/14.

The Audit Committee considered that:

- **The strategy for Internal Audit covered the Trusts key risks as recognised by the Committee**
- **The detailed plan for 2013/14 reflected the areas that the Committee believed should be covered as priority**
- **Sufficient assurances were being received by the Trust to monitor the Trusts risk profile effectively**
- **The level of audit resource was agreed as appropriate**

Accordingly the Audit Committee recommended to the Board that the Internal Audit Strategy for 2012/13 to 2014/15 be adopted by the Board and this took place at the Board meeting in June 2013.

5. Clinical Governance

The core business of every NHS organisation is healthcare and consequently it was appropriate and necessary for the Audit Committee to consider the clinical objectives and risks in the Assurance Framework and report to the Board on the controls and assurances relating to these. The Director of Nursing regularly attended the Audit Committee to report on risk and governance issues.

The Audit Committee also received regular updates on progress against the clinical audit plan from the Trust Clinical Audit Lead, Clinical Effectiveness Manager and Risk and Standards Manager.

In summary there were 290 clinical audits registered in 2012/13, of which 227 were completed, 47 carried forward and 16 (6%) incomplete. Within the total of 290 audits, the larger categories included CQC/NHSLA mandatory audits (78), patient surveys (47) and National clinical audits (41).

During 2012/13 the Trust participated in 100% of national clinical audits and 100% of national confidential enquiries that it was eligible to participate in. Results of all mandatory audits were **RED/AMBER/GREEN** rated and circulated to Medical Service Heads and Specialty Clinical Audit Leads for review and action plans.

The Clinical Audit plan for 2013/14 prepared by the Clinical Audit & Effectiveness Department (CAED) was presented to the Audit Committee in May 2013. The objective of the CAED was to continuously develop and improve the Clinical Audit programme to meet all necessary requirements, both from external accreditation and validation requirements as well as internal monitoring of standards and any local risks.

The plan had been developed to meet these objectives, as well as taking into account both local drivers and the requirements and recommendations of national bodies such as the Care Quality Commission (CQC) and also the Healthcare Quality Improvement Partnership (HQIP).

There were already 129 audits that had been identified and approved for inclusion in the plan, with a well established process for assessing and adding further audits during the year. The principles on which the plan had been prepared included:

- Prioritisation of National and Mandatory audits
- Increased engagement across clinical directorates
- An increase in the number of re-audits and inclusion of incidents and risks audits
- Inclusion of all clinical audits into the plan. Previously some audits had been monitored outside of the plan, including infection control audits, mortality reviews, trigger tool audits, nursing audits and patient experience audits in the acute setting
- Continued emphasis on clinical audit topics that supported organisational objectives and informed improvements in patient care
- Improved communication of outcomes across the Trust to enable shared learning

The Audit Committee considered that the Clinical Audit plan for 2013/14 included the appropriate national and mandatory audits, met the needs of the Trust and addressed specific risks. Accordingly the Audit Committee recommended to the Board that the Clinical Audit plan for 2013/14 be adopted by the Board and this took place at the Board meeting in June 2013.

6. Counter Fraud Services

During the year, RSM Tenon undertook the agreed workplan of 80 proactive days covering fraud awareness presentations, management of organisational fraud risk, compliance, governance and reporting. Work included attending staff inductions and presenting to staff groups; visiting all wards and departments across the Trust; preparation and circulation of posters, leaflets, newsletters and articles concerning fraud; reviewing key policies such as the Bribery policy, Procurement policy and Standing Financial Instructions; and conducting a fraud risk assessment focussed on agency use, charitable funds, expenses, mortuary and working whilst off sick.

In addition, a further 72 days of reactive investigation work were undertaken across 9 investigations, covering:

- falsification of time sheets by an agency worker (ongoing from 2011/12);
- non adherence to tendering rules;
- failure to work contracted hours;
- unauthorised use of Trust site;
- misuse of Trust telephones;
- sale of Trust medical equipment;
- non-attendance at placements;
- medical secretaries carrying out private work during NHS time
- a manager carrying out private work in NHS time.

The investigation ongoing from 2011/12 had been handed over to West Midlands Police and was proceeding to trial. Of the remaining eight investigations, five were closed with no action being taken; one resulted in a staff member resigning; one resulted in a staff member being dismissed and one was ongoing.

In previous years, NHS Protect operated a Qualitative Assessment process designed to measure the effectiveness of the LCFS function across all NHS Trusts, with ratings ranging from 1 ('inadequate performance') to 4 ('performing strongly'). The Trust's rating in 2011/12 was '3' and, to put this into context, there were no Foundation Trusts with a rating of '4' and only 17% with a rating of '3'. NHS Protect was undertaking a review of the Qualitative Assessment process, which as a consequence had been suspended for 2012/13. However, an NHS Protect Self Review Tool was completed by the LCFS and the Trust received an overall **GREEN** rating. RSM Tenon also confirmed that had the Qualitative Assessment process been in operation in 2012/13, its opinion was that the Trust would in all likelihood have achieved a '4' rating.

The LCFS presented the Annual Workplan for 2013/14 to the Audit Committee in May 2013. This detailed the proactive work that was proposed, which again involved 80 days of proactive work to develop fraud awareness, to manage fraud risk and to ensure compliance, governance and reporting. The intention was to build upon the existing fraud awareness and ensure there was a clearly demonstrable and embedded anti-fraud culture.

The Audit Committee considered that the LCFS workplan for 2013/14 met the needs of the Trust and addressed the Trust's specific fraud risks. Accordingly the Audit Committee recommended to the Board that the LCFS workplan for 2013/14 be adopted by the Board and this took place at the Board meeting in June 2013.

7. External Audit

The Trusts External Auditors Deloitte presented their report on the 2012/13 audit to the Audit Committee in May 2013. Deloitte reported that they would be issuing an unmodified audit opinion on the Trust Annual Accounts for 2012/13 and that the Annual Governance Statement complied with the guidance issued by Monitor. The audit process had once again gone smoothly, with all deadlines achieved and a tight timetable for preparation met.

All key risks had been reviewed as part of the audit process and Deloitte wished to draw attention to both the level of non-recurrent CIP being carried forward into 2013/14 and also the challenge to achieve further CIP in 2013/14. Deloitte noted that the non recurrent CIP being carried forward totalled around £4m and expressed the view that around £1.5m to £2m would be a more manageable level. Deloitte also noted that the plan for 2013/14 included a further £10m of CIP together with £3m of transitional support, plus that all Trusts were finding it increasingly difficult to identify further CIP savings. The Committee identified the opportunities available from improved IT systems and from transformation as key drivers for future cost reduction.

Deloitte also tabled the draft Representation Letter for the Committee to consider. Much of this followed a standard format, with Trust specific issues including collection of outstanding balances from commissioners, treatment of PFI in the financial statements, provisioning for bad debts and treatment of deferred income.

Following the presentation of the report, the Audit Committee concluded that there were no adjustments required to the surplus for the year as reported in the Annual Accounts.

Also presented to the Audit Committee in May 2013 were the findings and recommendations from the Deloitte external assurance review of the 2012/13 Quality Report. This review covered two aspects:

a) firstly, an examination of the content of the Quality Report to ensure that it complied with Monitor's published guidance as set out in the NHS Foundation Trust Annual Reporting Manual and to ensure that it was not inconsistent with other specified information; and

b) secondly, a programme of work to test three performance indicators mandated by Monitor, together with a locally agreed performance indicator chosen by the Council of Governors.

In relation to the first aspect of the review, Deloitte confirmed that based on the results of the procedures undertaken, nothing had come to their attention that caused them to believe that, for the year ended 31st March 2013, the content of the Quality Report was not in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual, nor was there any indication that the content of the Quality Report was inconsistent with other specified information.

Deloitte undertook detailed data testing across four key quality indicators of 62 day cancer waits, Clostridium Difficile, incidents resulting in severe harm or death and patient experience. The first three of these were mandatory with the final one being selected locally.

The review was carried out in accordance with Monitors six dimensions of data quality, namely accuracy, validity, reliability, timeliness, relevance and completeness. Deloitte confirmed they would be issuing an unqualified opinion. All four indicators received the highest possible rating of **GREEN** – signifying that all key standards were met – across all six dimensions, with the exception of 62 day cancer wait data validity which was **AMBER** rated. This was because from the 25 samples tested for this indicator, 2 were found to have errors in the recording of treatment dates, although neither had resulted in any breaches against the indicator. Deloitte had made recommendations for improvement in this area which had been accepted by the Trust.

Deloitte also commented that the across the board rating of **GREEN** for the Trust was an excellent performance as in their experience not many Trusts had achieved a similar outcome.

The Trust Annual Accounts, Annual Governance Statement, Quality Report and Representation Letter were each considered in detail by the Committee and it was agreed to recommend to the Board that they all be approved.

8. Review of Board Committee Effectiveness

In February 2013 the Trust was selected as one of 14 trusts for a detailed review led by Professor Sir Bruce Keogh, NHS England National Medical Director**.** Selection was based on Trusts having been outliers for two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR), although the most recent data from Dr Foster showed the Trust mortality index as 99.5 and SHMI at 1.04, both well within the expected range.

A Rapid Response Review (RRR) by 15 members of the Keogh review panel plus supporting staff took place during May. Members of the executive management teams of the 14 Trusts attended a risk summit in early June at which the individual review findings and proposed action plans were discussed. The Keogh review report was then published on 16 July 2013.

The RRR identified the Trust as improving and with a number of areas of good practice, although did not find evidence of these being in place systematically throughout the organisation.

The Keogh report highlighted in particular that further work needed to be undertaken at Board level to simplify the Trusts quality governance processes and communicate these to staff, as well as to review the performance information required to obtain more complete assurance on quality improvement.

The Trust commissioned Deloitte to carry out a review of its governance structure, with the Monitor Quality Governance Framework used as a standard to audit the Trust's structure against.

The Keogh review panel also expressed a concern about the level of understanding of quality governance from clinical directors and the Trust agreed to address clinical understanding as part of a wider development programme following its organisational review. NHS England will provide support in developing the education programme.

9. Conclusion and Audit Committee Opinion 2012/13

The Committee once again wishes to express its gratitude and appreciation to everyone who has contributed during the year to the work and effective functioning of the Audit Committee.

The Audit Committee considers it has obtained adequate assurance that the key controls and processes within the Trust to ensure corporate and financial governance continue to operate effectively and that this conclusion is supported by the reports of the Internal and External Auditors received by the Committee during the year.

As a result, the Audit Committee is able to provide reasonable assurance to the Board that there are no major weaknesses in the Trust's risk management, control and governance processes. The Board should however recognise that assurance given can never be absolute.

The opinion of the Audit Committee, based on the evidence placed before it during the year, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board, although work must continue to ensure that these are embedded throughout the whole organisation. In addition, there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Jonathan Fellows
Chair of Audit Committee
July 2013

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th September 2013

TITLE:	**Corporate Risk Register (as at 28th August 2013)**		
AUTHOR:	**Sharon Phillips** **Risk and Standards Manager**	**PRESENTER**	**Paula Clark** **Chief Executive**

CORPORATE OBJECTIVE: ALL

SUMMARY OF KEY ISSUES:

In addition to the operational risk registers (reported to Risk and Assurance Committee) the Directors are currently managing 26 corporate risks. Of these, 10 risks score 20 or above (pages 2 – 11 attached). Assurance is actively monitored and mitigating actions have been identified. The remaining risk scores are as follow:

Risk Score	Number of Risks
25	3
20	7
16	4
15	1
12	5
9	3
8	1
6	2

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 ALL**	**Details:** Refer to paper attached
COMPLIANCE	**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
	Other	**Y**	**Details:** Information requirements for the Annual Governance Statement –RR gaps in assurance and control

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	Y	Y	

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

The Dudley Group of Hospitals – Corporate Risk Register

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR034	6. To deliver an infrastructure that supports delivery.	Failure to achievement of 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). The Trust has made a poor start to the years CIP programme (£1.8m off plan at month 4).	8/5/2012	The Board has approved a programme of CIP savings proposals. A Programme Management Office (PMO) capability is established and has been operating effectively for some months. A CIP tracker is updated monthly. This lists all of the schemes with planned monthly savings, the status of the scheme and whether it has gone through the Quality impact Assessment process. Detailed monthly progress reports are made to the Board's Finance & Performance Committee, Directors and TME. A programme has been scheduled for each directorate to attend F&P to update members on their progress. All CIP proposals are risk-assessed for impact upon clinical standards and signed off by the Medical Director and Nursing. General Managers are required to attend the	5	5	25	The Trust has not identified sufficient deliverable savings schemes to achieve the required financial contribution of £15.7m for 2013/14. The Trust has made a poor start to the year's CIP programme (£0.8m off plan at Month 2). Some schemes remain to be fully developed and implemented or risk assessed. Some schemes will deliver benefits that are unlikely to yield cash savings in 2013/14. Many schemes are not recurrent creating pressure in future years. 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.	Board and Board Committee Reports. Reports to TME. Detailed scrutiny of Directorate and Corporate CIP Schemes at Directorate Performance Review Meetings and weekly Directors Meetings. PRINCE level project management of individual schemes. Monitor approval of plan. CIP Risk assessments Monthly DIP updates to Finance and Performance Committee	Completion of quality risk assessments. Absence of a clear understanding of Commissioner's roles in CIP quality assurance. Full alignment of Commissioner's QIPP and Trust CIP schemes. Delays in agreement of schemes and delivery by PFI Contract Efficiency Group. Future years CIP schemes require further development to enable them to be brought forward	CIP discussions continuing with each Directorate and form part of business plans. Traditional and service re-design and drive towards Lean. Support on longer term CIP opportunities by the Transformation Programme. Detailed monthly progress reports prepared. The Trust is seeking transitional funding support from the local CCG. As part of the new conteracting round agree a protocol with Commissioners

				QIA sessions to offer additional advice/understanding on schemes. Monitor approval of plan CIP/Transformation team in place. Traditional and Service re-design and drive towards Lean. Support on longer term DIP opportunities by the Transformation Programme.							
COR042	6. To deliver an infrastructure that supports delivery.	Failure to deliver financial balance in 2013/14, as 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.	31/12/2012	1. CIP in place. 2. Transformation Programme Board established. 3. CIP Transformation Team in place. 4. Traditional and service redesign and drive towards LEAN. 5. Detailed monthly progress reports.	5	5	25	3/4. Given the transformational nature of savings sources in 2013-14, the increased participation of clinicians in promoting clinical practice changes, is essential. This is in serious doubt given current trends in activity pressures and recent media publicity about patient safety issues. 5. The controls have delivered effective CIP savings scheme in previous years but the size of the savings target is greater and the need is for greater transformational change to deliver significant financial benefit.	1. Monthly Progress Reports. 2. Minutes of Transformation Project Board. 3/4. Transformation & CIP PMO established and resourced. 5. Monthly Progress reports.	3/4. Delivering widespread clinical change will be a cultural 'hearts and minds' issue that is notoriously difficult to measure.	3. Directors to take personal responsibility for the delivery of individual CIP projects.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR045	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	Sub-optimal management of Diabetes patients	4/1/2013	1. Diabetes Outreach Team available for advice Referral process in place. 2. Diabetes management plans formulated by DOT Team and written in patients notes. 3. Standardised insulin administration and testing equipment within Trust. 4. Diabetes protocols and guidance on Hub for staff. 5. Staff training for diabetes on induction and then 3-yearly updates. 6. Link Diabetes Nurses on all wards. 7. Staff responsible for prescribing, preparing & administering insulin are trained before doing so. 8. Datix trend monitoring 9. Pharmacy Audit for missed doses and insulin errors. 10. NCIsmonitor Trust compliance with diabetes screening for each patient admission, reports sent o Diabetes Team. 11. ED and EAU undertake routine blood glucose for all new admissions as part of biochemical test screen. 12. Attendance of Diabetes Mandatory Training included in managers monthly mandatory training reports.	5	5	25	4. Staff do not follow guidelines, surgical pre-assessment do not refer patients in timely manner to enable optimisation of diabetes control pre-theatre. 5, 7. Staff do not attend Mandatory Training. 4. Guidelines for surgical management of diabetes, hyperglycaemia and self-administration of insulin are yet to be ratified. 7. 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. Datix Reports. 5/7. Mandatory Training records. 9. Audit reports from Pharmacy. 2/3. National external diabetes annual audit. 1. Audit of patient referrals to Diabetes Outreach Team. 10. Nurse Care Indicator Audit. 6. Champions list. 4. Policies and guidelines. 12. Mandatory Training Reports.	Increase in diabetic-related incidents. 3. Mandatory status for training in diabetes only agreed in November 2012, so poor compliance at this point Trust-wide.	7. Improve knowledge and training of MAU and ED staff in the management of acute diabetes complications. 2. Ensure diabetes assessment is a mandatory part of the new nursing EPR, and monitor Nursing Care Indicators. 7. Ensure all medical staff who prescribe, prepare and administer insulin are trained. 4. Produce urgent Care Bundles for Diabetic Ketoacidosis and Hyperkalemia. 4. Produce guidelines and load on Hub for: Surgical Management of Diabetes Hyperkalemia Self-administration of Insulin 7. Improve medicines reconciliation service on EAU. 2. Ensure all patients have a lab blood glucose recorded on admission. Provision of department/profession specific training by DoT. Inclusion of diabetes care and insulin in medicines management mandatory training.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR007 (OP080)	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	Unable to admit emergency patients due to externally caused delayed discharge/transfer	31/3/2011	Daily monitoring of the delayed discharges via delayed list, ensuring accuracy and challenges by the ward re patients care is managed and escalated appropriately. Ward-based Discharge Team support and plan discharge. Use of estimated discharge at ward level. Escalation to MSH as appropriate. Lead Nurse meetings with patients and relative to identify discharge needs. Early notification to LA via Section 2 to prepare for patients likely needs. Agreed health economy escalation plan. Training on compliance with this. Issue of letter to prepare patients and family for discharge arrangements. Use 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. Daily multi-agency teleconference at Level 2 or above. MOA - Local Directorate solutions to manage delayed discharge. Training of Bed Managers and Discharge Facilitators across Directorates.	4	5	20	Poor service cover from multi-agency Discharge Teams because of vacancy, sickness, leave etc resulting in further delays. DISCO database. No ubiquitous cover across hospital. Patient or relative exercising "choice" exacerbates problem. DMBC overseeing a higher than agreed number of patients.	Escalation meeting daily at 9.15am. Information available on the HUB. Section notifications. Escalation Plan. Training Records. Letters to Patients. MOA Integrated Care Group Minutes and actions. Acute Medical Unit Provision of non-acute care.	Funding for 13/14 can only be provisionally agreed as it is unclear what elements of the re-ablement money will be available.	Oversight by Capacity Team; escalation to DoP's PRN. Use of standard 'expectations' letter. Lead Nurse contact. Early understanding of financial constraints from Local Authority and planned use of new re-ablement monies to increase current capacity and response from local authority. Escalation of issue to Director level. Working with CCG and LA to manage delayed discharge database, improve admission prevention SW input.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR003 (OP090)	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	Urgent care demand exceeds capacity	1/7/2011	1. Re-designation of surgical beds to medicine has taken place. 2. CD/MSH review of elective admissions to prioritise elective admissions, if cancellations are imminent. 4. New capacity management system partially deployed. 5. Discharge Co-ordinators DISCO. 6. Escalation Policy and contingency capacity policy reviewed and deployed. 7. Daily capacity meetings. 8. Work with primary care and commissioners to curtail urgent care demands, provision of virtual ward etc. 9. Directorates SOP.	5	4	20	1. Occasional inability to protect surgical beds. 2. MSH/medical staff not consistently engaged in Capacity Management. 7. Bed/Capacity Management approach/systems not aligned to predictive demand management within specialities/wards locally. Understanding of policies by all staff. Poor attendance at Capacity Meetings. Surges in Emergency surgical activity demand. Failure of all parties to contribute. Failure of parties to agree. DTOC remains above MOA. DTOC for Sandwell patients too high.	1. Board reports include elements of bed capacity etc. 2. Level of cancellations. 3. Attended SHA workshops, project group established. 3. Pilot with West Midlands Ambulance Service will provide additional control. 4. DISCO database. 5. Discharge Policy available to staff. 7. Urgent Care Project Steering Group in place, with full and active participation of the CCG Urgent Care Lead GP and Urgent Care Commissioning Manager.	Database only covers Dudley patients.	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. Empower non-medical staff to improve MDT-led discharge (ongoing). Imperative from Operations Directorate to attend. Constant reminder to Capacity Meetings. Engagement with all parties of all members of UG Team from DGH. Continuous Senior Medical Review in EAU. IST recommendations roll-out. (Follow up ECIST review in October 2013).

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR030 (MAT002 & G010)	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	The loss of experienced midwives from the service and replacement by newly qualified, inexperienced midwives from other hospitals has resulted in an insufficient number of midwives with the required experience for workload / activity / dependency and complexity of women requiring inpatient maternity services, resulting in increased risk of maternal and perinatal mortality / morbidity.	1/9/2011	1. Midwives have been and continue to be recruited to fill the agreed staffing establishment in line with the recommendations of BirthRate Plus, but the vast majority have been newly qualified midwives from other hospitals who lack midwifery experience and knowledge of RHH policies and procedures; 2. Midwives on the Staff Bank are utilised to cover shortfalls in numbers of staff on duty due to absence and whilst newly appointed staff are in their induction period / on study leave to undertake mandatory training and to gain experience. 3. The escalation policy is used for managing reduced staffing which provides clear direction and action to be followed when the staffing is compromised. 4. Managers ensure compliance with the absence/ annual leave / off duty policies;	5	4	20	1. High sickness absence levels both short and long term and the delay in OH service appointments and reports which prevents timely return to work. 2. High rate of maternity leave in the Band 5-6 midwife establishment; 3. Inability to recruit experienced Midwives form other hospitals; 4. The high level resource requirement of mandatory training;	1. All sickness absence managed appropriately as per Trust guidelines and reviewed regularly at Lead Midwives and Managers meetings; 2. Flexible employment opportunities available to Trust staff. 3. Mandatory training is planned to ensure that the impact of staff study leave is appropriately spaced out to avoid diminishing the workforce unnecessarily; 4. Annual leave policy adhered to. 5. Hospital provides accommodation available to staff who would otherwise need to commute long distances. 6. Strong cohesive Supervisor of Midwives team available to support MWs to gain experience and support them in practise.	1. Delays in OH dept reviews due to lack of capacity; 2. Child-bearing age group of midwife population; 3. Not all trainers adhere to the guidance that their training needs to the planned around all the other mandatory training or study days being delivered. 4. New staff coming into post in the Autumn months accrue annual leave but do not take it until after their induction period but then are restricted by the policy that AL is restricted around Christmas period, therefore it must be taken in the final quarter of the financial year. 5. Midwives with families reluctant to stay in hospital accommodation and are unwilling to commit to	Request HR/OH review service response, to ensure that staff are give timely appointments and reports are available to managers to ensure staff come back to work without delay. Ensure that Lead midwives /managers offer annual at short notice to staff when rotas identify surplus staffing levels. Ensure that inexperienced staff receive the support required to gain experience and achieve the competence level required to practise safely. Ensure that all staff receive appropriate support in their work, receive feedback, timely appraisals and have opportunity to attend staff meetings. Ensure that the quality and rigour of the local University Midwifery Programme develops midwives that are fit for purpose at the end of training.

				5. There is an agreement to continue the restriction of OOA bookings at the current level until the review with the CCG in July 2013; 6. There is a monthly review of MW : Birth ratio, staff appointments and vacancies with updates monthly to SHA and quarterly to Directors; 7. Development opportunity has been offered to senior midwives to gain experience as Band 7 shift coordinator so that there is another Band 7 available per shift to support the junior midwives on duty; 8. Unit manager and off duty coordinator to ensure best skill mix available within the current resource; 9. The Band 5 Midwife development pathway is in use to support newly qualified and adapted for newly appointed midwives from other hospitals. 10. An electronic diary is used for planning mandatory training.			5. The loss of midwives who travel long distances from home who leave when they gain local employment. 6. The loss of experienced MWs to retirement, other jobs etc. 7. Recruitment process is lengthy once appointment offer has been made.	7. Trust provides centralised recruitment personnel.	relocation. 6. Maternity Managers are unable to expedite recruitment process as responsibility lies with Central Recruitment team.	

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR026	5. To create a high commitment culture from our staff with positive morale and a can do attitude.	Nurse staffing levels are sub optimal in certain areas.	1/12/2011	Ward staffing levels have been reviewed with Matrons and presented to the Board. Significant investment in the workforce. Mass recruitment undertaken. Nurse bank established. Continue to use bank staff to cover vacancies. Move staff to under resourced areas. Accredited training programme established for novices and new graduates Actions plans developed. Matrons report to Board and Nursing Care Indicators. Rosters managed and monitored, Matrons and Lead Nurses, midwives and AHP Leads identify shortfalls in staff levels and rectify	5	4	20	Staffing levels fall below acceptable safe levels	Financial investment made in high risk wards in medical directorate. Agency expenditure remains low. (Reports on agency staffing at F&P Committee). Nursing Care Indicators reported at least quarterly to the CQSPE. Datix Incident Reporting captures shifts with staffing concerns reported to Clinical Quality & Patient Experience Committee. Staff Survey results Training records Monthly Matrons presentations to the Board	Staffing levels fall below acceptable safe levels	Explore investment opportunities. Use of Bank Staff to cover shortfalls. Continue with pro-active vacancy management for both graduate posts and novice programme.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR043	6. To deliver an infrastructure that supports delivery.	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	31/12/2012	Detailed monthly monitoring of exposure to penalties by Directorates and Corporate Information Teams. Escalation procedure of risk issues to Directors. Regular performance reports to Directors/F&P Committee and Board. Corporate and departmental dashboards in place for monitoring. Breach analysis and reporting regime in place.	4	5	20	Continuous increases in emergency activity compromise effective risk management processes. Clinical Departments are not sufficiently sighted on such performance risks and target achievement is always subservient to safety and quality concerns. Poor or inadequate IT solutions in place to provide constant monitoring of target achievement in certain instances.	1. Independent audit scrutiny of data capture and reporting. - Detailed assessment of exposure for each potential penalty presented to F & P, TME and Board in June. Ongoing updates of fines incurred and risk of future fines. - Inclusion of risk within financial figures (forcast assumes £500k will be incurred for penalties. 2. Monthly discussions with Commissioners. 3. Detailed monitoring by commissioners and strict escalation and investigation of breaches regime in place. 4. Directorate Performance Review Meetings.	1. In the absence of clear targets and definitions, data capture and reporting processes may be inadequate. 2. The Commissioners have initiated penalties in the first 2 months of the year for A&E and Ambulance breaches.	We are currently (June 2013) seeking to negotiate with Commissioners there deployment of any funds recovered through the imposition of fines and penalties (Concludes April 2013). Undertake detailed assessment of exposure for each potential penalty and develop agreed escalation and mitigation strategies (May 2013).
COR046	6. To deliver an infrastructure that supports delivery.	Reputational risk associated with the Keogh Mortality Review	25/3/2013	Action plan in place to ensure delivery of Keogh recommendations. Council of Governors briefing and review process. Media Pack. Staff briefed and advised of requirements and impact on clinical areas.	5	4	20	Unknown variables during November review or unannounced visits. No control over media coverage of Keogh Review or public perception.	CQC Review (February 2013). Action plan based on Keogh recommendations Monitor updated on progress monthly. Press conference July 2013 - Positive media stories, online video updates and engagement with journalists. Staff briefings	Media coverage continues to include negative or misleading stories	Utilise networking systems to provide updates and intelligence on review process. Increase level of engagement and media strategies to respond to damaging stories.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR053 (OP052)	3. To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio.	Failure to maintain 18 week Pathway	31/3/2011	Extensive training programme for medical secretaries undertaken to improve knowledge of Oasis and the 18-week Access Policy. Secretaries have weekly waiting list reports to validate, closely monitored by Assistant General Managers to gauge backlog. Breach reports are validated weekly by RTT Support team. Surgery is undertaken as a day case procedure wherever possible and clinically safe. Extra clinics arranged by RTT support clerk. Extra theatre lists arranged by Assistant General Managers. Diagnostics manage their waiting lists to achieve 2 week diagnostic wait. PTL reports of target outturns are validated prior to circulation team by RTT Support team. Directorate have developed demand and capacity models.	4	5	20	Secretaries do not follow policy. Emergency medical patient volumes outstrip medical beds causing outliers into surgery that subsequently has to use elective beds on B1. Trauma emergencies outstrip beds available on B2 and overspill onto elective ward. A high volume of emergency surgical patients impacts on bed availability for elective patients.	18 week reports. Directorate dashboard.		To retain and monitor 18-week headroom in individual pathways so any unplanned cancellations does not cause a breach. Ring-fence all of T&O and S&A beds, preventing medicine outlying at any stage. Increase bed base for surgery by 40 to deliver CCG's activity plan as part of the Estates Strategy.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR047	6. To deliver an infrastructure that supports delivery.	Failure to achieve Monitor targets	25/3/2013	Regular reports to the Board's Finance and Performance Committee, Directors and TME.	4	4	16		Key Performance Target Reports (monthly F&P). Monthly F&P Exception Report to Board. Quarterly Board Statement to Monitor.		Continue monitoring and performance management of RTT and A&E targets. Roll out of the Transformation Project and IST recommendations which directly impact on patient flow and targets.
COR048	6. To deliver an infrastructure that supports delivery.	Failure to understand the implications of the themes and recommendations arising from the Public Inquiry at Mid Staffordshire Hospitals NHS Foundation Trust and the impact on The Dudley Group	25/3/2013	Report to Board of Directors with proposals for learning and action planning.	4	4	16	Implications for the Trust not yet fully assessed.	Board Reports. Action Plan monitoring.		Dedicated Board workshop/time out to consider actions required to share the learning from these. Identification of lead Directors for all identified themes requiring local action. A Board review of all recommendations. Identification of formal reporting arrangements on progress against both lessons learned and actions arising from recommendations. Identification of a formal training programme to share the learning across the organisation.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR049	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	Failure to engage clinical staff in the major Transformation Programme leading to partial achievement only of the programme objectives	25/3/2013	Transformation Board established to oversee the Programme. Each project within the Programme has its own Steering Group with senior clinical engagement and/or clinical champion where possible. Strong project methodology adopted. Executive sponsor for each project. Risk Log maintained.	4	4	16	Some projects require clinical Champions not yet formally identified. Directorate Business Plans still not fully acknowledged or utilising the Transformation methodology or objectives. Executive Director project sponsorship not always consistent.	Project Charters. PIDs. Transformation Programme Board papers. Regular Transformation Report to Board. New dedicated Executive role (Director of Strategy, Transformation and Performance) - 12 months role ref. 8/4/13).		Develop a communication strategy for the programme overall. Appointment & engagement of Champions and Executive Leads as appropriate. Periodic review of programme progress and executive sponsorship thereof. Consider devolution of programme team to Directorate as part of Management Re-structure Ensure transformation and service improvement are core expectation of revamped clinical leadership roles following anticipated management restructuring

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR052	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	CCG wish to re-route the Respiratory Assessment Service nursing staff from its present workload of 75% on early discharge and 25% on admission avoidance to a mainly/only admission avoidance strategy, by using the team to follow up high risk COPD patients in the Community	18/6/2013	1) Change has not occurred yet, ongoing conversations with commissioners to try and dissuade them from these actions by presenting fully what the RAS team do. So they have a better idea of potential risks to themselves as well as the trust and patients. 2) Ways of managing the risk, if the change actually occurs include a) Trust to pick up the extra funding for the nursing staff that has been lost to the community admission avoidance strategy. So that Early discharge can continue arm in arm with increased admission avoidance. b) Staff transferred from elsewhere to cover the loss of early discharge service, such as proportion of Virtual Ward staff.	4	4	16	1) Unclear if CCG can be persuaded. 2) Unclear if Virtual Ward have capacity and ability to incorporate a proportion of their staff into RAS team. 3) Unclear if trust will find extra funding or take a gamble on non-evidence based admission avoidance strategy.	1) Medical and Respiratory LOS. 2) Re-admissions. 3) BTS audits of COPD, Asthma and Pneumonia. 4) Escalation level and ED breaches.	N/A - this is to identify risk of a near future plan, so neither plans or controls are in place yet.	No decision seems to have been made re what can or should be done. What happens in future depends on the decisions of CCG and decisions at a directorate level in the trust. The general manager is in discussions with the commissioners. My C.D. advised re. risk assessment. CANNOT DO MITIGATING RISK SCORE YET

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR038 (NP005)	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	Neonatal Capacity	1/4/2011	There are four beds identified within the Maternity Unit to provide Transitional Care. Robust off-duty procedures. Shift Lead Nurse monitor activity and Staffing levels/skill mix twice a day 4pm-5pm and 4am-5am and report findings to Matron ward round at 8am (Monday to Friday). Staff work flexibly to cover shortfalls. Use of Bank/Agency. Escalation Policy implemented when necessary. Monday to Friday monitoring from Shift Lead Nurse/Matron.	5	3	15	Bank/Agency do not always fulfil. Financial consequences of increased use of Bank/Agency. No monitoring in place at weekends.	Compliance with off-duty rota. Sickness Absence levels. Number of Incidents. Number of Compliments. Number of Complaints.	Number of occasions unit closed due to non-compliance of off-duty. Increase in incident trends.	Paediatric and Neonatal Strategy to be developed to identify workforce planning required to meet National recommendations and to be included in Directorate Business Plan. Business Case for additional staffing to be developed.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR032 (OP097)	6. To deliver an infrastructure that supports delivery.	Failure to implement Business Continuity Plan during a Major Internal Incident	1/12/2011	Business Continuity Plan in place developed with PFI Partners. BCP Group including PFI Partners established to review potential incidents and agree Mitigating Actions. This work has commenced to strengthen the Estates and FM Contingency Plans.	4	3	12	BCP needs review and updating in association with PFI Partners. This has now been completed and risk assessment amended accordingly.	CQC Risk & Assurance committee reports. IFM Reports and business continuity. RCA report(s) following business continuity incidents		Set up BCP Group including PFI Partners to review potential incidents and agree mitigating actions. Plans. Provide training and undertake exercise to improve response. Implement recommendations following HV incident July 2013.
COR028	2. To provide the best possible patient experience	Increase in the number and grade of avoidable pressure ulcers (Trust)	9/3/2012	Review of system and processes supporting capture and reporting of pressure ulcers. Safe systems operated. Skin bundles introduced. Formal 2-hourly charts and assessment records for all patients. Fluid bundles added to process improving patient hydration. New position to manage the interface between the community and the hospital. Formal reporting processes introduced. Formal round table meetings to discuss RCA providing peer challenge. Improved nursing care. "Love your Skin Campaign" international recognition. Regular reports to appropriate committees, confirming Trust position and monitoring arrangements. All Serious Incidents formally reviewed.	3	4	12	Staff currently being trained in new process. Not all staff yet trained. Trust appears high in reporting terms when compared with other Trusts. Need for Tissue Viability to check every Stage 3 and 4 reported.	Pressure Ulcer Documentation Audit. New staging process begins 1st April 13. Reports to and minutes from Risk Committee. Nursing Care Indicators. Audit of Quality Accounts. Report to and minutes from Patient Safety Group. Patient Safety Thermometer (from 14/3/2012). Quality Accounts. CQUIN		Monitor progress against CQUIN targets, working towards compliance with patient skin assessments, implementation of care plans and reduction in incidence of Stage 3 and 4 pressure ulcers. Plan to change to Midlands and East Staging Tool to commence April 1st. Current Stage 4 pressure ulcers will be reported as Stage 3 so likely to see reduction in Stage 4 pressure ulcers reported. Tissue Viability to provide report to Nursing Director of requirements in order to check all Stage 3 and 4 pressure ulcers.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR035	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	Rising urgent care demand on ED as a result of poorly planned management across health economy	23/5/2012	•Discussion with Local Walk-in Centre (WIC) with regard to protocol for pressure period management and triage back to WIC. •Operational policies for the management of 'Minors' stream and ambulance patients during pressure periods. •Creative use of other ED areas, other that treatment cubicles, during pressure periods. •Management of ambulance conveyances by liaising with WMAS to influence disposition of patient on a patient by patient basis	4	3	12	•Peaks in demand for ED may still not be manageable internally. •Establishment review process (Nursing) for specialist areas in the Trust, like ED, has not yet begun. •Local Urgent Care forum has been restarted to enable economy wide solutions to the urgent care demand	•Protocols for joint pressure period management with WIC. •Operational policy and procedure within ED for alternative methods of managing 'Minors' category demand. •RAT Policy (ED). •CCG Urgent Care Programme Board •Including support for WMAS in terms of suitable conveyance for patients		•New Transformation Project and Integrated Urgent Care solution underway with CCG clinicians. •Dudley Health Economy engagement with WMAS to support better conveyance of patients
COR039	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	Learning Disability Liaison Role	18/9/2012	PALS Manager provides advice and support to patients with Learning Disabilities and ward staff. Learning Disabilities Liaison Nurse commenced post 29 July 2013.	3	4	12	PALS Manager has a special interest but is not a nurse and has no specific Learning Disabilities nursing experience.	Audit of sample of in-patient case notes for people with a learning disability. Healthcare for all – (DH 2008). SHA Self Assessment Framework for Learning Disabilities - August 2012.	Audit identified gaps in provision for patients with learning disabilities Trust-wide. Gaps identified in meeting six criteria in Healthcare for all (DH 2008).	Review Learning Disabilities Action Plan.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR051	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	Potential compromise of clinical care due to the non-availability of clinical information at time of consultation	9/5/2013	1. Clinic are organised in advance, with Health Record preparing case notes up to 4 days in advance and having a process to identify and collect case notes not available at that time due to being tracked to another location. 2. Case note tracking system in place. 3. An internal email alert if case notes required and not at last tracked location. 4. For case notes not provided in time for consultation, process for provision of a temporary file which should be reconciled with case note folder at earliest opportunity. 5. Health Records have a reporting log for case notes not found at last tracked location and they monitor this on a regular basis. 6. Business continuity plans if IT system failures or planned down time so that clinical information is available. 7. Clinicians may have access to specialty shared drive and thus be able to gain access	3	4	12	1. Failure of logistics, to guarantee case note delivery in advance of clinic commencement. 2. Failure to know if all clinical information is available in case notes until commencement of consultation. 3. Non-compliance of case note structure resulting in inability to locate information even if filed. 4. Sub-optimal processes to retrieve and provide case notes for those appointment offered at short notice. 5. Clinics allowing 'walk-in' appointment where patient not identified on clinic list and thus notes not prepared. 6. Non-compliance of case notes tracking resulting in inability to locate and prepare case notes in time. 7. No central repository for clinical letters so availability to access clinical letters is permission controlled at speciality/ clinician level. 8. Failure to report duplicate Trust ID number for same patient resulting in failure to	1. Health Records policies and procedures available through the Hub. 2. Trust and local induction. 3. Screensavers on importance of case notes tracking; case notes structure and filing.	1. Lack of organisational accountability and limited to no audit process of compliance with case note structure and filing process; case notes tracking. 2. No central induction, training and accountability of those staff who have responsibility for management, tracking and logistics of case notes and electronic clinical information. 3. Under reporting on Datix of non-availability of clinical information. 4. Lack of feedback on outcomes from Datix reporting and actions taken. 5. Sub-optimal performance monitoring and action with regards to poor and or non compliance Trust or local policies and procedures.	1. To embed a culture of performance monitoring and action where poor or non compliance occurs. 2. To optimise preparation time for clinic preparation processes through minimising unnecessary work i.e. preparation of clinics/ appointments which are cancelled at short notice. 3. To introduce more onsite (clinical areas) retrieval of active records. 4. To minimise the delays in case notes returning to archive at Centafile. 5. To enforce case note structure and filing compliance. 6. To enforce case notes tracking on Oasis. 7. To encourage completion of Datix reporting of non-availability in order for organisation to have a better understanding of the frequency of occurrence and consequences of non-availability.

				to clinical letters. 8. Process to alert clinician if clinical information may not be available for consultation so they can make the clinical judgement if the consultation should proceed. If the decision is to not proceed with consultation, patient is informed, apology and explanation given and patient offered a rescheduled appointment. 9. Datix reporting of incidents where clinical information is unavailable; incomplete. 10. Reporting of duplicate number for same patient. Use of NHS number as unique identifier.			merge number and clinical information.			8. To investigate and produce a business case for consideration of a central repository for access to clinical letters. 9. To investigate and produce a business case for consideration of an electronic patient record system.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR019 (HS004)	6. To deliver an infrastructure that supports delivery.	Physical abuse to staff from patients/relatives	31/8/2011	1. Trust Guidelines and Policies accessed via the Hub. 2. Mandatory Conflict Resolution Training provided. 3. Conflict Resolution Training on Trust Induction. 4. Zero tolerance approach from Trust/Zero tolerance posters. 5. Incidents of physical abuse reported to and monitored by Strategic Health Authority. 6. Reporting of incidents on DATIX system and also to national SIRS database 7. Use of Posters displayed warning patients/visitors of consequences of violent behaviour. 8. In house Security staff who must attend within 5 minutes of a fast bleep-emergency (2222) alert 9. Use of Security warning codes on Oasis identifying patients with a history of being abusive. 10. Warning letters sent to patients/relatives and in some cases Exclusion of high risk violent offenders. 11. CCTV installed to deter violent behaviour in public areas 12. Use of other Trust sanction options and criminal prosecution by Poli ce.	3	3	9	1. Not enough staff aware of the V&A, Security, Lone Worker Policies, Policies not applied. 2. Staff attendance at Mandatory Training not comprehensive, accurate up to date maintenance of the staff training database is unknown. 3. Insufficient training dates/staff unable to attend because of ward shortages/high demand. 6. Research carried out has shown that NHS staff only record 25-30% of the number of violent incidents that Security staff called to assist with. 7. More publicity and education of the both staff and public is needed to impact on awareness of what is expected in relation to violence. 10. There is no data or records kept centrally by the Trust to monitor how many Warnings are given or if they have any effect. 12. Non Clinical Assaults on staff have increased but the numbers of sanctions/prosecutions have not.	1. No means of checking that staff access policies on Hub, their attention has been drawn to policies on CRT. 2. CRT is continuing to be delivered. 3. CRT is continuing to be delivered. 4. Posters are updated/replaced and maintained when necessary. 5. Process of reporting continuing. 6. Datix now used across Trust to enable staff to report and for incidents to be managed. 7. The number of articles in monthly Newsletter, CEO Update and press releases made. 8. 2222 and 1234 Bleep system is in place. 9. LSMS and Information Governance manager monitor markers on OASIS. 10. The number of cases that result in warning Letters or in serious cases exclusion. 11. A PFI review of security is taking place that will include whether CCTV is fit for purpose.	1. No feedback received of action taken by senior managers to address lack of reporting by NHS staff or use of sanctions in V&A policy in supporting staff. 2. The Trust must now comply with the new NHS Protect national Security Standards both the Organisational Crime Profile (OCP) and Self Review Tool (SRT) have been completed and submitted to NHSP Q.A. Evaluation process, who will direct necessary action to ensure compliance.	Develop a framework for quarterly monitoring of incidents and identify trends. Identify appropriate reporting forum: - QPDT Meetings - Directorate Governance Meetings - Patient Safety All Trust staff to attend Mandatory Training. Further advice to be received from NHSP on SRT and LSMS Work Plan has identified how Trust can improve on assessment made. Introduction of Quarterly monitoring by the H&S Group chaired by the SMD.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR021 (HS012)	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	Risks associated with the restraint of patients	27/4/2011	1. Safeguarding Vulnerable Adults Policy and guidance is available. 2. Restraint Policy has been updated and jointly approved by the Trust and the IFM Security services and is awaiting final approval by the Risk Committee. 3. Mental Capacity Act and Deprivation of Liberty (DOLS) procedures are in place. 4. Local Safeguarding Vulnerable Adults Board provides guidance and advice. 5. Safeguarding Vulnerable Adults medical lead and Nurse Lead are available to provide advice and support. 6. A small number of clinical staff within the Trust are MAPPA trained. 7. Security staff are trained/licensed to use restraint techniques. 8. Conflict Resolution Training is provided to frontline staff that mirrors the NHS Protect national syllabus.	3	3	9	3. There are still some gaps in staff knowledge in relation to Mental Capacity Act 2005. 7. Details of the training security staff receive in restraint are unknown or whether they receive refresher training at least once every 12 months in line with current practice/advice. 8. Not all staff attend training.	1, 2, 3, 4, 5, 6, 8, 10, 11, 12, 13, 14, 15 Ratified policies and guidelines. 2. The Trust LSMS has advised the on both the legality/practicalities of controlled holding of patients in accordance with NHSP Guidance and best practise. The Trust has received Counsels advice from IFM and this has been incorporated into Trust policy. 9. LSMS monitors quality of service from local police (LPU) there is now a national MOU and SLA in place that will support the Trust obtaining a local SLA/Violence Reduction Agreement.	7. IFM Security need to be requested to provide evidence of what training security staff receive and that their programme of refresher training meets current standards and practise.	A programme to deliver appropriate training for staff working in identified high risk areas has been developed and is being delivered. To develop a framework to monitor that appropriate training for staff working in identified high risk areas is delivered. To explore investment in fit for purpose breakaway – restraint training for staff in areas of high risk. To deliver the agreed training programme for MCA.

				9. Support from the local police is available. 10. Learning from Serious Case reviews. 11. Complaints of excessive force are investigated. 12. One to one carers are utilised to manage patients to pose an adverse risk/danger to staff. 13. There is a 24/7 availability of an S.I.A. licensed security team on site. 14. The Trust has a Director lead for security and two security managers (LSMS) who can provide support and advice. 15. Bespoke restraint training is provided for staff.						

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR044	6. To deliver an infrastructure that supports delivery.	The need for a Medical 'Workforce Plan' - a fit-for-purpose workforce is needed to meet service needs	3/1/2013	1. Appointment of Trust junior and middle grade medical staff to support specialty rotas. 2. Locums to cover 'gaps' in rotas. 3. Ad hoc Trust appointed posts in individual departments. 4. We are beginning to explore the roles of non-medical staff performing the duties traditionally performed by doctors.	3	3	9	1. Some of the Trust posts are still not recruited to. 2. Locums are expensive, unreliable, of lower quality and have no commitment to the organisation. 3. Ad hoc Trust appointed posts are difficult to fill, difficult to fill with quality and a considerable drain on departments to appoint in isolation with other departments in the hospital (e.g. short listing, interviewing etc). 4. The recruitment of non-medical alternatives – e.g. surgical nurse practitioners, Physician's assistants, has not been rolled out to its full potential. 5. No process for overseeing education and training of locum and ad hoc post holders. 6. Little flexibility in the system if a doctor leaves a deanery rotation early (e.g. maternity leave, obtains consultant job, illness etc).	1. A business case for Junior and Middle Grade Trust doctors based upon the needs of departments working together rather than in isolation was approved & recruited to. 2. Rotations are staggered with deanery posts so that times of 'changeover' do not coincide. 3. Rotas are less hard pressed leading, so there is more flexibility if there any 'gaps' in the rota. Therefore EWTD less likely to be breached. 4. 'Spreading the load' with existing doctors reduces stress hard pressed areas. Junior doctor satisfaction is important in external QA such as deanery visits, JEST, GMC trainee's surveys etc. 5. Posts to be under the educational stewardship of a new 'Junior Trust Doctor Tutor' post.	Assessment of the impact of the Trust doctors has not yet been completed, as the post holders are not yet in post: 1. To analyse reduction of locum spend which we presume to reduce over time. 2. To ensure a steady stream of high quality candidates for posts, and retain them. 3. To ensure adequate appraisal and training of post holders, and revalidation if necessary. 4. This requires the assurance of available educational and clinical supervisors, clinical skills, IT and mandatory training. 5. Processes to be established for any doctors who run into difficulty.	1. Implementation of a Trust Programme for Junior and Middle Grade Trust Doctors. a) To recruit high quality, consistent junior and middle tier In-house training schemes, that supplements the deanery trainees. b) Review how we can use existing funded posts, and also to offset the money currently spent on locum posts. The rotations could be viewed in isolation. 2. Develop a further rotation to offset pressures in the Anaesthetic service. This will work to the same principles. a) Review programme and extend to other departments if proven beneficial. Surgery at FY level 3. Develop a business case for advanced surgical nurse practitioners to take on the work traditionally performed by FY1 doctors in surgery. 4. To explore the role of Physicians assistants for other departments where posts may be threatened or where there is demand.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR013	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	Relationships with PFI Stakeholders deteriorates - risk to successful management of contract due to potential differing approaches to the management of the contract	1/12/2011	Operating the PFI contract in line with the project agreement, and within the Trust's SFI's. Formal contact/performance meetings monthly. Formal Liaison Committee Meetings with Summit Healthcare. Retaining a good working relationship with the SPV and Contractor Directors and Managers. Flexible partnership approach across services to resolve issues quickly and to the satisfactory of all parties. Revised and reviewed scheme of delegation for Trust representative (April 2012). Being open and honest with all Stakeholders in the PFI Agreement (SPV, Trust, Contractors). New Liaison Committee established between Trust and SPV to resolve long standing contractual matters. Ensure communication with Stakeholders is regular and timely.	4	2	8	Added tension in relationship contractually as result of service review process and need to take £2 million out of contract this year and next. Slow progress on CEG actions due to commercial sensitivities within SPV.	Minutes of contract meetings. Correspondence between both parties. Minutes of the Liaison Committee Meetings, Summit Board and Trust Board. Service Reviews timetable. Quarterly Estates Assurance Report to F & P Committee. Minutes of Contract Efficiency Group process.		Involve SPV board in design and methodology for service review process and engage IFM consistently throughout service review process.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR022 (HS005) (AM027)	6. To deliver an infrastructure that supports delivery.	Lack of storage space for equipment	1/9/2011	Guidance in place for both storing and disposal of equipment. Interserve FM undertake regular environment inspections, where equipment is found in corridors it is their responsibility remove to a safe place. Procedures in place when disposing of equipment by contacting Interserve FM Helpdesk to ensure appropriate action is taken. Formal review at Trust Health & Safety Group. Summit Healthcare, Interserve FM and the Trust have agreed to store equipment pro-tem in C Block Services Corridor. Regular inspections are currently undertaken by Summit Healthcare, Interserve and Trust representatives the findings of which are distributed to all partners and the Trust's operational staff.	2	3	6	Sufficient storage space not catered for in the original building design. Large items of equipment is purchased without the thought of where the equipment is to be stored. Staff continue to dispose of unwanted equipment within corridors.	Summit Healthcare regularly monitor the situation, undertake meetings with partners on the matter of hospital storage. Health and Safety Group Minutes.	Storage space still a major concern and need to be dealt with in an effective and proper manner. Staff continue to dispose of unwanted equipment within hospital corridors.	Development of further storage being considered as part of site control plan development, following production of Estates strategy.

Ref	Strategic Objective	Risk	Start	Current Controls	Cons	Like	Score	Gaps in Control	Sources of Assurance	Gaps in Assurance	Mitigating Actions
COR040	2. To provide the best possible patient experience	Sewage backing up from blockage in the foul system from non-flushable clinical or other items being disposed of in WC's or sluices	23/10/2012	Foul drainage system inspection - Interserve. Educational e-mails - posters and communications from Infection Control to Matrons and Lead Nurses on what must not be flushed down foul system. Posters advising patients/visitors on what cannot be flushed. Monitoring foul drainage blockage statistics. All GM's via the weekly Operations Meeting telling them to get the message out to staff. Infection Control have spoken to the Matrons. Hand towels are being changed to bio-degradable hand towels from the 3 December 2012. Blockages are being traced back to the originator and the service area is being challenged to change their ways with a possible outcome that repeat offenders will be charged for loss of income to affected areas. Educational e-mail to Trust. Educational posters.	3	2	6	Tuffie Wipes and clinical items flushed cannot be traced to area they originated to. Policy not in place holding any abuse to account.	Interserve are inspecting key blockage points within the foul drainage system monthly. Infection Control has issued clear instructions that staff must not dispose of Tuffie wipes, hand towels, pads or similar down sluices. Communications have placed information on the Hub advising staff of the importance of not putting Tuffie wipes, hand towels, pads or similar down sluices or WC's. Areas that have suffered blockages are having signage advising patients, staff and visitors not to put anything inappropriate (mostly hand towels) into the foul drainage. Monitoring foul drainage blockage statistics (which has seen a distinct drop in occurrences).	Not known at this stage.	External engineering advice being deployed to consider long term solution to this issue.

Enclosure 10

The Dudley [illegible]
NHS Foundation Trust

Paper for submission to the Board on 5th September 2013

TITLE:	**Keogh Final Action Plan – July 2013**		
AUTHOR:	**All Directors**	**PRESENTER**	**Paula Clark** **Chief Executive**

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

SUMMARY OF KEY ISSUES:

The attached action plan has been prepared in response to the final Keogh Rapid Response Review issued in July 2013.

IMPLICATIONS OF PAPER:

RISK	**R**		**Risk Description:**
	Risk Register: Y		**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 the actions identified by Lead Directors in response to this.

The Dudley Group NHS
NHS Foundation Trust

Keogh Investigation Action Plan – July 2013

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Quality Governance Structure	1. The Trust should undertake a comprehensive review of the effectiveness of its governance structure. This should review all committees and group agendas and the information reviewed to ensure that all the Trust's quality priorities have a clear focus at an appropriate level.	**High**	1.1 Engagement of Deloittes to conduct a review of the quality governance structure. (The review will cover (though not exclusively) the following areas: Board of Directors composition, background skill sets, gaps in knowledge/ experience etc. • Portfolios of Directors • Backgrounds of NEDs Scope and working of the Board and its Sub Committees: • Do we have the 'right' public, private agendas? Is NED challenge appropriate and well evidenced? • Do we have good Sub Committee coverage or do we miss things? • Do we do work in Committee that should be done at Board or vice versa? • Should we reorganise our Committees to facilitate better working and make responsibility and accountability clearer? Relationship between Board and Council of Governors • Is the degree of Governor Challenge adequate, appropriate and well evidenced? • Does the Council have an appropriate Sub Committee structure? • Recruitment and retention of appropriately qualified and experienced governors Board relationship with Clinical Directorates and Departments • Can the Board be assured that its decisions are being implemented? • Adequacy of Board Assurance Framework • Relationships with the Clinical directorates • Trust Management Executive and clinical directorates roles and responsibilities Clinical and business governance processes and assurance. We are anxious that the review should promote best practice from Deloittes exposure to the wider NHS and the best of the public and private sectors.	**PA**	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Quality Governance Structure	2. The Board should consider how it reviews management information provided to it to demonstrate adequate challenge on the progress being made on the Trusts quality priorities.	**High**	2.1 This will be covered by the terms of the Deloitte Review at 1.1 above and the Board's response to it.	**PA**	**September 2013**
	3. Following the HAY group training the Trust should ensure that all senior clinical staff are aware of their responsibility for governance in their directorate and are held accountable for this. If this is still not embedded, further training may be required.	**High**	3.1 **Delivering governance** Developing the outcome of the work undertaken by Deloittes (1.1 above) agree with directorate management teams what good governance looks like (via an engagement piece of work) a) Meeting agendas and minutes b) Reports to Board c) Directorate review balanced scorecard	**RC/JC**	**September 2013**
			3.2 **Accountability** Clearer framework for accountability via peer reviews (balanced scorecard, with consequences) – this needs to be both bottom up and top down.	**RC/RB**	**September 2013**
			3.3 **Training** This will be delivered via the governance team during the engagement piece above and as required thereafter to the current structure.	**RC/JC**	**September 2013**
Understanding of Trust's quality objectives in the organisation	4. The Trust should ensure that its quality priorities, are embedded at ward level through dissemination at regular ward and directorate meetings. The Trust should also consider how it uses lessons learnt from the review of mortality indicators to further inform its quality priorities	**High**	4.1 Review communication and information cascade systems in general and specifically in relation to quality governance. (To be reported to the September Board). 4.2 Review the mortality alerts and outliers at directorate performance meetings. 4.3 Utilise the output from above in the next quality priority setting process. Refer also to Section 9	**PC**	**September 2013** **September 2013** **November 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Quality impact assessment of CIPs	5. All CIPs should be fully assessed for their quality impact prior to implementation and should be regularly reviewed. Where a concern over quality is identified, this risk should be properly mitigated before the plan is allowed to go ahead/continue.	**High**	5.1 All CIPS are assessed by the Medical and Nursing Directors for their quality impact prior to implementation. The process has been amended to require Clinical Directors and General Manager's attendance. This is now part of the procedure 5.2 Identified concerns will be followed up at the Directorate Performance Review meetings (*Refer to 6. Below)*	**D Mc / PH**	**Implemented**
	6. Executives and senior staff should be able to clearly and consistently articulate the impact assessment and monitoring process within their area of responsibility.	**High**	6.1 Review the format and agenda of the Directorate Performance Review meeting to incorporate the quality impact of CIPs. **6**.2 Governance - See template Directorate meeting agendas at 3.1 above. Ensure that new and extant CIP quality Impact assessments are reviewed at Directorate level – escalated or terminated.	**PA** **RC**	**Implemented** **Implemented**
Role of Governors in challenging the Board	7. Governors should consider how they can be more proactive in their role of holding the Board to account on all aspects of quality.	**High**	7.1 Undertake a review of the CoG effectiveness. Self assessment to be undertaken by the COG Development Group. 7.2 Review and confirm the current arrangements for Governor participation and challenge of the Quality Agenda including the quality accounts.	**JE/RJ** **PA / DMC**	**October 2013** **October 2013**
Developing a learning Culture	8. The Board should review its approach to learning and ensure there is a clear focus in the organisation on learning from incidents and when things go wrong. It should disseminate this approach through the clinical and operational leadership and ensure that regular audits are undertaken to monitor progress.	**High**	8.1 Investigation Manager to review incident reporting process including the opportunities to learn from incidents and ensure that incident reporting is robust, investigations are completed in a timely manner and lessons shared and results monitored. 8.2 Audit process to be confirmed and added to Forward Audit Programme.	**DMc** **DMc**	**In progress** **As part of above**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Understanding of mortality issues throughout the Trust	9. The trust should review how it can introduce more rigour and challenge into the overall mortality review process. This should include developing a clearer understanding of the root causes of mortality data at both Board level and within Directorates and prioritised action plans to drive improvements in care pathways.	**High**	9.1 The Medical Director and Deputy Medical Director will review the mortality process in light of the comments received from the investigation team. 9.2 The detailed information from the Mortality and Morbidity Review meeting will be formally received at the CQSPE and Board. 9.3 Mortality and Morbidity review data and learning will be discussed at the Directorate Performance Review Meetings and disseminated at Directorate level. 9.4 Mortality data education training sessions will be held for all Clinical Directors and Medical Service Heads. 9.5 The mortality tracker will be linked to the M&M meetings and clinical coders / matrons will be involved in future meetings (with immediate effect). 9.6 Feedback and learning from mortality reviews initiated as a result of the mortality tracker data will be fed into the Mortality and Morbidity meetings. The mortality reviews themselves will now involve nursing and coding staff. 9.7 The Trust will engage with the North West AQuA programme including Board development. 9.8 The Trust will audit against the AQuA mortality checklist, reporting the outcome to the September CQSPE.	**PH** **PH** **RC** **PH** **PH** **PH** **PC/PH** **PH**	**With immediate effect** **With immediate effect** **Implemented** **October 2013** **Implemented** **With immediate effect** **Implemented** **September 2013**
Mortality review process and dissemination of lessons learnt	10. The Trust has an opportunity to build on the work already carried out in this area. The current systems could be better joined up to ensure the benefits are being realised and themes from reviews can be summarised and shared more effectively.	**High**	10.1 *Refer to 9.5 & 9.6 above.*	**PH**	**As above**
	11. There is a need to engage clinical teams more in the mortality review process and emphasising clinical director leadership of this issue	**High**	11.1 *Refer to 9.3 & 9.4 above*	**PH**	**As above**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
	12. Consider having coding representation in mortality review meetings.	**Medium**	12.1 *Refer to 9.5 above*	**PH**	**Implemented**
	13. Given the emphasis on Palliative care coding the Clinical Coding team may wish to focus one of their internal audits solely on this	**Medium**	13.1 Department to attend a workshop that provides training to ensure consistency of coding for treatment and full understanding	**PA**	**October 2013**
Infection Control Concerns	14. The Trust should review how it can further embed the infection control audit programme at ward level, including the lessons learnt from the overall board monitoring.	**High**	14.1 The Trust will develop a ward dashboard of quality indictors to be monitored at the Directorate Performance Meetings with Executives. 14.2 The Saving Lives audit and MRSA screening audit will be added to the Trust Audit Plan and reviewed at Audit Committee (Committee of Board).	**DMc**	**August 2013** **Implemented**
Managing capacity including bed management and patient flows.	15. The Trust should discuss more sustainable solutions to the high capacity levels and bed management challenges with its key stakeholders such as the CCG and social care colleagues.	**Urgent**	15.1 Play a constructive part in the Dudley Urgent Care Board, Black Country Urgent Care Board Area Team Urgent Care Board to: a) Identify an innovative solution to ambulance diversion to appropriate solutions b) Review Ambulance handover measurement and fining processes c) Ensure that capacity chases demand using WMAS predictions to influence availability of staffing in ED d) Construct working relationship with Sandwell MBC to support their patients repatriation	**RC**	**November 2013** **Implemented** **September 2013** **August 2013**
Care bundles	16. The trust should audit use of the new care bundles and ensure that all wards are using them effectively.	**High**	16.1 The Falls Care bundle and Pressure Ulcer Care bundles will be added to the Clinical Audit Programme and audited.	**DMc**	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Patient Experience Strategy	17. The board should review its approach to developing a patient experience strategy and ensure it is clear how its priorities in this area will be measured and monitored.	**High**	17.1 The Patient Experience Strategy will be reviewed in conjunction with the CCG and other partners. A stakeholder event will be held on 10th July to review the Strategy, priorities and systems for measuring and monitoring these. 17.2 Through the review of the governance arrangements (*1.1 above*) the Trust will evaluate the effectiveness of establishing a Patient Experience Group reporting to a Board Committee.	**PC**	**Implemented** **October 2013**
	18. Ensure the friends and family test is embedded across all ward and all staff members are aware of their responsibilities	**High**	18.1 The results of the Friends and Family Test will be displayed in all wards and public areas and will be discussed at directorate meetings. This will added to the Nursing Care Monthly Audits and reported to Directorate Performance Meetings with executives.	DMc & PC	**Implemented**
Complaints process	19. Review of the Trusts compliance against the DH and Ombudsman requirements for complaints management and also to improve the patients experience from this process including: • Ensuring responses to complaints are timely and patients' expectations are managed. • Reviewing style of response to complaints to address patients in an empathetic manner and use language that is easy for non-clinicians to understand.	**Urgent**	19.1 The Complaints and PALS teams will be amalgamated from October 2013 as part of organisational restructure. 19.2 An Interim Quality Manager has been engaged to undertaken a review of the Complaints processes against the Ombudsman's requirements	DMc	**October 2013**
	20. Implement a more effective process to capture learning for the Trust from complaints and ensure these are shared at ward level.	**Urgent**	20.1 Development of a complaints liaison role to support patients and capture learning from complaints. 20.2 Review the arrangements for capturing the learning from both complaints and incidents and develop and share ward level information. Report quarterly to the CQSPE Committee on complaint outcomes, learning and implementation.	DMc DMc	**August 2013** **October 2013**
Patient experience themes.	21. The Trust should consider the themes noted in the broad patient experience feedback obtained in this review. This should be used to further review its strategic approach to responding to patient feedback	**High**	21.1 *Refer to 16.1*	PC	**Implemented**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Management of Outpatient Appointments	22. The Trust should review its outpatient appointments process to consider how it can address the frequent complaints.	**Medium**	22.1 The Trust is conducting a phased demand and capacity review across all outpatient specialties, starting with areas that have issues with meeting the current demand levels for appointments and have frequent complaints about the service. Ophthalmology, Dermatology and Respiratory are due to be complete by November 2013 with all other specialties completed by December 2014. The output from these reviews are being managed through the Outpatient Steering Group.	**RB**	**Initial November 2013** **All December 2014**
Process to capture informal feedback from patients	23. Continue to promote informal feedback routes and ensure staff and patients are aware of the methods that can be used.	**Medium**	23.1 *Refer to 17 above* 23.3 Continue to distribute 'How did we do today' information cards to patients. 23.3 Continue to promote feedback mechanisms on the Trust website 23.4 Further develop patient experience information on the intranet to raise staff awareness	 PC PC PC	 **Implemented** **Implemented** **October 2013**
Workforce and Safety					
Staff engagement and Survey rates	24. The trust should continue to undertake its own work on staff engagement to understand what improvements staff would like to see.	**High**	24.1 A Draft Staff Engagement Strategy will be presented to the CQSPE Committee in August 2013 24.2 The Trust will explore further opportunities to capture staff views e.g. Graffiti boards. 24.3 Staff Engagement Officer appointed.	PC PC PC	**August 2013** **September 2013** **Implemented**
Theatres staff engagement	25. The Trust should review the staff engagement in theatres and obtain assurance that learning from the whistle blowing case and external review findings have been fully addressed.	**Urgent**	25.1 Review to be undertaken in theatres utilising team meetings and opportunities for individuals to raise concerns. Reviewer engaged to deliver project.	PC	**End of August**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Mandatory Training	26. The Trust should monitor and take action where mandatory training is below expected levels, particularly on significant areas where there have been recent incidents such as information governance and resuscitation.	**High**	26.1 The HR team will continue to track Mandatory Training levels and report performance to the Finance and Performance Committee, and directorate management teams. We aim to show a steady increase in performance each month to achieve our target of green in all subjects.	AR	**Continuing**
			26.2 Information governance is a 12 month renewable target The Trust will invest in a dedicated trainer for this subject to achieve green by October 2013. This will also enable us to show staff how to access the on line training for future years and therefore make it a sustainable figure.	AR	**October 2013**
			26.3 Resuscitation training is being reviewed to make the training easier to access and to look at the level at which staff are completing the training.	AR/ DMc	**September 2013**
			26.4 Mandatory training is the completion of basic resuscitation only, and a review of the training needs analysis will ensure that the right people receive the right training.	AR/ DMc	**October 2013**
Nurse staffing levels and skill mix	27. The Trust should take urgent action to ensure there are sufficient registered nurses to unregistered staff on all shifts.	**Urgent**	27.1 Nursing staffing escalation procedures to be reviewed to ensure all shifts working below identified staffing levels are supplemented with extra nurse / bank/agency staff. All Shifts working below this level after escalation will be reported on Datix and to the Senior Nurse / Manager out of hours	DMc	**Implemented**
			27.2 Nurse to patient ratios have been added to the Nursing Care Indicators. Manual data collection to be completed in June whilst electronic process is being developed.	D Mc	**Implemented**
			27.3 NCIs reported to Director of Nursing monthly then to CQSPE and the Board of Directors. Exceptions that fall below acceptable standards will be monitored and action plans and a recovery meeting held.	DMc	**August 2013**
			27.4 Recruitment of 18 more qualified nurses. Adverts placed (circa 3 months to complete). Short listing completed	DMc	**September 2013**
			27.5 An application for further staff to support the ongoing process to take between 40 – 50 newly qualified graduates (at risk) will be made. Interview process to commence week beginning 24 June 2013 for graduates qualifying in Sept 2013).	DMc	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
	28. An updated review of nurse staffing; levels and staff mix should be undertaken by the Trust which reflects patient dependencies, ideally using a nationally accredited tool e.g. AUKUH Safer Nursing Care Tool. This should focus on reviewing staffing on the high risk wards. The risk assessment should take into account dependency of patients and also other factors such as high temporary staff usage and high incident and infection rates. It should also ensure Francis recommendations are fully reflected in the new staffing model.	**High**	28.1 The Trust has committed to use the AUKUH / Safer Nursing Care tool . A Commissioning control plan is being developed. The initial start up briefing meeting was held on 25th June, following which the timeline for staff training and data collection was confirmed. The 20 day data collection process finishes on 31/07/13 28.2 A Staffing audit of all wards will be undertaken. The outcome of this review will be reported to the Board of Directors.	DMc	Implemented **August 2013** **October 2013**
Nurse staffing levels and skill mix	29. The Trust should review its nursing staff rotas and embed the consistent use of the Allocate e-rostering that it is implementing.	**High**	29.1 Implementation of new e rostering system with Allocate in accordance with the approved project plan and timeline. The Trust currently operates an electronic roster system "SMART" the functionality of which is inferior to ALLOCATE with regard to the management information available. The implementation of Allocate will be rolled out as per the project plan. The immediate action until full roll out is to ensure that the SMART system is being operated effectively which will be delivered through the Matrons and the General Managers in Directorates.	PA/ DMc	**September 2013**
	30. The trust should review its use of bank and agency staff to minimise this as a solution for capacity challenges and vacancy cover.	**High**	30.1 An extra capacity nurse pool team has been developed to roster extra nurses daily that are used to supplement staffing. These nurses report to the site co-ordinator who will deploy to appropriate areas. The extra graduates (those who are not identified for substantive vacancies) are being placed in posts where nurses are on long terms sick leave and maternity leave. This will reduce the use of bank and agency staff and improve continuity. These nurses will be moved into a vacancy as they arise which will minimise both the trained nurse and sickness vacancy levels.	DMc / RC	**Implemented**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
	31. The Trust should consider conducting an internal audit to check that the hours worked by its bank nurse are complaint with the European Working Time Directive.	**High**	31.1 An audit of compliance with the European Working Time Directive will be undertaken by Internal Audit. This has been added to the internal audit plan	PA	**Quarter 2** **Implemented**
Equipment and safety checks	32. The trust should reiterate its processes to staff to ensure important equipment and safety checks are completed. Compliance should be regularly audited and non compliance should be followed up urgently.	**Urgent**	32.1 The audit of equipment and safety checks now forms part of the NCI monthly audit and daily checks are undertaken. Additional checks are also undertaken by the Practice Development Team. The Audit has been added to the annual plan and is reported via Audit Committee and CQPSE. It also forms part of the Matrons presentation (monthly) to Board.	DMc	**Implemented**
Quality of Root cause analysis (RCA)	33. The trust should review its process for RCAs to ensure there is sufficient time and review built in to improve the quality of analysis and learning to be shared from the incident. The Trust may wish to use the NPSA toolkit to support the analysis.	**High**	33.1 A full review of the incident reporting and investigation process (including RCAs) has commenced. (Refer also to 8.1 – 8.2) 33.2 The use of the NPSA toolkit will be explored as part of the above review.	DMc	**WIP**
Inconsistent pressure ulcer preventative care	34 Systems should be reviewed to ensure staff can readily identify those patients with high need for pressure ulcer preventative care. White boards already in use on wards could be used to identify patients more effectively – using a magnet or silicone identifier.	**Urgent**	34.1 Magnets (depicting pressure ulcers) will be added to whiteboards on all wards.	DMc	**September 2013**
	35. Systems are needed to ensure that staff are made aware of how well their ward is doing in terms of number of PU free days and of the themes coming out of the RCAs. Ward managers to find effective methods of feedback to staff how well their area is doing and how many PU free days they have achieved. Consider display poster in the clinical area.	**High**	35.1 Laminated wall signs depicting pressure ulcer free days will be displayed on all wards. 35.2 A "How we are doing" board will be displayed on every ward covering the Quality Indicators.	DMc DMc	**Implemented** **Implemented**
	36. TVN to ensure all ward managers are looking at the 50 day dash charts available via the Tissue Viability (TV) intranet site to encourage competitiveness.	**Medium**	36.1 Tissue Viability team to publish a plan of the initiatives to raise awareness of harm free days	DMc	**September 2013**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Availability of equipment and delays from external provider.	37. Repose mattresses were available in the department – link nurses to promote and encourage their use.	**Urgent**	37.1 Buffer stock of 20 mattresses now on site which has eliminated the delay of equipment.	DMc	**Implemented**
	38. Performance indicators need to be reviewed for the contract with Karomed and penalties implemented where failings are occurring.	**Urgent**	38.1 Contract amended.	RB	**Implemented**
	39. TVN team to work with A&E link nurses to develop education in the department and carry out weekly audits of equipment use.	**Urgent**	39.1To develop a team of link nurses within the A&E department to provide in department education and training. 39.2 Weekly audits to be completed as per point 37	DMc	**Commencing July 2013** **Implemented**
Availability of equipment and delays from external provider	40. Staff should report equipment delays via datix so that management and the TV nursing team are made aware of how often this is occurring in real time.	**High**	40.1 To work with the communications department and link nurses to raise awareness of the reporting requirements for equipment delays via datix. 40.2 Datix Manager to ensure TV team receive an alert for each incident reported.	DMc DMc	**July 2013** **July 2013**
	41. Documentation audit by TVN team and/or link nurses to identify extent of delays.	**Medium**	41.1 Tissue Viability will review with the link nurses the possibility that their audit can identify delays 41.2 Tissue viability will discuss the audit of records with equipment coordinators.	DMc	**September 2013**
	42. Consider use of Anderson score in A/E rather than Waterlow to encourage assessment of all patients.	**Medium**	42.1 Tissue viability has looked at Anderson tool. This is a tool that is a useful prompt prior to Waterlow. As our emergency department are already using waterlow there is no need to add the Anderson tool	DMc	**Complete**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Divergence from guidelines and inaccurate documentation	43. Ward teams to carry out weekly SSKIN bundle audits of a minimum of 5 sets of notes per area with an aim to achieve 100% compliance.	**High**	43.1 Weekly auditing of PU prevention and Management documents is ongoing – Link Nurses to audit 6 sets of notes per ward area where possible. 43.2 Link Nurses are provided with protected time to complete this (7.5 hours per week)	DMc DMc	**Implemented** **Implemented**
	44. Action plans need implementing where compliance is not reaching 100% with particular focus on those elements of the bundle most commonly not being followed.	**High**	44.1To develop an escalation process for those wards not achieving 100% 44.2To relook at audit questions to ensure questions are achievable 44.3Link nurses are guaranteed protected time (7.5 hours per week) to provide training/education and facilitate audits.	DMc DMc DMc	**July 2013** **July 2013** **Implemented**
	45. TVNs to support link nurses to educate re waterlow assessments. Consider use of flash cards or other quick grab educational tools which can be displayed (posters etc)	**High**	45.1Waterlow guidance has been added to the pressure ulcer prevention document to offer guidance to nurses in real time 45.2 E- Learning package to be created to test knowledge and to offer guidance on the assessment and completion of the waterlow. 45.3Visual campaign to be created regarding waterlow accuracy	DMc	**Implemented** **September 2013** **September 2013**
	46. Link nurse and TV team to educate in this area.	**High**	46.1 Lead Nurse and Link Nurse from vascular ward to re-educate staff around the use of dynamic systems – spreadsheet of training to be held by TV Team.	DMc	**WIP**
	47. Link nurses to audit Waterlow assessments and implementation of preventative actions.	**High**	*This forms part of the PU prevention and management audits. See actions in points 37 & 38*	DMc	**Implemented**

Themes	Recommended Action	Priority	Planned and Completed Actions	Lead	Action Date
Communication	48. TV Team and matrons to feedback the themes to all involved and set actions for staff locally to improve practice.	**High**	48.1 RCAs completed for all pressure ulcers above a stage 2 48.2 Weekly meetings to discuss pressure ulcer RCAs and share learning	DMc	**Implemented**
	49. A patient information leaflet should be designed if there isn't one already in use. Documentation should demonstrate that the patient has received the leaflet and their risk has been discussed.	**High**	49.1 There is a patient information leaflet in the back of the pressure ulcer prevention document which is perforated so can be removed to issue to the patient. There is space on the document for the nurse to sign to demonstrate the leaflet has been given and discussed 49.2 To monitor compliance by adding to the monthly Nursing Care Indicator Audits	DMc DMc	**Implemented** **September 2013**

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meetings held on 25th July and 29th August 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.** • **Financially the Trust has performed well in the first weeks of the year and at the end of July, recorded a small surplus of £0.8m.** • **However the Committee noted with some concern some early slippage on CIP schemes.**			
IMPLICATIONS OF PAPER:			
	Risk	**Risk**	**Details:**

RISKS	**Register**	**Score** **Y**	**Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in Q4 & Q1** **Financial deficit now forecast**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **Monitor has rated Trust at 'Amber/Green' for Governance & '3' (good) for Finance at Q1. 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 note the Committee's intention to refer the increase in C Difficile numbers in Q1 for consideration by the Clinical Quality Safety and Patients Experience Committee.

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 25th July and 29th August 2013

1. Background

The Finance & Performance Committee of the Board met on 25th July and 29th August 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. Acute Medical Unit progress report

The Committee received a progress report from the Clinical Director and General Manager of Emergency Medicine. Good progress has been achieved with length of stay dropping on average to under 12 hours. One of two new onsultant posts had been appointed to. The facility will be an important factor in managing peak winter flows.

3. Sickness absence review of highest sickness departments

The Director of HR reported on detailed plans to reduce sickness in the 10 'hotspot' areas of the Trust. Fast track access to physiotherapy for stenographers was also reported.

4. Cost Improvement Programme

The Committee considered a detailed report on the Trust's £12.4m Cost Improvements Programme (CIP). To date savings of £4.4m have been actioned. However this is already £1.8m behind plan. Particular problem areas are the Directorate of Surgery, where savings have not yet been identified; Trust wide schemes, where declared schemes are not delivering savings to timescale; and Medicine, where schemes have been declared but have a high risk of failure due to workload pressures. There has also been delay in approving schemes due to the unavailability of the medical and nursing directors (who have to personally 'sign off' schemes.

The Committee received a presentation from the General Manager of Women & Children's Directorate on that Directorate's CIP Programme. This is currently forecasting a shortfall of £210,000.

The General Managers for Surgery and Medicine will be asked to present to the next Committee meeting.

5. Maternity services at Russells Hall

The Committee received a report from the Director of Operations on the projected number of births at RHH. This had now fallen below the 4,800 plan and agreed staffing ratios. It was agreed to liaise with commissioners to lift the cap on referrals to the 4,800 plan

6. A&E Department workload analysis

The Director of Operations presented a report analysing comparative performance KPIs and case mix differences in two months when 4 hours waiting performance had been 90.89% and 96.7% respectively. He concluded that the key driver of comparative performance was the availability of bed capacity 'behind the ED Dept'.

7. CQIN Progress Report

The Committee received a report from the Director of Operations on progress against the 18 CQIN targets, with a total value of £6.1m in 2013-14. To date £61,000 has been lost through the poor take up of the national NHS Friends & Family test in A&E. Neighbouring trusts have had a similar experience.
Of other CQINS values, some £2.1m is still considered to be at risk.

8. Directorate staff appraisal improvement plans

The Committee received a report from the Director of Operations on progress against Directorate and Departments' Appraisal rate improvement Plans
Overall Directorates were now reporting an above 80% compliance rate. However, Directorates of Emergency Medicine, Specialist Medicine, and Diagnostics were still below this threshold and had agreed a trajectory of improvement with him.

9. Facilities and Estates Report

The Deputy Director of Operations (Estates and Facilities) presented his quarterly report. The Committee discussed in detail performance aspects of the RHH PFI contract with Summit Healthcare Ltd and estates issues in respect of Trust services provided from third party premises in the community.

Cleaning audit scores were noted to have improved to:

Russells Hall	97.2%
Corbett Hospital	98.9%
Guest Hospital	98.6%

10. Workforce KPIs

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

a. Absence
The Trust absence rate for the month of June is 3.84 % (4.35% in May) and was 4.02% in 2012. The 2013-14 target is 3.50%.

b. Turnover
Turnover continues to remain consistent and within target at 7.81% (7.76% in May)

c. Pre-employment Checks
Pre-employment checks managed through the Centralised Recruitment Department perform at 98%, together with 100% for Medical Workforce recruitment.
Staff bank also performed at 81%.

d. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small decrease on previous months to 70.6%.
Appraisals have increased again this month to 83.5% (82.3% in May).

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

f. Vacancies
The current live vacancy rate has reduced slightly to 227 FTE.

g. Employment Tribunal Summary
The Committee noted that the Trust had 7 live ET cases submitted during 2012-13.

11. Financial Performance for Month 4 – July 2013

The Trust made a small trading surplus of £0.9m in July . Although a surplus was forecast, this figure was marginally ahead of Plan, due to receiving a one off insurance claim settlement of £0.6m in July. For the 4 months period in total the trust is now recording a small surplus of £1.1m.

However, due to a number of factors the forecast for the year in total has deteriorated and a small annual deficit is now forecast. Principle factors are:

- Continued confusion in the NHS commissioning landscape with outstanding sign off of additional payment for extra activity still outstanding.
- Significant slippage on the Trust's CIP programme delivery.
- A significant deterioration in the 'run rate' of Trust spending, particularly on bank and agency nurses.

The Trust's balance sheet and liquidity position remains strong, however the Committee noted, with concern that available cash reserves had deteriorated to below £30m for the first time in the life of the FT.

Capital spending is now below phased plans due to slippage on IT and medical equipment programmes.

12. Performance Targets and Standards

The Committee noted that the Trust had met or exceeded all tagets for access and waiting set for Acute providers in July. In addition the Committee noted the following matters:

a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for July was 96.7% and the Trust remains on schedule to meet the Quarter 2 target.

b) Diagnostic 6 week waits

The Trust has achieved this performance target to date but fell marginally short in July (98.1% of patients seen within 6 weeks compared with a 99% target). This was reported to be the result of increased rates of referrals coupled with staff sickness and leave.. This is a notoriously difficult profession to recruit to due to a national shortage of trained staff.

c) Never Events

The Trust had no ‘never events’ in July.

d) DC Difficile Infections

The Committee has expressed concern about the ambitious nature of this target in 2013-14 and wishes to refer the increase in C Difficile numbers in Q1 for consideration by the Clinical Quality Safety and Patients Experience Committee.

e) Mortality Indices

The Committee noted that all current reported mortality indices are within expected ranges:

Standardised Hospital Mortality Indicator (Dept of Health)	1.08 (increased from 1.04)
Hospital Standardised Mortality Ratio (Dr Foster/HED)	99
CHKS Risk Adjusted Mortality Index (CHKS)	96

The Committee noted that the Medical director will prepare detailed reports on mortality to the Board and Clinical Quality Committees.

13. Monitor 2013-14 3 Years Annual Plan assessment

The Committee noted the confirmation of Monitor of the Annual Plan rating :

financial risk rating of ‘3’ and governance rating of ‘amber/red’.

14. **Matters for the attention of the Board of Directors or other Committees**

The Board is asked to note the Committee's intention to refer the increase in C Difficile numbers in Q1 for consideration by the Clinical Quality Safety and Patients Experience Committee.

PA Assinder
Director of Finance & Information
Secretary to the Board

Appendix One

Appendix Two

Appendix Three

Appendix Four