The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 7th November 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 – R Cattell, D Badger**		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 3rd October 2013	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 3rd October 2013	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Enclosure 3	D Mcmahon	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 4	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report including Mortality Report	Enclosure 5	D Bland	To Note & Discuss	10.00
	7.2 Audit Committee Exception Report	Enclosure 6	J Fellows	To Note & Discuss	10.10
	7.3 Infection Prevention and Control Exception Report	Enclosure 7	D Mcmahon	To Note & Discuss	10.20
	7.4 Keogh Review Progress Update	Enclosure 8	P Clark	To Note & Discuss	10.30
	7.5 Dementia Report	Enclosure 9	R Edwards	To Note	10.40
	7.6 Research and Development Report	Enclosure 10	P Harrison	To Note	10.50
	7.7 Board Assurance Framework	Enclosure 11	P Clark	To Note	11.00
	7.8 Role of Governor Report	Enclosure 12	J Edwards	To Note	11.10
	7.9 Quality Metrics Report	Enclosure 13	D Mcmahon	To Note & Approve	11.20
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 14	D Badger	To Note & Discuss	11.30
9.	**Date of Next Board of Directors Meeting** 9.30am 5th December, 2013, Clinical Education Centre		J Edwards		11.40
10.	**Exclusion of the Press and Other Members of the Public**		J Edwards		11.40

	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).				

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 3rd October 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
Richard Beeken, Director of Strategy, Performance and Transformation
Paula Clark, Chief Executive
Denise McMahon, Nursing Director
Paul Harrison, Medical Director

In Attendance:
Helen Forrester, PA
Elena Peris - Cross, Administrative Assistant
Richard Cattell, Director of Operations
Annette Reeves, Associate Director for Human Resources
Liz Abbiss, Head of Communications and Patient Experience
Julian Sonksen, Surgery and Anaesthetics

13/043 Note of Apologies and Welcome

Apologies were received from Jonathan Fellows, Non Executive Director.

13/044 Declarations of Interest

There were no declarations of interest received.

13/045 Announcements

There were no announcements to be made.

13/046 Minutes of the previous meeting on 5th September, 2013 (Enclosure 1)

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

13/047 Action Sheet 5th September, 2013 (Enclosure 2)

13/027.2 Charitable Funds- Georgina Chair

Richard Miner, Chair of the Charitable Funds Committee informed the Board that he had met with the Chair of the Georgina Ward Charity Committee and had started building a positive relationship, updates on this will be brought through the normal 6 monthly report to Board.

13/038.2 Report to the Mid Staffs NHS Foundation Trust Public Enquiry.

This is on the Agenda at item 7.4

13/058.3 Francis Report

This is on the Agenda at item 7.4

13/058.4 Finance and Performance Committee Report

This is on the Agenda at item 8.1

13/058.5 Food and Nutrition Report

This is on the Private Board Agenda.

13/058.6 Chief Executives Report

Food: This is on the Private Board Agenda.

ED patterns: This is included within the Chief Executives Report, item 6.

13/048 Patient Story

Denise McMahon presented a video of a patient who explained her experience of giving birth on the Maternity Ward.

Denise McMahon highlighted the point the patient raised in the film regarding her baby being transferred to the Neonatal ward, explaining that this would not usually happen, and if capacity allowed we would situate mothers with babies who need neonatal care in side rooms, however these are prioritised for still birth cases when capacity is high.

The Board were content to note that the patient was pleased about her experience.

The Chairman asked how many babies we had currently delivered this year following the Board's decision to place a cap on levels.

Richard Cattell, Director of Operations informed the Board that we were on 4800 and were content with this position, he said the current challenge is having the correct staffing ratio against the profitability of the service.

David Badger, Non Executive Director assured the Board that this is being kept under review by the Finance and Performance Committee.

Ann Becke, Non Executive Director pointed out that our Maternity unit has a good reputation and therefore we attract further afield mothers; we need to prioritise Dudley mothers.

Paul Assinder enlightened the Board to the issue that the insurance premium for Maternity is going up each year.

The Chairman asked for this issue to come back to Board early in the New Year.

Richard Beeken pointed out that this should be included in the Trust's Integrated Business plan.

Report on Maternity to return to the Board, early in the New Year.

13/060 Chief Executive's Report (Enclosure 3)

The Chief Executive presented her report including:

ED Performance: The Trust hit the Q2 target at 96.6%, giving us the best results in the Black Country. The Board noted that this was a real credit to the ED team and the rest of the Trust as colleagues in surrounding areas had been on level 4 for the majority of the last week. The Chief Executive pointed out that to achieve 95% in the next quarter we must continue to make small improvements across the whole of the Trust. The Board noted significant pressures in Surgery are causing delay.

The Chairman pointed out that the numbers are about the same as last year however the acuity of patients seems more intense.

Richard Cattell, Director of Operations explained that we had been busier in Q2 with more complex cases, Dudley also has a higher ambulance conveyance rate than the rest of the Black Country.

The Chief Executive added that we are also having a lot of very elderly patients coming into Resus.

The Chairman informed that Board that he had seen 'Tweets' from Liz Pope, Clinical Executive of Quality and Safety at the CCG following her stay in her ED.

Richard Cattell explained that GPs and Senior Executives of the CCG had been in ED all week to see firsthand the pressures we are facing, they were struck by the number of patients arriving from nursing homes. He added that emergency surgery has also been up by 20% in the last year.

David Bland, Non Executive Director asked if we had invited the GPs in to the Trust

Richard Cattell, Director of Operations clarified that it was a joint agreement which can only be good for both organisations.

Friends and Family Test: The ED token system has started and has substantially increased the amount of feedback we receive from 1% to 27.5%. The card system is still available alongside this. The national roll out into Maternity has been delayed however; we have taken the decision to start the system in our Maternity unit. The National data from the Friends and Family tests results are due out today.

Inpatient cancer patient experience survey: We have seen a couple of disappointing results and continue to work with patients to give them sufficient information. The work on an information pod outside of C4 continues.

Patient Experience Event: An action plan is being developed with feedback from this event included.

Patient Led Assessments: The Trust received good feedback overall however food was an issue. It is important we understand why we did not do well in some areas compared to neighbouring Trusts.

Richard Beeken speculated that it may be down to local interpretation, we need to understand how other organisations carry out their assessments.

David Badger, Non Executive Director asked if there was a breakdown of percentage targets in specific areas as we could do with understanding where the hotspots are.

The Chief Executive assured that she would attempt to find this out.

Integrated care pioneer bid: The Trust was shortlisted and has made it to the last 25. The Board noted that there is no money involved in this however it would be brilliant to be a successful site because of support and kudos.

David Badger, Non Executive Director expressed he was happy to see the health economy looking at this issue collectively.

David Bland noted his concern that this is not represented on the Health and Wellbeing Board.

The Chief Executive assured the Board that this was discussed at the Strategy Committee last night and contact has been made with the Chair of the Health and Wellbeing Board.

13/061 Quality

13/061.1 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:

- **Serious Incident Monitoring Report:** There was one Never Event reported in July, this was discussed with the CCG and it was agreed it is not a Never Event.

Denise McMahon, Director of Nursing assured the Board that it was appropriate to report this as a Never Event to be safe. A table top event was held with all the organisations involved and all were satisfied it was not a Never Event, consequently we received positive feedback for our openness and the way we managed the issue.

- **Maternity Smoking:** The Trust has moved into the green rating area for this.

- **NICE Guidance:** The Board took note of the encouraging reduction in the backlog of requests we receive.

The Chief Executive pointed out that the item on CT scanning will be in the next business case.

13/061.2 Infection Prevention and Control Exception Report (Enclosure 5)

Denise McMahon, Director of Nursing, presented the Infection Prevention and Control Exception Report given as Enclosure 5**.** Board members noted the following points:

C.Diff: The Board noted the concerning figures of C-diff with 6 cases in September. The Trust's annual target is 38 which gives us allowance of 3 per month. A 72 hour meeting was held which was well attended and the attendees worked through the principals of Janice Stevens' report, the Nursing director said she was satisfied we were meeting these principles however we are moving forward by increasing checks and continuing with fast isolation. The Board were informed that no transmission had occurred between patients or wards as all cases were type tested and it was found that they were all different, showing no outbreak had occurred. We now currently have a figure of 21 against 38.

MRSA: The Trust has maintained 0 cases of MRSA.

Norovirus: The Trust has maintained 0 cases of Norovirus.

MSSA and Ecoli: We have seen the lowest numbers of Ecoli and MSSA in the month of September.

The Chief Executive asked if we could triangulate the frailty and Acuity of patients against the rise in C.Diff.

Denise McMahon, Director of Nursing assured the Board that you could relate the two and we were looking at each individual case with a specialist data analyst to find out more.

Paul Harrison, Medical Director pointed out that the biggest problem we have preventing us from further improving in this area is antibiotic prescribing, discussing this with Clinical Directors it has been said that electronic prescribing would improve this.

Paul Assinder, Director of Finance and Information informed the Board that Monitor had issued the performance indicators and had recognised that this is the most difficult target to achieve.

The Chairman asked if other trusts were mirroring our own spikes in figures.

Denise McMahon answered; this would not be known until the end of October.

The Board took note of the issues arising in the Infection Prevention and Control Report.

13/050.7 Keogh Review Progress Update (Enclosure 6)

The Chief Executive presented the Progress update given as enclosure 6.

The Board were reminded that they met with Monitor in August to look at how we monitor actions; it has been agreed to use the Keogh template that other trusts have used which is in

the papers and has been colour coded for ease of reference. The Chief Executive was pleased to note that we are on track with most areas except the Patient Experience Strategy however, we are moving forward well with this. It has now been decided that some aspects of the Francis action plan will be moved into the Keogh plan however this will not happen before Julie Cotterill, Governance Manager forms the best method of doing this.

The Chairman asked why the items that were in the initial report that have been closed are not on the action plan.

The Chief Executive informed him that this is how Monitor has asked to see the plan.

David Badger, Non Executive Director showed his concern over the delay in getting the NHS staffing tool as a number of the outcomes in the plan depend on having the tool.

The Chief Executive added that this is outside our control. We have gathered the data and are just waiting for the release of the tool, this does not stop us with recruitment and it is vital we push on with this.

Ann Becke, Non Executive Director pointed out that we didn't wait for Keogh; we were working on this before the team came in however we have had problems with recruiting staff.

The Chief Executive agreed adding, we received a very poor response to job adverts.

Denise McMahon reminded the Board that we had just taken on 50 graduates from Wolverhampton University and she would keep the Board updated on their progress

The Board received the report noting that it would be going to Monitor monthly as well as to Board.

13/061.3 Francis Report (Enclosure 7)

The Chief Executive presented the report given as enclosure 7 including:

A lot of the actions will be staying open because they are out of the Trust's control and need national action however the action plan will be slimming down as some of the actions will eventually be moved into the Keogh action plan. The Board noted the report will be coming quarterly to Board from now on.

David Badger, Non Executive Director pointed out item 76 on page 1 which is around governance and the arrangements around the Trust's Governors being accountable to the Members and General Public, informing the Board that there is a specific piece of work by the Membership Engagement Committee to address this that is to follow.

The Chairman announced that from now on this will be a quarterly report that will next be back to the Board in January.

13/061.5 Organ Donation half yearly report (enclosure 8)

David Badger, Non Executive Director explained that the Organ Donation report comes to Board as a half yearly update and once a year the Lead clinician and nurse attend the Board meeting. He informed the Board that it was vital we are relentless in the pursuit to ensure care givers are having the conversation of donation all over the Trust. The Board recorded thanks to Steve Waltho for chairing the Organ Donation Committee.

Julian Sonksen, Lead Clinician gave the Board the organ donation presentation including:

- Background – the last 5 years of the committee and its work.
- Actions the committee has taken in the last year
- A missed opportunity – a slide on a scenario where the opportunity of a donation was missed as the conversation had not taken place with the family.
- Local Data – The Board were informed that donation can only happen in a small amount of cases where the patient died whilst on a ventilator. Nationally the numbers for donating were very low, the target has now been met nationally 87.5 % increase in the West Midlands.
- The Donor Recognition Project including examples of International Donor Recognition
- The proposed site of the Dudley Group Organ donor artwork.
- Next Steps
- Board Recommendations.

David Bland, Non Executive Director thanked Julian Sonksen for the presentation commenting on how encouraging it was. He went on to ask if an organ donation card can be overruled by the next of kin.

Julian Sonksen said he would hope the family would want to fulfil the card holder's wishes.

Rebecca Timmins, Specialist Nurse confirmed that 9 times out of 10 the family support the wishes of the cardholder, however they can overrule.

The Chief Executive asked if the opt out legislation that has been passed in Wales would be introduced to England.

Rebecca Timmins informed the Board that no suggestion had been made for England.

Richard Cattell, Director of Operations asked what the national efforts were to get families discussing this early on.

Rebecca Timmins clarified that there was a national advertising campaign and there are ideas to go into schools to educate children on organ donation.

Ann Becke, Non Executive Director asked what happens when a member of staff does not agree with organ donation and does not want to have the conversation with a family about this.

Julian Sonksen informed the Board that every person would then have a duty to ensure they ask support from someone else in order that the conversation is held by someone.

Rebecca Timmins added that she or another member of the regional on call team is always available in case they need to attend a family to offer support and have the discussion around donation.

The Chairman thanked Rebecca and Julian for their fantastic work, the Board took note of the progress in the report.

13/061.6 Revalidation Report (Enclosure 9)

The Medical Director presented the Report given as enclosure 9 including the following points:

- Revalidation of all Doctors has now become mandatory by Act of Parliament.
- There is a staged implementation process.
- The Trust has received only one deferral for our trust which is a good result, we are significantly below the 10% national average.
- The Trust was required to undertake a self assessment report (ORSA) which we received a green rating. We do however have more work to do around developing a secondary team of appraisers and completing the internal Audit of this process.

Denise McMahon, Nursing Director asked what happens when we receive a deferral.

The Medical Director said that this depended on the reason, this case was due to the Doctor needing more time to complete the appraisal, I made the recommendation to the GMC for deferral which was approved and the Doctors appraisal was postponed until January.

The Chairman thanked the Medical Director for the report and the good progress it shows, the Revalidation Report will be brought to the Board again in March 2014.

13/062 Finance

13/062.1 Finance and Performance Report including list of Potential Fines. (Enclosure 10)

David Badger, Chair of the Finance and Performance Committee presented the overview report from the Finance and Performance including the following issues:

- **CIP:** The Committee have taken note and raised concern that the Trust and especially the Directorate of Speciality Medicine have fallen behind with savings.

- Bowel Cancer Screening Services at Russell's Hall: The Board asked the Committee to monitor implementation. The first report was disappointing and raised concerns over delays. The current completion is scheduled for the end of February however Richard Cattell, Director of Operations is investigating possibilities of bringing this date forward.

- **Workforce KPIs:** The Board noted the good results of absence levels being the lowest in recent memory.

- **Mandatory Training:** A new trainer is in place and we are now in a position to develop a new mandatory training programme.

- **Appraisals:** The rate has increased again this month and we are continuing to improve in this area.

- **Financial Performance:** This is a volatile area, the Trust is back to break even position with a small surplus at the end of August.

- **Performance Targets:** The Board noted good A&E performance. There are concerns around diagnostic waits however the spike in referrals is positive.

The Chairman asked if there was a specific reason we have seen a spike in referrals.

Richard Cattell, Director of Operations assured that he in investigating this matter.

- **C-diff:** This matter has been referred to the Clinical Quality, Safety and Patient Experience committee.

- **Mortality Indicators:** The Trust continues to report within the expected ranges.

- **Commissioner Performance Fines (Appendix 4):** The Board received the information around the potential fines we are exposed to.

The Chairman asked why we thought there was a slight increase in the SHMI indicators.

Paul Harrison, Medical Director explained that this was a complex area. One issue with SHMI data is that it includes patients that die within 1 month of discharge, consequently it includes deaths that cannot be reviewed by us.

13/063 Any Other Business

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

13/064 Date of Next Meeting

The next Board meeting will be held on Thursday, 7th November, 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 3 October 2013

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
13/027.2	Charitable Funds Committee Report	Charitable Funds Committee Chair to meet with Georgina Unit Fund Chairman Re: their activities.	RM	3/10/13	Done
13/049	Chief Executives Report	Outcome of Georgina Unit Patient Experience Review to be presented to Board.	MG	7/11/13	In Chief Executives Report
13/048	Patient Story	Business Case for wired and wireless solution to the Finance and Performance Committee. Volunteers to check that wards have a supply of headphones.	JT MG	31/10/13 7/11/13	 All wards have a full supply of headphones and details of how to obtain further sets.
13/050.4	Risk and Assurance	Kevin Shine to produce a full briefing on CQC Risk Profile to the Finance and Performance Committee.	KS	31/10/13	
13/050.5	Audit Committee	Audit of Sickness Absence to be presented at the Finance and Performance Committee.	AR	31/10/13	Completed
13/038.6	Quarterly Safeguarding Report	Report on the Winterbourne Report findings to be presented at a future Board meeting.	DM	7/11/13	On Private Board Agenda
13/048	Patient Story	Report on Maternity to return to the Board early in the New Year.	RC	9/1/14	To November Private Board

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 7th November 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Cancer Patient Experience Survey 2012/13 Update
- 95% Hospital/Emergency Department 4 Hour Wait Target
- GP Observations in Emergency Department and Emergency Admissions Unit
- Ambulatory Emergency Care Network Pilot
- Friends and Family Test Performance
- Staff Survey 2013
- Integrated Business Plan
- CQC Risk Bandings

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive Update – November 2013

Cancer Patient Experience Survey 2012/13 Update:

A full action plan has been drawn up to address the cancer survey results and this will be taken to CQSPE Committee. Key elements include:- improvements to patient information, individual Multi Disciplinary Team (MDT) actions where tumour groups have low scores, and implementation of a new peer review measure.

Environment for Staff and Patients on the Unit:
Progress on the two variations reported last month:

1. Swapping the drug store and seminar room on C4 to provide a better storage environment for the controlled drugs and to ensure staff do not have to leave the ward to access the drug store.

   A start date is awaited from the appointed contactor – this is expected to be imminent.

2. Improvements to the Georgina "pod" to create a separate waiting/clinic area – costs are expected into the Trust beginning November then C4 will be able to agree funding with the Leukaemia Appeal Fund for this project.

Information Pod:
Drawings have been prepared by the information pod supplier and financing of the project agreed with a 50:50 purchase price split between White House Cancer Support and the Trust cancer charity (£22,500 based on current design). Further to this the Trust charity would fund a laptop and The White House would fund someone to operate the pod.

The proposal was to site the pod in the wide corridor near to C4, however concerns have been raised regarding fire safety. Technical information, including the surface spread of flame tests, has been requested from the supplier to enable this project to progress further.

95 % Hospital/Emergency Departments 4 Hour Wait Performance:

After achieving the 95% wait target for quarter 2, we have had an extremely challenging October and are currently performing at 91.7%. Each clinical service and ward will need to play its part in returning our performance to 95%+ and indeed to hit the 95.5% performance which will trigger winter incentive payments from the CCG from 1st November. Increased scrutiny of performance in all areas during the remainder of Q3 will be undertaken.

GP Service Observations – Emergency Department/Emergency Admissions Unit:

The Board will be aware that we have recently had a number of GPs and CCG colleagues working shifts in ED to more fully understand the pressure faced in that department and to help Dudley solve its urgent care problems. We await their review of their findings but the headlines would suggest that they saw numbers of patients who were not necessarily in the best place for their care, challenges around the access to mental health services and the impact of a high number of ambulances arriving in a short period of time. We will share their broader findings.

Ambulatory Emergency Care Network Pilot (AECN):

The Board will recall that we have been actively involved in the AECN for some months now. From 5th November we will be undertaking a pilot of a new way of working in our admissions area. Ambulatory Emergency Care is provided on the 'diagnose to admit not admit to diagnose' premise. We are putting aside an area in EAU to provide the space, the doctors, nurses and probably most importantly the diagnostic input to make this important activity successful. The outcomes should be less people seen in ED, less people admitted to hospital and more people either being discharged home or being referred to the most appropriate service.

Friends and Family Test Performance:

	Q1 April to June cumulative	Q2 July to Sept cumulative	Oct 13 Wk 1	Oct 13 Wk 2	Oct 13 Wk 3
	01.04.13	01.07.13	30.09.13	07.10.13	14.10.13
Date range	**30.06.13**	30.09.13	06.10.13	13.10.13	20.10.13
Number of eligible inpatients	*5821*	*5922*	*449*	*458*	*448*
Number of respondents	*1487*	*1474*	*63*	*106*	*145*
Ward FFT score	**72**	72	63	85	75
Ward footfall	**26%**	25%	14%	23%	32%
Number of eligible A&E patients	*12800*	*13435*	*988*	*967*	*913*
Number of respondents	*432*	*898*	*284*	*215*	*383*
A&E FFT Score	**60**	55	52	66	59
A&E footfall	**3%**	7%	29%	22%	42%
TRUST FFT Score	**70**	66	54	72	64
TRUST footfall	**10%**	12%	24%	23%	39%

Inpatient FFT Score	80+	A&E FFT Score	70+
	72-79		60-69
	<72		<60

% of footfall	April-June 13	<15%	15% +
	July 13-Mar 14	<20%	20% +

FFT Scores key	Top 20% of Trusts (based on Q1 scores)
	Between Trust baseline and top 20%
	Trust Q1 baseline

Scores for inpatients remain level from quarter one to quarter two with a score of 72. Response rate has also remained consistent over the quarters – though some variation can be seen week on week.

The introduction of the token system into A&E has resulted in a dramatic increase in response rate – from three per cent in quarter one, and seven per cent in quarter two to a massive 42 per cent in October week three. Comment cards are also being completed to ensure we gain qualitative feedback to help drive improvements.

Wards/A&E have been asked to update their individual action plans for quarter two to include increasing both their response rates and their scores.

A new winter incentive scheme has been introduced by Dudley Clinical Commissioning Group which includes a payment of £8,000 for each month that the Trust achieves a

combined response rate of 15 per cent from November 2013 to March 2014. With the introduction of the token system we are confident this can now be achieved

Annual Staff Survey:

This is currently out within the organisation and has been sent to all staff this year. The response rate is just over 30% as at 31st October and we are continuing to remind staff of the importance of giving their views so that we can improve both their working lives and services for patients.

Integrated Business Plan (IBP) Progress:

The date for submission of the Annual Plan has been brought forward by Monitor by two months, to 31/3/14. This significantly compresses the timetable and adds risk to our ability to consider each speciality and service in detail and to gain full clinical and management engagement in the process. The IBP planning sessions with each speciality and service are now being timetabled in between 4/11 and 20/12 and Richard Beeken will facilitate each half day session. The product of these sessions will then be aggregated in January and February 2014 and capacity, workforce and financial plans will be drawn from these for a 2 year detailed plan and a 5 year plan overall. The Board will need to consider how it wishes to engage the governors and the membership in the production of this plan. The Council of Governor's Strategy Committee is receiving regular updates on the IBP process and the product on a regular basis.

CQC Risk Rating:

I am pleased to report that the Trust has been put into Band 4 in the 1-6 Risk Banding from the CQC whereby 1 is considered high risk up to Band 6 which is considered low risk. This is particularly pleasing as all the other Keogh reviewed trusts have been banded in either 1 or 2.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th November 2013

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 12th September 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:

Friends and Family Survey Results - the Committee received results for August 2013 and noted that the A&E score continued to fluctuate and dropped to 43 in August. The A&E response rate was low but the Trust scores were in line with the national average. The inpatient FFT score has consistently remained above 70 since May and was 73 for August with the National Average score of 70. The Committee discussed the positive comments received and areas for improvement. 'Waiting Times' remained the main request for improvement from patients.

Keogh Patient Experience Event Update - over 60 people attended an event in July. Attendees were asked to consider what a "great" service looked like and what "great" things we were doing for patients. They were also asked to consider the barriers that get in the way of a great service. Attendees focussed on specific actions the Trust could take to provide the best possible patient experience. Feedback from the event would inform the Patient Experience Strategy.

Quality Dashboard Report for Month 4 – the following key issues were highlighted:

- **C.Difficile** –the Trust was back on trajectory. There had been a reporting error for one case in April.
- **Maternity: Increase in Breastfeeding initiation rates by 2% per year** –the Trust was slightly under target, although there had been an improvement in performance from the previous month.
- **Maternity Smoking in Pregnancy** –the Trust had dropped outside of the target for July.
- **TAL Appointment booking within 4 days** –the Trust had met with CCG representatives to discuss this performance measure and the application of the 4 day deadline for bookings. There may now be scope for the definition to change which would impact on the performance score.
- **Nursing Care KPIs** - The report included a ward based summary of NCIs. Ward B4 had the most red rated NCI areas. Scores for protected mealtime assistance were particularly low for July and the scores for Think Glucose were also down.

The Committee was advised that the CQC was introducing a New Surveillance model from April 2014. Data packs, initially based on around 120 indicators would be used and would replace the QRP which would be phased out over the remainder of the financial year. The data packs would inform the key lines of enquiry for the CQC inspections. Trusts would be rated as Outstanding, Good, Requires Improvement or Inadequate. These would be issued from December 13, with all Trust's receiving a rating by December 2015

Mortality Report – The Committee received the revised report format presented and discussed at the Board workshop and focussed on the Summary and Action Log. They were advised that the Trust wide external mortality indices were within normal range. The Trust SHMI was rising although the HSMR remained low. The crude mortality rate showed a slight increasing trend over the past three quarters. The Medical Director also updated the Committee on the action plan:

- **Reference 0813/1** - Congestive Heart Failure – this related to an audit to determine the reasons why this group of conditions were outside of the normal range for SHMI and was nearing completion.
- **Reference 0813/2** – High number of excess deaths in cancer conditions –discussions continued with coders and Audit Leads. Clinicians were under coding secondary disease.
- **Reference 0813/3** - Fluid and Electrolyte disorders – Medical Service heads would undertake a patient level case note review and share good practices.
- **Reference 0813/4** - Review of directorate and speciality level mortality audit meetings and reviews. The Medical Director referred to the speciality level M&M Meetings and noted that some specialities managed this process better than others. Work was progressing to bring these areas into line with the rest of the Trust.

Health & Wellbeing Strategy - The Committee received the Strategy for consultation and a report on progress against this. Work had continued for some months on the following six strands:

1. Managing long term sickness and incapacity to work
2. Promoting physical activity in the work place
3. Promoting mental wellbeing through productive and healthy working conditions
4. Work place interventions to promote smoking cessation
5. Obesity prevention identification, assessment and management
6. Promoting environments and schemes to encourage and support mental and physical health and wellbeing.

Drugs and Therapeutics (10th July 2013) - the Principal Pharmacist presented the Drug and Therapeutic Committee meeting summary and highlighted the following:

- Discussion and review of a Risk Assessment on the use of unlicensed medicines within the Trust.
- Review and recommendation to approve antibiotic guidelines including vancomycin continuous and pulsed IV therapy guidelines and cellulitis guidelines.

Implementation of ward-based pharmacist non-medical prescribers (NMP's and their impact on Patient Discharge) - the Principal Pharmacist informed the Committee that the Business Case Proposal came about following a Patient Safety Leadership walk round in Pharmacy. To avoid late prescribing and processing of discharge medicines, pharmacists would write discharge letters on the wards and would also undertake some medicines management and check that patients had enough medicines to take home. This would help to improve discharge times. The Committee supported the proposal for consideration at F&P.

Serious Incident Monitoring Report (August 2013) - 8 new incidents were reported in August (3 Patient Falls resulting in Fracture, 2 Wrong tests Requested/performed, 1 Appointment not available, 1 Stillbirth (Pre-delivery) and 1 Unexpected admission to SCBU (Neo Natal)). There were 31 open general SI's in total. 3 incidents were recommended for closure. The Committee considered the Incident Trends where four wrong test requested/performed all occurred in radiology (September 2012, May 2013, June 2013 and August 2013). RCAs were in progress for the latter two. There were no breaches in the 2 day reporting from date of identification and no breaches in the completion of the RCA within the agreed time scales. An extension was granted for 2013/15351 where the Trust was awaiting results of an internal disciplinary hearing. The Committee **noted** the current position and supported the closure of the 3 SI's recommended.

Patient Safety Leadership Walk Rounds Update - In July report the Group received a report highlighting 45 actions that had breached their completion time scales. In response the CQSPE Committee had requested a further report to look at these in more detail. Since that time the governance team had taken additional steps to drive the completion of actions arranging 1:1 meetings and escalating issues to the Clinical Directors, General Managers and Matrons. Breaches in completion dates had reduced dramatically from 45 to 11.The Committee received the paper and reviewed the agreed actions that had breached completion time scales.

Patient Safety Group (13th August 2013) - The following issues were discussed:

- **Medical Devices (Meeting of 25th July 2013)** – The PSG received an update on key issues arising. The purchase of additional wheel chairs was raised. Matrons felt that due to the number of wheelchairs out of circulation (for repair) still more were required. There was also a continuing issue with Telemetry/Wi-Fi.
- **Health and Safety - Compliance with Central Alerting System (CAS) Safety Alerts Reports** - Matrons raised concerns about the reporting of patient falls as RIDDORs
- **Any Other Business** - A Safeguarding issue relating to a vulnerable adult was raised under any other business. This was referred to both the Safeguarding Lead and the Safeguarding Board.

Safeguarding Group (22nd August 2013): The following issues were discussed:

- **Winterbourne Report** - The action plan developed in response to this report was being reviewed. An updated action plan would be provided for the 'Patient Safety' meeting.
- **Autism NICE guidelines** - An initial review to assess Trust compliance suggested partial compliance. The guidelines will be reviewed in more detail and an action developed.
- **Dudley Safeguarding Children's Board** - A change in the allocation of Health Visitors away from GP

practices had resulted in several agencies identifying problems in ensuring good communication links were maintained, this was being reviewed.

- **Access to medical records** - A lack of understanding across the hospital of who had 'rights' to access patient records had been identified. It was reported that Social Workers, IMCA and staff from care homes were able to access medical records. Clarity would be sought.
- **Assessment of patients in ED** - Concerns were raised about delays in follow up of patients identified as having safeguarding issues who were then transferred to EAU.

Infection Prevention & Control Forum Report (13th June 2013) - The following issues were discussed:

- **MRSA and C. Difficile** - At the time of the meeting there were 18 days remaining in the quarter and the Trust was 1 case under target:
- **Surgical Site Infection Report -** for the module period Oct-Dec 2012, of the 92 patients receiving neck of femur (NOF) repairs 4 patients had surgical site infections (SSIs); 2 of these patients were already in hospital and 2 were readmitted (4.4%; national average 1.6%). This module was repeated Jan-March 2013; of the 112 patients receiving this procedure 3 patients had an SSI (2.7%; national average not yet known). This data was submitted to Public Health England (PHE) and results were awaited.
- **Report from Clinical Units** - **ED/EAU/AMU/MHDU** - there were issues regarding isolating patients in a timely manner in ED/EAU as there were no side rooms. This was an issue for patients with diarrhoea and suspected TB (along with other infectious diseases).

***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 12th September 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 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7 November 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 15th October 2013 and considered:

- The external auditors plans and fees for both the Trust and Charitable Funds 2013/14 audits;
- Progress reports from Internal Audit, Local Counter Fraud Specialist (LCFS), Clinical Audit and the Information Governance (IG) Toolkit;
- The annual review of Standing Financial Instructions.

A summary of the key issues discussed and items referred to the Trust Board is shown below.

External auditors plans and fees for audit of Trust and Charitable Funds 2013/14:

Deloitte set out the proposed audit plans and fees for both the Trust and the Charitable Funds audits for the 2013/14 financial year.

In accordance with both International Standards on Auditing and also the Audit Code for NHS Foundation Trusts issued by Monitor, the main areas of focus for the Trust audit will be the issuing of an opinion on the financial statements, together with reviews of the arrangements for efficient use of resources and of the completeness of disclosures in the Annual Governance Statement. The audit will be risk based in approach. Deloitte noted that the efficient use of resources (value for money) element of the audit process is attracting increasing attention from Monitor.

Deloitte will also be required to provide assurance on the Trust Quality Accounts. Monitor is still to confirm details of the two mandatory indicators on which the auditors will be required to issue an opinion, whilst a third local indicator will be selected by Governors in due course.

Deloitte highlighted the increasingly tight deadlines to which the financial statements, Quality Accounts and Annual Report must be produced, meaning there is limited time after preparation of draft information for both internal and external review. The Committee suggested that consideration could possibly be given to an early draft of the Annual Report being presented to a board sub-committee, such as Finance and Performance, as this document was probably least prescriptive in layout and approach.

The audit of Charitable Funds will be carried out in accordance with International Standards of Auditing and with the reporting framework in the UK relating to charities.

Since April 2013, International Accounting Standard (IAS) 27 – Consolidated and Separate Financial Statements applies to all NHS bodies, requiring the Trust to consider whether the charitable fund represents a subsidiary. This is likely when the Trust (a) has control over the fund and (b) benefits from the fund. If these conditions are met, the accounts of the Charitable Funds will need to be consolidated with those of the Trust. The current expectation is that accounts will be consolidated, with the consequent requirement to restate comparative 2012/13 figures in the 2013/14 financial statements.

Progress reports from Internal Audit, Local Counter Fraud Services (FCFS), Clinical Audit and Information Governance (IG) Toolkit:

Progress on LCFS is in line with plan. A further 4 referrals to the LCFS had resulted in investigations, with 2 requiring no further investigation and the remaining 2 ongoing. A review of declarations of interest received from Consultants, Clinical Directors, Executive Directors and Non-Executive Directors had also been undertaken which had highlighted that Consultant interests were not being recorded on the centralised register of interests. This had now been addressed.

Progress on Clinical Audit had seen a further 50 clinical audits recommended for inclusion in the plan, while Clinical Audit is now included in the quarterly performance meetings held with all Directorates as part of the process of follow up on recommendations arising from audits. The RAG risk rating system for reporting audit results remains on track to be introduced in the current financial year.

Progress on the Information Governance Toolkit continues to show steady improvement, with the assessment against version 11 in July 2013 remaining satisfactory, with a 79% score, up from 78% previously. As at the end of September, 75.3% of Trust staff had completed IG training, with the target being to achieve 80% by end October.

Two information governance incidents had been reported to the Information Commissioner, one relating to two faxes sent to the wrong recipient in error and one relating to the theft of several items including some patient identifiable information from a community nurse's vehicle. In both cases, the Trust contacted all of the patients involved, with the theft incident also reported to the police. The sending of faxes to the wrong number has also been recorded as a Serious Incident. The Trust has received confirmation from the Office of the Information Commissioner that there will not be any follow up action taken against the Trust.

Since the last Committee meeting a further 5 Internal Audit reports had been finalised, with 23 reviews in progress or scheduled to be undertaken. The 5 completed reports were:

- Claiming and Processing of On Call Payments : AMBER/GREEN opinion
- Compliance with the Appraisal/Personal Development Policy : RED opinion
- Compliance with the European Working Time Directive (EWTD) for Bank Nursing Staff : RED opinion
- Bank Workers – Pre-Employment Checks and Induction Attendance : RED opinion
- Local Understanding and Application of the Patients Property and Procedure on the Emergency Assessment Unit and Ward B (Trauma and Orthopaedics) – Advisory only

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

A detailed discussion took place on each of the 3 audits receiving RED opinions and it was agreed to refer the discussions and proposed actions to the Board.

a) On Compliance with the EWTD, the audit found that the policy is not clearly understood by all staff, plus that, due to the limitations of the national NHS Payroll system, there are currently no processes in place for compiling comprehensive information to ensure breaches of the EWTD are avoided. For agency staff, although it is the agencies that are responsible for ensuring compliance, there is currently no reference to EWTD or working hours in the statements agency staff are required to sign. It is understood that the Allocate system when fully rolled out by April 2014 may be able to track total hours by individual. The Committee considered this issue should be referred to the Board in order that a robust system to track possible breaches of the EWTD can be put in place as soon as possible;

b) For Bank Workers – Pre-Employment Checks and Induction Attendance, although there is a policy in place that is aligned to the NHS Employers Standard Checks, there were instances identified where the policy had not been followed, particularly in relation to evidence required to verify identity checks. The Committee understands that consideration is being given to the centralised HR Recruitment Team carrying out bank pre-employment checks rather than the Staff Bank team and the Committee felt this issue should be referred to the Board as one that needed to be resolved urgently. The Committee also plans to invite the Director of Human Resources to the January Audit Committee meeting to provide an update on how pre-employment checks can be or have been improved;

c) In relation to Compliance with the Appraisal and PDR Policy the internal auditors noted that there is a strongly designed process in place, whilst there has also clearly been significant effort made at a central level to focus attention on conducting appraisals. Disappointingly however, on the ground, compliance was found to be inconsistent, with appraisals not always undertaken at least once in every twelve month period, different appraisal documentation in use, overall ratings not always given and managers and employees not always signing the appraisal documentation to accept the outcome of the appraisal and sign up to the stated forthcoming objectives. There clearly remains work to do to change the culture of the organisation with regard to appraisals and the Committee understands HR has been tasked with reviewing the quality of appraisals. The Committee plans to invite the Director of Human Resources to the January Audit Committee meeting to update the Committee on how appraisal quality can be improved, however the Committee also felt it important that the Board recognise the need to provide full support in order to achieve the cultural change needed across operational management.

Annual review of standing financial instructions: the Trust Standing Financial Instructions (SFI) detail the financial responsibilities, policies and procedures to be adopted by the Trust in order to ensure probity, accuracy, efficiency, effectiveness and that all financial transactions are carried out in accordance with the law and with Government policy.

In line with recommended practice, the SFI are reviewed annually, to take account of any

changes to the control environment or any additional financial governance arrangements.

The Audit Committee reviewed the SFI in detail and agreed the following amendments:

a) The updating of the LCFS name and contact details;
b) The updating of job titles for Director responsibilities;
c) Inclusion of references to the Bribery Act 2010 in the sections dealing with losses and special payments, casual gifts and hospitality
d) Removal of PFI variation authorisation limits for officers below Trust Representative
e) Inclusion of the Deputy Director of Finance – Financial Reporting to authorise Charitable Funds requisitions not exceeding £5,000.

As can be seen, none of the amendments are particularly substantive. The Committee also discussed the ongoing involvement of Non-Executive Directors (NEDs) in contract tenders.

The current tendering arrangements, which have been in operation for four years, require a NED to be present for all tender openings above £150,000, together with NED involvement in the tender evaluation process for all tenders in excess of £400,000. There is however not much consistency across NHS organisations, with others having lower thresholds, or in some instances no NED involvement.

The Committee noted that the benefit of involving a NED is that it allows impartial challenge in the tendering process and gives the Trust Board additional assurance when it is asked to approve the relevant contract. After discussion, it was felt that the current limits remained appropriate, but that the current approach could be improved by the introduction of a rota for NEDs involvement in tenders, to avoid any imbalance of workload.

It was also discussed whether a recommended approach for NED involvement was required. However the Committee considered that rather than be prescriptive, each NED should determine the process and level of involvement by which he or she felt able to obtain the necessary assurance in order to be able to inform the Trust Board accordingly. Before reaching a final conclusion however, this question of approach to the process would be discussed further amongst the Chairman and NEDs.

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:

The Board of Directors is asked:

a) To note the approval of the Audit Committee to the proposed external audit plans and fees for both the Trust and Charitable Funds audits for the 2013/14 financial year.

b) To consider the presentation of an early draft of the Trust Annual Report to a Board sub-committee given the tight deadlines required to be met;

c) To note the three RED opinion Internal Audit reports on Compliance with Appraisal Policy, Compliance with the EWTD and Pre-Employment Checks and Induction Attendance for Bank workers and actions taken;

d) Approve proposed amendments to the Trusts Standing Financial Instructions and in particular to the involvement of NEDs in the contract tendering process.

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

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th November 2013 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:**	Denise McMahon – Director of Nursing

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 24 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	August '13	September '13	As of 25th October 2013	Totals so far 13/14
A1	2	0	0	0	0	0	0	0	0
A2	12	0	1	0	1	1	1	0	4
A3	0	0	0	0	0	0	1	1	2
A4	0	0	0	0	0	0	1	0	1
B1	0	0	0	0	0	0	0	0	0
B2	1	0	1	0	0	0	0	0	1
B3	4	0	0	0	0	0	1	0	1
B4	3	0	0	0	0	0	1	0	1
B5	0	0	0	0	0	0	0	0	0
B6	2	0	0	0	0	0	0	0	0
C1	7	1	1	0	0	0	0	0	2
C3	6	0	1	1	1	0	1	1	5
C4	4	0	0	0	0	0	0	0	0
C5	1	0	0	2	0	0	0	1	3
C6	3	0	0	0	0	0	0	0	0
C7	7	0	0	0	0	0	0	0	0
C8	2	0	0	0	0	1	0	0	1
MHDU	0	0	0	1	1	0	0	0	2
CCU/PCCU	0	0	0	1	0	0	0	0	1
Critical Care	0	0	0	0	0	0	0	0	0
EAU	1	0	0	0	0	0	0	0	0
SHDU	1	0	0	0	0	0	0	0	0
Total	**56**	**1**	**4**	**5**	**3**	**2**	**6**	**3**	**24**

See Appendix 1 – Board Report (2013/2014)

C. difficile – We have reported 24 post 48 hour toxin positive cases against a trajectory of 22 cases so far this year (annual target no more than 38 cases). The Trust has held two 72 hour meetings to review and establish an action plan to bring the number of new cases back within trajectory.

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.

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	-66.7%	1	3	-66.7%	5	7
May-13	4	3	33.3%	5	6	-16.7%	10	11
Jun-13	5	3	66.7%	10	9	11.1%	6	6
Jul-13	3	3	0.0%	13	12	8.3%	9	11
Aug-13	2	3	-33.3%	15	15	0.0%	8	11
Sep-13	6	3	100.0%	21	18	16.7%	12	17
Oct-13	3	4	-25%	24	22	9.1%	6	9
Nov-13		3			25			
Dec-13		4			29			
Jan-14		3			32			
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	24	38	-36.8%				56	72

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	0.0%	-	0	0.0%	-
Oct-13	-	0	0.0%	-	0	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 bacteraemias 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	7	25
Sep-13	4	29
Oct-13	1	30
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	30	

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	32	106
Sep-13	17	123
Oct-13	3	126
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	126	

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th November 2013

TITLE:	**Keogh Improvement Plan and Progress Update – October 2013**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Paula Clark** **Chief Executive**

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

SUMMARY OF KEY ISSUES:

The Board met with Monitor representatives on 15th August to discuss the Keogh Review and Action Plan and to agree how the Trust would track progress against this. It was agreed that the Monitor template would be used to confirm the Trust position monthly.

The attached report focuses on the urgent actions discussed at the Risk Summit. The "Improvement Plan & our Progress" describes the issues identified by Keogh, the actions we are taking and how we will keep the public updated on progress. Progress is monitored in accordance with a colour coded key on the front cover where "blue" denotes "delivered".

"How we are checking that the Improvement Plan is working" summarises how the Trust is checking that the actions we are taking are being delivered and how the Board is assured that actions have been implemented and quality of service has improved.

Whilst the Trust has continued to progress the identified actions, some residual work remains to ensure actions are implemented in full and fully embedded.

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, note the progress against urgent actions and identify any further actions required.

The Dudley Group NHS Foundation Trust

Keogh Action Plan and Progress as at 30th October 2013

KEY
Delivered
On Track to deliver
Some issues
Narrative - Disclose delays/risks/plan to recover
Not on track to deliver

The Dudley Group NHS Foundation Trust - Our Improvement Plan & our Progress

What are we doing?

- The Keogh review made 39recommendations, of which 9 were urgent. A Risk Summit , chaired by Paul Watson(Regional Director – Midlands and East, NHS England) was held on 6th June 2013 and focussed on supporting the Trust in addressing the urgent actions identified to improve the quality of care and treatment. The Trust recognised all of the recommendations and has ensured that related actions are being addressed by the Trust to improve the quality of services provided to patients.
- Specifically, the Keogh review said that the Trust needed to:
    - Review current nursing and staffing levels using a nationally recognised tool and action any changes required for improving both the quality and safety of care.
    - Review the staffing levels on two large (72 bedded) wards and take action to split these into separate wards
    - Further embed a culture of learning from incidents, complaints and mortality reviews, including reviewing data more systematically to target improvements.
    - Review the complaints process and the way we respond to patients needs.
    - Fully embed patient safety and quality processes at ward level.
    - Review and simplify the Quality Governance processes and arrangements and communicate these to staff
    - Review the performance information required to obtain complete assurance on quality improvement

The Trust has responded positively to the review process with some urgent issues already addressed and many other actions in progress. The Trust accepted the findings and welcomed the support of risk summit members to increase the pace and focus of improvement. Further support was offered to develop clinical leadership with input from NHS England and the NHS Leadership Academy to embed accountability and ownership for quality improvement in the organisation.

- This "Plan and Progress" document shows our plan for making these improvements and demonstrates how we are progressing. It builds on the "key findings and action plan following risk summit" document which we agreed immediately after the review was published http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx.

Who is responsible?

- Our actions to address the Keogh recommendations have been agreed by the Trust Board.
- Our Chief Executive , Paula Clark, is ultimately responsible for implementing actions in this document together with the Executive Directors who provide the executive leadership for quality, patient safety and patient experience .
- Ultimately, our success in implementing the recommendations of the Keogh plan will be assessed by the Chief Inspector of Hospitals who will re-inspect our Trust during 2014.
- If you have any questions about how we're doing, please contact Paula Clark (01384 321012 or at communications@dgh.nhs.uk

How we will communicate our progress to you

- We will update this progress report monthly and will continue to hold a monthly Board meeting in public where we will update our local community on the progress we are making.
- We will share our progress with our Governors and stakeholders by providing regular updates and briefings
- We will update our staff by providing regular briefings, through our Trust magazine and via our intranet .

Signed by the Chief Executive of The Trust (on behalf of the Board)

.....

Paula Clark

The Dudley Group NHS Foundation Trust - Our Improvement Plan – October 2013

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
1. The Trust's quality governance arrangements are complex and were not embedded consistently below Board level	• The Trust should review its quality governance arrangements to develop and consider how it can embed these further at directorate and ward level	November 2013	Deloittes	The Trust commissioned Deloittes to review the Quality Governance arrangements and advise on best practice. The Board will consider the recommendations from this in November 2013.	
2. Systematic learning from incidents, reviews and complaints was not clearly evidenced by the Trust.	• The Trust should review how it can embed a culture of learning from incidents, RCAs, complaints and mortality reviews, including reviewing data more systematically to target improvements. • The Trust should also review its complaints process to ensure that it is fully addressing the Ombudsman's requirements and there is adequate resource to support this.	September 2013 October 2013	West Midlands Quality Network Clinical Commissioning Group Central Support Unit	A review has been undertaken and actions have been agreed. A review has been undertaken. The Trust complies with statutory requirements. An action plan is in place.	
3. The Trust's mortality review process is currently not identifying opportunities for systematic improvement	• The Trust needs to consider how it will review mortality data more systematically and use this alongside its learning from directorate reviews to target improvement actions more effectively.	October 2013		The Trust has revised the mortality review process and board report. Reporting is now comprised of mortality data, feedback from Directorate performance reviews and speciality mortality meetings. Local Speciality and Directorate level actions reflect a trust level log of ongoing actions in response to the data ,which is reviewed monthly.	
4. The Trust has capacity challenges which its operational management procedures are not addressing fully	• The Trust's system for bed management, patient flows and discharge need to be urgently reviewed and improved to address operational effectiveness issues and improve patient experience	October 2013	Emergency Care Intensive Support Team (ECIST) to review processes NHS England	Agreed ambulance handovers. Pilot schemes to improve flow to start from 1st November have been funded • Ambulatory Emergency Care •Capacity Management •Improved weekend medical cover	

The Dudley Group NHS Foundation Trust - Our Improvement Plan – October 2013

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
5. The Board's patient experience strategy needs further development and embedding at ward level.	The Trust Board has more work to do to agree a Patient Experience Strategy with clear performance metrics, embed this and demonstrate that it is effectively monitoring performance.	• Mid July 2013	Healthwatch Clinical Commissioning Group Stakeholder Event	Information gathered at event fed back to participants. Meeting arranged with CCG and Healthwatch to discuss strategy development and metrics	
6. The Trust's nurse staffing levels/skill mix need urgent review along with some other staffing issues identified.	•The Trust should review its current staffing levels for nursing and medical staff using a nationally recognised tool; it should then action any changes required for improving both the quality and safety of care. •There is an urgent action identified to make sure that nurse staffing levels are assessed using an evidence based methodology. This should be reviewed in conjunction with the clinical teams to ensure each ward has appropriate nurse staffing levels and the appropriate ratio of registered to unregistered nurses on all wards. •The Trust should review how it can improve engagement in the national staff survey. It should further review staff engagement in theatres, following up the external review undertaken in 2012.	• Sept 2013	No additional support was required.	• AUKUH (Tool to measure staffing levels) Data collected. • National Database not yet available. • Daily Nurse to Patient Ratio published on wards as per RCN Best practice.	
7. A number of the Trust's processes relating to patient safety and quality were not being consistently applied at ward level.	The Trust should review its processes to ensure all equipment and safety checks are undertaken appropriately.	• July 2013	No additional support was required.	• Delivered. • In Place. • Audit now embedded.	
8. Consistency of pressure ulcer care including prioritisation of patients and access to equipment	The Trust should review its processes to provide appropriate care and equipment for patients that are high priority for pressure ulcer prevention. The Trust should also audit compliance with its pressure ulcer care bundles	• July 2013 • July 2013	No additional support was required.	The Trust has reviewed pressure ulcer care bundles and implemented bundle usage and compliance as part of a monthly audit review. Audits are now part of the Forward Audit programme.	
9. Theatre Staff engagement.	The Trust has agreed to undertake a follow up review of theatres, specifically around staffing levels and response to an earlier whistle-blowing issue.	Sept 2013	No additional support was required.	•The Theatre investigation is complete. • External advisor contacted for a scoping exercise. • Initial safety checks implemented.	

The Dudley Group NHS Foundation Trust - How we are checking that our improvement plan is working

Oversight and improvement action	Timescale	Action owner	Progress
Independent External Review of Quality Governance arrangements by External Auditors.	Delivery November 2013	Director of Finance	
Monthly progress update report on Keogh actions by Lead Directors to Board.	Monthly	Executive Directors	
Mortality & Morbidity Reports to Clinical Quality Safety and Patient Experience Committee	Monthly	Medical	
Governors holding Board to account on all aspects of quality	November 2013	Governors	
Working with a range of partners, who are providing support on a variety of areas, including mortality levels and service quality. These partners include the Emergency Care Intensive Support Team, AQuA (Advancing Quality Alliance).	From July 2013 onwards	Executive Directors	
Monthly scrutiny by the Clinical Commissioning Group through Clinical Quality Review meetings.	Monthly	Director of Nursing / Medical Director	
Local economy level consideration of whether the trust is delivering its action plan and improvements in quality of services by a Quality Surveillance Group (QSG)	Monthly	Chief Executive	
Update reports to the Dudley Health Scrutiny Committee confirming progress against the Action Plan.	When requested	Director of Nursing	
Trust Reports to the public about how our trust is improving via briefings to local media and monthly public board meetings.	Monthly	Chief Executive	

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

on Thursday 7th November 2013

TITLE:	**Dementia – progress report**		
AUTHOR:	**Becky Edwards** Deputy General Manager, Medicine	**PRESENTER**	**Becky Edwards** Deputy General Manager, Medicine
CORPORATE OBJECTIVE: SGO1, SGO2, SGO3, SGO6			

SUMMARY OF KEY ISSUES:

The Medical Directorate Management team last presented to the Board of Directors on this subject in April 2013. This report provides the requested 6 monthly update on progress being made against the Directorate's previously articulated 3 point approach to improving Dementia care within the Trust.

The report shows consistent improvement against the national Dementia CQUIN, with achievement of the Find, Assess, Investigate, Refer element since June 2013. Carers surveys are underway and 41% have been completed against a year end target of 144.

A number of initiatives are being piloted by the Older Peoples Mental Health Team including Dementia Care Bundles and Dementia Champions to improve the care provided to patients with Dementia across the Trust. Following the establishment of a Dementia Project Group, the work undertaken to date on Mental Health Assessment is being reviewed.

The development of a Dementia unit as part of the Frail Elderly Pathway is still a priority and work is underway via an established project group to produce a business case for capital investment.

Progress against these actions is being monitored via the Long Term Conditions Steering Group.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description:** OP028 – confused patient(s) becoming agitated/aggressive OP031 – confused patient leaving ward/hospital

	Risk Register: **Y**		**Risk Score:** OP028 – 12 Op031 – 15
COMPLIANCE and/or LEGAL REQUIREMENTS		**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF THE BOARD OF DIRECTORS ARE:

1. Note the content of the report and progress being made with respect to the Directorate's 3 point plan on Dementia services

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

N/A

Background

The Board of Directors has received two previous reports regarding the work being undertaken to support patients with a diagnosis of dementia. Three key work strands had previously been identified;

1. Improved Identification (and diagnosis) of patients with Dementia
2. Improved care and treatment of patients with dementia
3. Improved environment of patients with dementia

In June 2013, Dementia was aligned to a Transformation project looking at a wide range of Long Term Conditions. At this point a further work stream was added in line with the requirements of the 2013/14 Dementia CQUIN;

4. To ensure appropriate support for carers of people with dementia.

This report provides an update on each of these work streams.

1.0 Improved Identification (and diagnosis) of patients with Dementia

The national Dementia CQUIN mandates that 90% of all emergency admissions over the age of 75 are screened for Dementia and are provided with appropriate follow up if required. This CQUIN has a potential income of £275,768 for the Trust.

The Trust struggled to achieve the 90% target in all areas and in June 2013 employed a Band 2 position on a temporary basis to support with this work. Since this investment the Trust has achieved over 90% in all areas for 3 consecutive months.

	Screening of all emergency admissions over 75	For patients identified at risk of Dementia - full assessment	Referred according to the Dudley Dementia Pathway
December	61.3%	100%	100%
January	69.78%	91.20%	100%
February	73.72%	100%	100%
March	71.25%	93.08%	100%
April	81.34%	100%	97.56%
May	83.04%	100%	100%
June	99.22%	100%	100%
July	99.36%	100%	100%
August	100%	100%	98.08%
September	99.6%	100%	100%

A business case has been produced to fund this post on a substantive basis or on a fixed term basis until the end of the CQUIN.

2.0 Improved Care and Treatment for Patients with Dementia

A number of actions have been taken since the update provided in April 2013 to improve the care of patients with dementia.

- The Older Peoples Mental Health Team have developed a care bundle which is being piloted on the acute confusion station on C3 with a view to being rolled out across the Trust.
- The team have invested in a stock of 'Dementia Survival Guides' produced by the University of Worcester which pulls together practical tips for supporting patients and carers in a pocket size guide.
- A 'Dementia Champions' initiative is being developed to spread knowledge and best practice across the Trust.

Work previously undertaken to establish a RAID type model is being reviewed following a lack of progress previously.

3.0 Improving the Environment for patients with Dementia

Following the unsuccessful bid for Department of Health funding to improve the environment for Dementia patients, the Trust has been fortunate enough to have benefitted from the input of Dr David Oliver, former Clinical Director for Older People at the Department of Health. The team is now working through a series of recommendations, one of which was to consider the development of a Frail Elderly Pathway. A visit to University Hospital North Staffordshire was undertaken in September where a Frail Elderly Unit and Dementia Unit have been established. In addition, a visit was arranged to a local Dementia Gateway in June to understand how the Local Authority has used best practice recommendations to make this environment Dementia friendly.

The development of a Dementia unit in the Trust is being led by the project group detailed below and once an agreement is reached on future location of services a business case will be produced to fund the capital investment required.

4.0 Ensuring appropriate support for carers of people with dementia.

The National Dementia CQUIN requires the Trust to undertake a survey to assess how well supported carers of people with Dementia feel. This CQUIN has a potential income of £ 55,154 for the Trust.

The Trust agreed to complete a minimum of 144 surveys across the financial year and starting using a standard questionnaire to measure how well supported carers feel from June 1st. As of 18th September 2013 a total of 59 surveys have been completed, 41% of the target. A minimum of 14 surveys per month is required for the next 6 months to achieve the full payment at the end of the financial year.

In addition a qualitative piece of work has been undertaken to explore the involvement of carers of people with Dementia in discharge planning. An action plan to address the findings from this work is now being completed.

5.0 Future Plans

In summary, the following work is a priority for the Trust in 2013/14 to ensure Dementia services are of the highest quality across the Trust:

- Continue to work with both commissioners and Mental Health colleagues to develop a Mental Health Assessment team that builds on the principles of RAID.
- As part of the Frail Elderly Pathway development, include the concept of a Dementia unit and changes to the environment for consideration.
- Roll out of Dementia bundles
- Roll out of link nurse

6.0 Monitoring Progress

A project group has been established to drive forward these developments. The project group includes nursing, medical and managerial input and will provide regular updates via the Long Term Conditions Steering Group.

The Dudley Group NHS
NHS Foundation Trust

Appendix One

CQUIN Performance Summary

The national Dementia CQUIN is split into three sections;

- Find, Assess ,Investigate and Refer
- Clinical Leadership
- Supporting Carers

This CQUIN also addresses two of the identified work streams detailed above;

- Improved Identification and Diagnosis of patients with Dementia
- Improved support to carers of patients with Dementia

	Required performance	Current Performance	On target for achievement	Risks to performance
Find, Assess, Investigate, Refer	>90% of emergency admissions over 75 screened for dementia, assessed appropriately and referred where necessary	>90% in all 3 areas since June 2013		Band 2 post currently funded to achieve target. Risk to performance if business case is not approved
Clinical Leadership	Named Clinical Lead Training Programme Approved	Mandy Aworinde named as clinical lead for dementia. Training programme agreed with CCG in April 2013		Non Identified
Supporting Carers	144 carers surveys to be completed by end of March 2014	Carers surveys started June 1st 2013. 59 completed to date. 41% of target achieved		Non Identified. 15 completed surveys per month required

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 07/11/2013

TITLE:	**RESEARCH & DEVELOPMENT**		
AUTHOR:	**M Marriott, R&D Facilitator/ G Kitas, R&D Director**	**PRESENTER**	**Paul Harrison, Medical Director**

CORPORATE OBJECTIVE: **SO1 through to SO6 (research seeks to improve all aspects of patient care)**

SUMMARY OF KEY ISSUES: Update on research funding, recruitment, training, activity, staffing

IMPLICATIONS OF PAPER:

RISKS	**Risk Register** **No**	**Risk Score**	**Details:**
COMPLIANCE	**CQC**	**Y**	**Details:** Evidence to support compliance with Essential standards of Quality & Safety Outcome 16 – Assessing and monitoring the quality of service provision.
	NHSLA	**Y**	**Details:** Staff working on approved studies will be covered by normal NHS indemnity arrangements.
	Monitor	**Y**	**Details:** R&D activity included in the Annual Report.
	Other MHRA	**Y**	**Details:** SAEs for all drug/device studies are reported on study by study basis to MHRA by study sponsor

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	✓		

RECOMMENDATIONS FOR THE COMMITTEE:

The Board is asked to receive the report and approve its contents.

The Dudley Group NHS
NHS Foundation Trust

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS ON 7TH NOVEMBER 2013

RESEARCH & DEVELOPMENT REPORT

Summary

The Research & Development Directorate (RDD) has continued to open large numbers of observational studies in order to maximize recruitment. The new R&D Facilitator, Rebecca Storey, has been identifying suitable studies, liaising with departments that wish to expand their research portfolios and re-organising the internal financial reporting structures of RDD. There is a new impetus to boost recruitment to Dermatology, Diabetes and Gastroenterology studies, built on availability of research nurses employed by the Comprehensive Local Research Network (CLRN) and funding for nurses already employed by DGNHSFT.

BBC CLRN NHS Acute Trusts	Recruitment target ABF yr 01/10/12 – 30/09/13	Recruitment units 01/10/12 – 30/09/13 as of 02/09/13	% share of recruitment units	Provisional ABF funding 2014/15 £	Difference £
Dudley Group	9000	7240	6.29	404,608	-3,390
Heart of England	20293	33098	28.74	1,848,716	784,343
Sandwell & West Birmingham	9158	9606	8.34	536,475	-127,925
University Hospitals Bham	19000	19038	16.53	1,063,301	-171,372
Walsall Healthcare	1851	2159	1.87	120,289	29,766

*Weighted for study complexity. Complete data unlikely to be available until November 2013.

Activity (from 01/10/2012 to 31/08/2013):

National Institute for Health Research portfolio studies only:
Number of recruiting studies as of 16/09/2013: 79: 71 academic; 8 commercial
Closed studies still collecting data: 51 (A) 8 (C).
Recruiting non NIHR studies: 15 academic; 8 commercial
Publications for 2013 calendar year to date: 61(this figure includes conference posters and articles)

Education and Training:

The Trust continues to host Good Clinical Practice (GCP) training, both full day and refresher courses. On 20/05/2013 a promotion for International Clinical Research Day took place across two sites of the Trust, marking the beginning of a year of

raising research awareness amongst DGH staff and patients. We also hold awareness sessions at the Health Hub.

The Clinical Research Unit laboratory gained Good Clinical Laboratory Practice accreditation in May 2013, thanks to the hard work of Jackie Smith, Chief Research Biomedical Scientist. The scheme is aimed at those laboratories who wish to demonstrate to sponsors of clinical trials and government agencies worldwide that the clinical laboratory operates to a standard that assures the reliability, quality and integrity of the work and results generated.

Research Governance Implementation:

A total of 36 studies were assessed by the protocol review sub-committee between 09/04/2013 and 16/09/2013.

Reported Serious Adverse Events:

Oncology/Haematology: 2
Cardiology: 11
Chemical Pathology: 4
Dermatology: 1

Issues:

R&D support for setting up new studies and processing study amendments has been reduced for the last 8 months following the departure of a full time Band 4 Research Support Officer. Due to staff reconfiguration within R&D, this post is now to be replaced by a Band 3 Administrator.

Archiving space has been at a premium for some time; during the next few months time will be devoted to restructuring the archive and placing documentation for completed studies in storage outside the Clinical Research Unit.

New Cross R&D Department has approached DGH to fund a research nurse for a new NIHR vascular study. We will seek assistance from the CLRN research nurse pool in the first instance.

There are currently capacity issues regarding additional ultrasound scans in radiology.

Recommendations

The Board of Directors is asked to receive the report, note the issues raised, and approve its contents.

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th November 2013

TITLE:	**Board Assurance Framework – October 2013**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Paula Clark** **Chief Executive**

CORPORATE OBJECTIVES: ALL

SUMMARY OF KEY ISSUES:

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

This report identifies the Trust Assurance Framework and specifically:

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

In addition to the operational risk registers (reported to Risk and Assurance Committee) the Directors are currently managing 21 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (8 risks in total). The report shows the assurance to date of the effectiveness of the management and control of these risks. Action plans are in place, or being developed to address any gaps in control or assurance identified at this time. New assurance / updates highlighted in yellow

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD:

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

THE DUDLEY GROUP NHS FOUNDATION TRUST
BOARD ASSURANCE FRAMEWORK – RISKS SCORING 20 AND 25 as at OCTOBER 13

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR045 **25** **Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	1. Diabetes management plans formulated by DOT Team and written in patients notes.	1/2. National external diabetes annual audit.	1.National Diabetes Inpatient Audit 2012 and National external diabetes annual audit results.(March 13) 2) CQPSE Cttee April 13 National Diabetes Inpatient Audit shows overall continuing improvements in diabetes care, Nationally the Trust ranks highly on the majority of outcomes. It is believed to be related to the impact of the Front Door Diabetes Team and the protocols developed in the Trust as part of the Think Glucose project. 2. Audit Committee May 13 - Annual Clinical Audit report 2012/13		1 / 2. Staff do not follow guidelines, surgical pre-assessment do not refer patients in timely manner to enable optimisation of diabetes control pre-theatre.	2. Ensure diabetes assessment is a mandatory part of the new nursing EPR, and monitor Nursing Care Indicators.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **20** **NEW Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	3. Standardised insulin administration and testing equipment within Trust	2/3. National external diabetes annual audit.	As above			
			4. Diabetes protocols and guidance available on Hub for staff to use	4.Policies and guidelines	4. Monthly NCI audits of THINK GLUCOSE There is a review group meeting regularly to formulate local policy/guidelines for surgical patients Blood Glucose and Ketone Monitoring Chart in place in clinical areas			4 Produce urgent Care Bundles for diabetic Ketoacidosis and Hyperkalemia. 4 Produce guidelines and load on Hub for: • Surgical Management of Diabetes • Hyperglycaemia • Self-administration of Insulin
			5. Staff training for diabetes on induction and then 3-yearly updates monthly updates for staff attendance now available for ward and department managers to monitor attendance compliance.	5. Mandatory Training records. 5 Mandatory training reports	5. Training registers and evaluation sheets 5.Diabetes update sessions records 5. Completed training included in April 2013 mandatory training reports	5. Mandatory training records show 38.7% at Sept 12	5. Staff do not always attend mandatory training	
			6. Link Diabetes Nurses on all wards.	6. Champions list	6. Think Glucose Champions on wards.			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **20** **NEW Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	7. Staff responsible for prescribing, preparing and administering insulin are trained before doing so. (NPSA/2010/RRR013).	7. Mandatory Training Records		.	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	7. Improve knowledge and training of MAU and ED staff in the management of acute diabetes complications. 7. Ensure all medical staff who prescribe, prepare and administer insulin are trained 7 Improve Medicines Reconciliation Service on EAU.
			8. Datix monitoring for trends.	8. Datix Reports.	8.Quarterly aggregated report of incidents to CQPSE 8.Monthly Serious Incident Reports to CQPSE 8. Monthly Summary of key issues arising from CQPSE to Board	Increase in diabetic related incidents Datix trend reports and reports from the diabetes outreach team have identified issues with inappropriate management of diabetes,		
			9. Pharmacy Audit for missed doses and insulin errors.	9. Audit reports from Pharmacy	9. Annual Audit Results 9. Nurse Care indicator report to CQPSE (Medication)			
			10. Nursing Care Indicators monitor Trust compliance with diabetes screening for each patient admission, reports sent by Nursing Directorate to Diabetes Team.	10. Nursing Care Indicator Audits	10. Monthly NCI audits of THINK GLUCOSE CQSPE - May 2013 "The greatest improvement has been in the Think Glucose criteria with an increase of 26% on previous year's performance (79% compliance)."			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. **COR045** **20** **NEW Lead Director : R Cattell**	Diabetic Management	CQC Outcome 4,6,16	11. ED and EAU undertake routine blood glucose for all new admissions as part of their biochemical test screen. 12. Diabetes Outreach Team available for advice Mon – Fri 9am to 7pm and Saturday 9am to 5pm. Referral process in place.	12 Audit of patient referrals to Diabetes Outreach Team.	11. Effective from 13/03/13 12.Audit Results			

Board Strategic Theme: Patient experience	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG02: To provide the best possible patient experience	a) Mobilising the workforce with a passion for getting things right for patients every time	Section C: Clinical and Quality Strategy. Appendix 3E	Outcome 12, 13, 14	CQSPE
		b) Creating an environment that provides the facilities expected in 21st C healthcare and which aids treatment and or/recovery	Appendices 3 C & 3F	Outcome 8 Outcome 10	CQSPE
		c) Providing good clinical outcomes and effective processes so that patients feel involved and informed	Section C: Clinical and Quality Strategy.	Outcome 1,4	CQSPE

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

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

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

Board Strategic Theme: Clinical Partnerships	Strategic Goals		Key Priorities			Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG04: To develop and strengthen strategic clinical partnerships to maintain and protect our key services		a) Demonstrate a distributed leadership model with empowered clinical leaders			Section G: Leadership & organisational Development	Outcome 12, 13, 14	CQSPE
			b) Promoting risk sharing with CCGs			Appendices 3a & 3d	Outcome 6	F&P
			c) Developing clinical links with local GPs and healthcare practitioners			Appendix 3d	Outcome 6	CQSPE
			d) Develop new clinical networks that provide resilience through a more distributed service model			Appendices 3a & 3d	Outcome 6	F&P
Risk Ref	**Risk Description**	**Monitor / CQC / NHSLA ref**	**Current Controls**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**	**Gaps in Control**	**Mitigating Actions**
COR003 (OPO90) **Score 20** **Director : R Cattell**	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	1.Re-designation of surgical beds to medicine has taken place. 2. CD/MSH review of elective admissions to prioritise if cancellations are imminent. 3. New capacity management system partially deployed. 4. Discharge Co-ordinators DISCO.	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	**Reports to Board** April 13 - Transformation Report May 13 Estates Strategy Finance and Performance Reports 2. Capacity Team operating training and Capacity HUB area 3. New operating model for capacity meetings 4. Multi agency discharge planning forum meeting minutes. 4. Discharge Process/policy	4 Database only covers Dudley patients	1. Occasional inability to protect surgical beds. . 3. MSH/medical staff not consistently engaged in Capacity Management. 3 Poor attendance at capacity meetings	1. 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)

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR003 (OPO90) **Score 20** **NEW Lead Director : R Cattell**	Urgent care demand exceeds capacity	CQC Outcomes 4 & 6	5..Escalation Policy and contingency capacity policy reviewed and deployed 6. Daily capacity meetings. 7. Work with primary care and commissioners to curtail urgent care demands, provision of virtual ward etc. 8. Directorates SOP 9. Admit on the day of surgery to reduce pre-op LOS 10. IST recommendations roll out	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 Managers.	5."Ready to go " - Information on patient discharge pathways available on the HUB **7. Board April 13** - Transformation Report (including update of Urgent Care Redesign Project). **Board June 13** -Transformation Report (including update of Urgent Care Redesign Report		5 Understanding of policies by all staff 6.Bed/Capacity Management approach/systems not aligned to predictive demand management within specialities/wards locally 7. Failure of all parties to contribute. 7. Failure of partners to agree Surges in Emergency surgical activity demand Delayed Transfer of Care remains above MOA Delayed Transfer of Care for Sandwell patients	5 Discussion at capacity meetings. 7. Engagement with all partners of all members of urgent care team from DGH

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR007 (OP080) **Score 20** **NEW Lead Director : R Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	1. Daily monitoring of the delayed discharges via the delayed list, ensuring its accuracy and that challenges by the ward to the patients care is being managed and escalated appropriately. 2. Ward-based Discharge Team support and plan discharge. Use of estimated discharge at ward level. Escalation to Medical Service Head as appropriate. 3. Lead Nurse meetings with patients and relative to identify needs for discharge.	1. Escalation meeting daily at 9.15am. Information available on the HUB	1.Daily Delays report. 1. Monthly KPI reports to F &P on bed occupancy & medical outliers. 1. ED targets (part of performance information to monthly Board meetings)		2.Poor service cover from multi-agency Discharge Teams because of vacancy, sickness, leave etc resulting in further delays. DISCO database. 2. Not ubiquitous cover across hospital 3. Patient or relative exercising "choice" exacerbates problem.	2 .Oversight by capacity team, escalation to Director of Operations. 3 Use of standard “expectations letter” Lead nurse contact

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR007 (OP080) **Score 20** **NEW Lead Director : R Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	4. Early notification to LA via Section 2 to prepare for patients likely needs	4.Section notifications	4. Timeliness of Section Notifications			4.Early understanding of financial constraints from Local Authority and planned use of new re-ablement monies to increase current capacity and response from local authority.
			5. MOA - Local Authority and PCT signed off.	5 MOA	5. Signed MOA 5. Urgent Care Programme Board Minutes and actions April 2013		5 DMBC overseeing a higher than agreed number of patients.	5 Escalation of issue to Director level.
			6. Agreed health economy escalation plan.	6.Escalation Plan	6. Compliance with Escalation Plan			
			Provision of training on compliance with the escalation plan.	6.Training Records	6.Training undertaken May 2012			
			Issue of letter to prepare patients and family for discharge arrangements	6.Letters to Patients				
			7. Utilisation of independent company Care Home Select (CHS) to support patients/relatives in identifying suitable 24-hour care placement. Matron/Lead Nurse ensure that understanding of discharge processes is provided by all nurses/carers.	7. Integrated Care Group Minutes and actions.				
			8. Daily multi-agency teleconference at Level 2 or above.		8. Notes of meeting			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR007 (OP080) **Score 20** **NEW Lead Director : R Cattell**	**Unable to admit emergency patients due to externally caused delayed discharge/transfer**	CQC Outcome 6	9. Directorate solutions to manage delayed discharge. 10. Training of Bed Managers and Discharge Facilitators across Directorates. Escalation of issue to Director level.	9.Acute Medical Unit 9. Provision of non acute care 10.	**Acute Medical Unit Business Case - Board 6th Oct** **Acute Medical Unit Business Case - F&P 25 Oct** **Additional Board** - July 12 Provision of Non Acute Care report – exploration of Trust options. None recurrent winter pressure monies secured on LHE initiatives, into all of 2013/14	9.Funding for 13/14 can only be provisionally agreed as it is unclear what elements of the reablement money will be available.		Working with CCG and LA to manage delayed discharge database, improve admission prevention SW input. Also X Refer to the Transformation Action Plan.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR053 (OP052)	Failure to maintain 18 week Pathway		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.	18 week reports. Directorate dashboard.	Key Performance Target reports to F&P monthly Monitor Risk Rating		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.	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.

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR026 **Score 20** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	1. Ward staffing levels have been reviewed with Matrons and presented to the Board. The Trust has committed to use the AUKUH / Safer Nursing Care tool 2. Rosters managed and monitored. Matrons and Lead Nurses, midwives & AHP Leads identify shortfalls in staff levels and rectify 3. Significant investment in the workforce. Mass recruitment undertaken.	1.Staff Survey Results 2 / 4 Datix Incident Reporting captures shifts with staffing concerns reported to CQPSE Committee 3. Financial investment made in high risk wards in medical directorate.	Workforce KPIs reported to F&P monthly. **CQSPE Committee** – May 2013 National Staff Survey - Update on Activity CQSPE - May 2013 Aggregated Report of incidents **Board May 13 -** F&P Report **Income & Expenditure Position – Year to 31:03:13 (Appendix 5) and investment in front line staff.** The Trust has successfully recruited in excess of 50 graduates and qualified nurses	1/3.Nursing skill mix review for specialist departments will conclude in April. Further investment is likely. 1/3.Nursing skill mix review for specialist departments will conclude in April. Further investment is likely.	1 Staffing levels fall below acceptable safe levels.	1 / 3 .Explore investment opportunities. 1. Use of AUKUH/Safer Nursing Care tool 1 / 3 .Explore investment opportunities.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont. COR026 **Score 20** Lead Director: Denise Mcmahon	Nurse Staffing levels are sub optimal in certain areas.	CQC Outcome 13	4. Nurse bank established. 5. Continue to use bank staff to cover vacancies. Move staff to under resourced areas. 6. Accredited training programme established for novices and new graduates. 7. Actions plans developed. 8. Matrons report to Board and Nursing Care Indicators to CQPSE.	2 / 4 Datix Incident Reporting captures shifts with staffing concerns reported to CQPSE Committee 5. Agency expenditure remains low. (Reports on agency staffing at F&P Committee). 6 Training Records 8. Nursing Care Indicators reported at least quarterly to CQPSE. 8.Monthly Matrons presentation to Board	Reports on agency staffing at F&P Committee. **8.CQPSE** NCI reports – Aug, Nov 12, Mar 13, May 13 - 12 wards on level 1 escalation, 4 wards on level 2 escalation. 8.Matrons report to Board (monthly)	**F&P Committee – May 2013 - Income & Expenditure Summary April 2013 Agency (medics, qualified and unqualified and others) spending and trends reported. Upward trend in all but Medics.**		4 / 5 Use of Bank Staff to cover shortfalls. 4 / 5Use of Bank Staff to cover shortfalls. 6 Continue with pro-active vacancy management for both graduate posts and novice programme.

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR 034 **Score 25** **Lead Director: P Assinder**	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £15.5m (5.5% of budget). The Trust has made a poor start to the year's CIP Programme (£1.8m off plan at Month 4). This has continued into month 05 (£2.361m behind plan) although part of this shortfall relates to a timing issue linked to the requirement to have a fully signed off Quality Impact Assessments before budgets can be removed from the ledger. It is anticipated that there will be a much improved performance in September that will claw back the majority of the shortfall.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1. The Board has approved a programme of CIP savings proposals.	1. Board and Board Committee Reports. Monthly CIP updates to F&P Committee including attendance by Directorates to present their latest position	**1. F&P Committee** -Jan 13 - Financial projections 2013/14 onwards -Feb13- Report on IT CIP) -March 13 – Financial Plan March 13 - Financial Budget Package 2013/14 April 13 - Income & Expenditure Summary Draft Outturn 2012/13 May 13 - Income & Expenditure Summary April Monthly CIP reports to F&P	1 Absence of alternative CIP schemes to 'call forward' when slippage occurs. Future years CIP schemes require further development to enable them to be brought forward. Absence of a clear understanding of Commissioner's roles in CIP quality assurance CIP Directorate Presentation – Specialty Medicine F&P 26 Sept 2013	1. After the first 4 months of 2013/14, delivery of the CIP target is behind plan. Whilst some of this is attributable to a timing difference linked to the QIA process, concern is increasing as to the deliverability of the programme in the current financial year (particularly organisation-wide schemes).	1. Horizon scanning of potential new saving ideas commenced. Initial look at using an external company to pay agency medics resulting in a VAT saving (information supplied and seeking to arrange meeting for October). Development of a process to promote successful CIP ideas that have worked well in other organisations with a challenge to apply here. Brand developed - requires rollout of ideas

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont . **COR 034** **Score 25** **Lead Director: P Assinder**			2. A Programme Management Office (PMO) capability is established and has been operating effectively for some months.	2. PRINCE level project management of individual schemes.	2. Transformation & CIP PMO established and resourced	2. Full alignment of Commissioner's QIPP and Trust CIP schemes. 2.Delays in agreement of schemes & delivery by PFI Contract Efficiency Group	2. Some schemes remain to be fully developed and implemented. Some schemes will deliver benefits that are unlikely to yield cash savings in 2013/14.	1. Detailed monthly progress reports prepared. 2. The Trust is seeking transitional funding support from the local CCG of £3m.
	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £15.7m (5.5% of budget). A Transformation, IT and Traditional CIP combined Programme of £15.3m, 5.9% of budget has been developed. This has a very high risk of failure.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	3. Regular reports are made to the Board's Finance & Performance Committee, Directors and TME.	3 Detailed scrutiny of Directorate and Corporate CIP Schemes at Directorate Performance Review Meetings and weekly Directors Meetings. 3 Reports to TME 3 Meetings held with each Directorate chaired by the Director of Operations.	3.**F&P Committee** 2013/14 Financial Efficiency paper 29th Nov 2012 3. Financial efficiency process and plans (Jan 13)	Some concern that schemes include a level of duplication between Directorate specific plans and Corporate-wide savings. .	3. Many schemes are not recurrent creating pressure in future years. 3. The efforts of managers and Trust staff is diverted on the management of day-to-day operational pressures rather than the achievement of efficiency savings.	Forecast sessions to be held with Directorate Finance Leads to test robustness of year-end estimates and CIP Plans, including the requirement to demonstrate a bridge analysis of monthly movements from plan and previous forecasts.
			4. All CIP proposals are risk-assessed for impact upon clinical standards and signed off by the Medical Director and Nursing Director.	4.CIP Risk assessments	4 CIP risk assessments (2013/14) **4.F&P Committee** Financial Plan (March 13) March 13 - Financial Budget Package 2013/14	4.Completion of quality risk assessments		

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
			5. General Managers are required to attend the QIA sessions to offer additional advice & understanding on schemes. 6. 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. 7. A programme has been scheduled for each Directorate to attend F&P Committee to update members on their progress. 8. Separate sessions have been co-ordinated by the Director of Operations with each Directorate to assess the achievability of current plans, the possibility of exploring future opportunities and planning for future years.		Example CIP QIAs Cost Improvement Programme (CIP) Identification, Monitoring and Reporting RSM Tenon Audit Report 12.13/14	Some Directorates have failed to achieve CIP targets. directorate		
Risk	**Risk Description**	**Monitor /**	**Current Controls**	**Sources of**	**Positive**	**Gaps in**	**Gaps in**	**Mitigating Actions**

Ref		CQC / NHSLA ref		Assurance	Assurance	Assurance	Control	
			9. CIP/Transformation Team in place. Traditional and service re-design and drive towards Lean. Support on longer term CIP opportunities by the Transformation Programme. 10. Monitor approval of plan.	Session held in May to scope methodology and deliverability of length of stay savings culminating in plan of closing 60 beds by Halloween as a result of efficiency gains. 10. Monitor approval of plan.	Transformation Programme update _ Sept F&P 10. Monitor Finance and Governance Risk Ratings			

Risk	Risk Description	Monitor /	Current Controls	Sources of	Positive	Gaps in	Gaps in	Mitigating

Ref		CQC / NHSLA ref		Assurance	Assurance	Assurance	Control	Actions
COR 42 **Score 25** **Lead Director:** **P Assinder**	Failure to deliver financial balance in 2013/14as a result of further efficiency abatement to NHS Tariff and clinical cost pressures, the Trust is required to deliver unprecedentedly high cash releasing Cost Improvement s in 2013-14. A Transformation, IT and Traditional CIP combined Programme of £15.3m, 5.9% of budget has been developed. This has a very high risk of failure.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1. CIP in place. 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.	1. Monthly Progress reports 2. Minutes of Transformation Project Board 3/4.Transformation & CIP PMO established and resourced. 5.Monthly Progress reports	1 F&P Committee – May 2013 Income & Expenditure Summary April 2013 **2/3 Board – 1st Nov** Transformation programme Structure Report and 4th April 13 Transformation Programme Board 2/3 Board – 6th June 2013 Transformation Programme update 3/4Transformation Project Board inaugural meeting January 2013. 5. F&P Committee – May 2013 Income & Expenditure Summary April 2013	Audit Committee May – Deloitte Report 3. /4Delivering widespread clinical change will be a cultural 'hearts and minds' issue that is notoriously difficult to measure.	3 / 4 Given the transformational nature of savings schemes in 2013-14 the increased participation of clinicians in promoting clinical practice changes is essential. Whilst the vast majority of clinicians are on board the pressure from increased activity and maintaining high clinical quality standards may impact on their ability to be fully involved in the process. 5. The controls have delivered effective CIP savings schemes in previous years but size of the savings target is greater and the need is for greater transformational change to deliver sig financial benefit.	3. Directors to take personal responsibility for the delivery of individual CIP projects.

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR043 Score 20 Lead Director: Paul Assinder	The Trust will be working to a much more onerous NHS Standard Acute Contract in 2013-14 than hitherto. The DoH and NHS England have already declared that CCGs MUST invoke financial penalties for non-compliance issues, including: • Never Events • Infections • Re-admissions • RTT waits over 52 weeks • 18 weeks RTT • Cancelled Operations Crystallisation of this risk will have a major impact upon the Trust's income in 2013-14 and seriously compromise financial stability. Target performance levels for 2013/14 set by DoH are extremely challenging for infections.	Monitor Compliance with Terms of Authorisation Financial Risk Rating	1 Detailed monthly monitoring of exposure to penalties by Directorates and Corporate Information Teams. 2 Escalation procedure of risk issues to Directors. 3 Regular performance reports to Directors/F&P Committee and Board 4 Corporate and departmental dashboards in place for monitoring. 5.Breach analysis and reporting regime in place	1. Independent audit scrutiny of data capture and reporting. 1. Monthly discussions with Commissioners. 2. Directorate Performance Review Meetings 3. Detailed monitoring by commissioners and strict escalation and investigation of breaches regime in place.	An interim balanced score card is now in use. A new performance management framework will be fully deployed by Q3 of the 2013/14 financial year	1. In the absence of clear targets and definitions, data capture and reporting processes may be inadequate. 1. The Commissioners have initiated penalties in the first 2 months of the year for A&E and Ambulance breaches	2 Continuous increases in emergency activity compromise effective risk management processes. 3 Clinical Departments are not sufficiently sighted on such performance risks and target achievement is always subservient to safety and quality concerns Poor / inadequate IT solutions in place to provide constant monitoring of target achievement in certain instances.	1 We are currently (June 2013) seeking to negotiate with Commissioners deployment of any funds recovered through the imposition of fines / penalties (Concludes April 2013). 2 Undertake detailed assessment of exposure for each potential penalty and develop agreed escalation and mitigation strategies (May 2013).

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Report of the Governor Development Group to the Council of Governors

7th November 2013

TITLE:	**Defining and Developing the Governor Role at The Dudley Group**		
AUTHORS:	**Governor Development Group**	**PRESENTERS**	**Mr Badger & Mr Johnson**

CORPORATE OBJECTIVE: (*Please select from the list on the reverse of sheet)*

To ensure best corporate governance practice

SUMMARY OF KEY ISSUES:

The Trust is required to define and publish the Role of Governor at The Dudley Group NHS Foundation Trust following the Health and Social Care Act 2012 and the reports of Sir Robert Francis and Sir Bruce Keogh.

The attached report from the Governor Development Group sets out their considerations and recommendations for discussion and/or approval by the Council of Governors and Board of Directors. It sets out the current position and identifies areas for future development.

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

RISK	**Y**		**Risk Description: The Keogh report represents significant reputational risk to the Trust**
	Risk Register:		**Risk Score: Keogh Review risk**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details: Governance / Licence**
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	**Approval**	**Discussion**	**Other**
	x	x	

RECOMMENDATIONS FOR THE Council:

The Council is asked to consider the report's recommendations.

DRAFT

The Dudley Group NHS
NHS Foundation Trust

Report of the Governor Development Group to the Council of Governors and Board of Directors

The Role of Governor at Dudley Group

"Governors should consider how they can be more proactive in their role of holding the Board to account on all aspects of quality" **Sir Bruce Keogh**

1. The Review of the role of Governors in Dudley

The Health and Social Care Bill's passage through Parliament, in 2011-12, generated significant discussion around the future role of the Foundation Trust Governor. In the event the subsequent Health and Social Care Act 2012 made only a few, but nevertheless significant, changes to that role and to a great extent these have already been addressed by the Board of Directors and Council of Governors in Dudley (*Governor Role Description*, June 2013 refers).

Notwithstanding this national inertia, the Board of Directors and Council of Governors, in sensing a trend towards increasing expectations of the governor role within the NHS community and amongst various regulators, commissioned the Governor Development Group (GDC) to consider the future role of governor, in the light of the 2012 Act and to make recommendations for change, as appropriate.

Moreover, it is now clear from a variety of sources, including CQC, Monitor, NHS England, Sir Bruce Keogh and Sir Robert Francis, that there is an expectation that Foundation Trusts will develop the role of governor in a way that adds greater value to patient experience and service quality. In particular, it is expected that in future governors will assume a greater role in setting quality standards in foundation trusts and assure themselves and the wider community that such standards are being adhered to.

This report considers the role of governors in Dudley, following the passing of the 2012 Act but of greater importance, following the reviews of Sir Robert Francis QC and Sir Bruce Keogh.

DRAFT

2. Primary and Secondary Governance in Dudley

Upon the formation of the Foundation Trust in Dudley it was agreed to establish a small group consisting of governors, executive directors and non-executive directors to promote the developing relationship between Governors and the Trust and to ensure that key matters would be anticipated and addressed. The Governor Development Group (GDG) fulfils this role, reporting to the Council of Governors and the Board of Directors as appropriate. This process is designed to ensure that Governors have a clear voice in the development of governance matters within the Trust.

In 2010/11 after three years of operation, the GDG proposed a full review of respective roles, relationships and processes within the Trust. At this time governors and directors were acknowledged by the Group to have worked well together. However, governors were increasingly challenging the GDG to review the governor role in the light of research from the FTGA as well as other Trusts.

The Council of Governors commissioned a formal review of the role of governors in 2010. The Review's terms of reference were agreed through GDG and Deloitte were commissioned to ensure an external independent presence throughout the process. Governors were each given an opportunity to be involved through specifically designed workshops and these were very well attended and 'animated'.

Deloitte's conclusions were virtually universally well received by both governors and directors, with a small number of exceptions (notably amongst governors who saw their own role ending as a result of proposed structural changes to Council). The major recommendation was a significant reduction in the size of the Council (which had been amongst the largest in the FT community) and a revision of the CoG committee Structure.

During the process of the 2010 Review, the terms "Primary and Secondary Governance" were defined to distinguish the differences in roles between directors and governors. These concepts have proved extremely beneficial in the subsequent deployment of governors and non-executive director roles and responsibilities within the Trust. Deloitte representatives certainly considered this notation a suitable methodology for defining boundaries of activity between these important groups. These principles remains valid and provide a useful foundation from which to review current practice.

The Review's recommendations were fully implemented and the new structure of the Council of Governors and the governor role have now been operating effectively for over 18 months.

It is noted however that several new governors, elected or appointed since 2011/12, have joined the Trust at a time of animated debate about the future statutory role of governors. Nationally, all sorts of additional statutory and non statutory responsibilities have been mooted and of course new governors do not enjoy a background of the discussions and debates of the Deloitte Review and the developed concepts of secondary governance. As a result this terminology, which found a high level of support in 2010, now finds mixed reaction amongst Governors, whilst Directors, largely an unchanged group since 2010, remain comfortable with the principle.

DRAFT

3. The Challenge of Francis and Keogh

In addition to the formal changes made by the 2012 Act, a significant new external drive for reform has arisen, both directly and indirectly, from the Second Report of Sir Robert Francis QC into the Mid Staffordshire Enquiry (the Francis Report) and from the investigation into 14 Trusts, including Dudley, with apparent excess unexpected deaths by Sir Bruce Keogh, the Chief Medical Officer of the NHS (the Keogh Review).

The Francis Report into Mid Staffordshire made general recommendations for the NHS in its entirety and states -

> "*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.*
>
> *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."* *(1)*

The Keogh Review into Dudley Group observed that:

> *"The governors* (in Dudley) *who attended the focus group appeared well briefed by the Trust and noted a transparent relationship with the Board. They could articulate their current focus on collating patient experience stories and understanding of some of the Trust's quality priorities, especially pressure ulcers. However, the governors could not provide examples of where they had challenged the Board and requested further information and assurance, in particular on areas of quality and patient experience. The governors also were not fully aware of the impact of the integrated community services on the Trust's operations and staff.*
>
> *Governors should consider how they can be more proactive in their role of holding the Board to account on all aspects of quality"* *(2)*

Essentially Francis and Keogh, though not prescriptive in form or function and thus providing the opportunity for local agreement on how the role should develop, have a clear expectation that governors of foundation trusts will in future *"make a* (greater) *difference"* *(1)* in the experience of patients and other service users. In particular, in the words of Keogh, "*Governors should consider how they can be more proactive in their role of holding the Board to account on all aspects of quality"* *(2)*

DRAFT

4. The Governor Development Group's Review

The Council of Governors commissioned the GDG to undertake the review and to report back to full Council on 7th November 2013.

A meeting was held on 30 July to which all governors were invited, with the objective of understanding the implications for governors of the Health and Social Care Act 2012; the 2 Francis Reports' and their recommendations; and findings of the Keogh Review; and preparing a Governor perspective on the current position and requirements.

At the meeting, which was in the form of a discussion and workshop, Governors agreed the following terms of reference for the review:

1. To undertake the Annual Review of Council of Governors' effectiveness for 2012/13
2. To consider how the Council can most effectively discharge it's statutory responsibilities particularly related to the new requirements contained in the Health and Social Care Act 2012
3. To review current arrangements for Governor participation and challenge in the quality agenda

GDG has debated these issues in detail, taking soundings from existing governors and directors accordingly. Interim conclusions were presented on 29th August 2013 at a meeting of the GDG with Paula Clark and Paul Assinder. Additional discussion followed between the Lead Governor and Deputy Chairman, followed by a further meeting of the GDG on the 19th September 2013. That meeting agreed the principles upon which this report is based.

The GDG Review also undertook an analysis of how governors currently undertake their roles and seek to satisfy the requirements of the 2006 and 2012 Acts. **Appendix A** – captures the Statutory Roles and Responsibilities of the Council of Governors, as set out in the 2006 Act, and updated with additional items from the Health and Social Care Act 2012.

GDG's key conclusions are as follows:

Recent events have highlighted the importance of the role of the Council and the contribution that governors can make to governance and the assurance processes. Consequently, governors have become increasingly aware of their responsibilities to Members and the staff who elect them, and to the organisations which appoint governors.

a. It is pleasing to note that the Keogh Review Team observed that governors demonstrated a high level of engagement and support for the Trust's leadership team.

b. Building on the relationships that have been established, the challenge for the Council is to adopt a more proactive approach to providing independent scrutiny, using relevant information in order to hold the Board to account. The progress of implementing the Action Plan, and more importantly, the impact of the outcomes, will be a major item on the future agendas of Council meetings.

c. The Council understands that it does not have responsibility for operational decisions or management. The challenge for the Council and the Board, therefore, is to agree processes whereby governors can be clear and assured about the levels and outcomes of Non Executive Director challenge to the Executive

Director members of the Board, in particular the impact that their activities have on the quality and safety of services.

d. Governors do not have detailed knowledge of the day to day operational side of the Trust and rely on information provided by the Board. Consequently it is essential that the wealth of data collected by the Trust is converted into meaningful information about the safety and quality of the wide range of services provided by the Trust.

e. Recent national and local events have raised the concerns of governors about obtaining robust assurance about the quality and safety of services and have given further impetus to considering practical solutions in order to:

- fulfil the role of governors as defined by the Department of Health and other bodies;
- monitor the Trust's services on behalf of patients, relatives, the public and stakeholders and to be assured that patients are fully involved in their care and treatment;
- be assured that clinical care is good by NHS standards and performance measures;
- be assured that the experience of patients, carers and relatives is good, including for example, washing facilities, privacy, quality of food and quietness at night (and other markers of quality);
- be assured that communications are good and that complaints and concerns are efficiently and promptly addressed;
- be assured that the Trust is being run efficiently and that the finances are being managed effectively;
- be assured that the Trust is addressing the issues raised by the outcome of the Mid Staffordshire NHS Trust Inquiry and the Keogh Review; and
- be aware of the views of staff about the quality and safety of the services provided by the Trust, and to have a better understanding of the views of staff expressed in staff surveys and the action being taken by the Trust.

The Trust is fortunate to have a highly engaged and dedicated Council of Governors which is firmly established in many aspects of the Trust governance model. However, at the meeting on 29th August 2013 GDG considered that the contribution of governors could be further enhanced by the following recommendations:

1. **Council of Governor meeting agenda**
   There should be a greater involvement of governors in the preparation of agendas for Council meetings.

2. **Buddying system**
   Consideration should be given to introducing a system of some governors "buddying" Non-Executive Directors which would provide a greater understanding of the Non Executive Director role.

DRAFT

3. **Visits to patient environments**
   Governors will continue to contribute to the Patient Safety Walk Rounds, piloted during August, now extended for participation by governors generally and to be the subject of a further report to the Council of Governors in February 2014 for amendment or final ratification as appropriate.

4. **Attendance at key Non Executive Director led committee meetings**
   Governors would wish to see governor attendance as "participating observers" at key Board committees and other meetings at which quality, safety, patient experience, serious incidents, complaints and claims are discussed.

5. **Improved information**
   Whilst the Council may be considered by some to be insufficiently proactive, it is felt that improved information with less focus on data and greater emphasis on information, analysis, themes, potential future trends and outcomes would provide greater opportunities for effective challenge. This is particularly relevant in respect of qualitative information.

6. **Meetings of Governors**
   Regular Governor only meetings should be held to facilitate discussion of areas of common interest.

7. **Relationships with relevant organisations**
   Dudley is fortunate that Dudley Clinical Commissioning Group, Healthwatch Dudley and Dudley Council for Voluntary Service are co-terminus with the Dudley Metropolitan Borough Council which should enable mature relationships to be developed. There is already evidence of cross membership between the organisations which should be encouraged.

The Governor Development Group Governor members discussed these 7 recommendations with Directors at length and it was agreed that future development of governors' role in Dudley should be organised around 5 key themes:

1. Patient and wider public engagement
2. Patient Experience and Quality
3. Improve information to Governors (information not data)
4. Improve Governors' "feel" for the Organisation
5. Increase NED accountability to Governors

Directors endorsed each of the recommendations above with the exception of governor observer status at Board of Director Committees and the proposed formal governor-NED 'buddying' mechanism. Upon reflection these proposals were considered to compromise the independence of governors in fulfilling their secondary governance role.

Governors and Directors present at the meeting on 29th August agreed that these recommendations (above 1,3,5,6 & 7) should be commended to the Council of Governors and Board of Directors for early adoption.

DRAFT

6. Continuing the governor development journey in Dudley

In debating the effectiveness of the role of governors in Dudley, GDG reflected upon the significant changes that had been achieved since the foundation trust's inception in 2008. Of particular note here are:

- **Lead Governor Role** – The Lead Governor has a very narrow statutory role which DGFT has developed to support our particular local governance model. The Lead Governor model in Dudley has developed to reflect on our local approach to governance. In summary the role in Dudley has been that of a genuine leader of governors rather than someone identified to liaise with Monitor if things go wrong with the relationship with the Chairman

- **Patient Safety Walk Rounds** – These genuinely allow governors to develop a 'feel' for what is happening on the ground in wards and departments and fosters a joint understanding with Directors and NEDs.

- **Quality Accounts** – Governors are fully involved in determining Quality Account Priorities, reviewing outcomes, providing a commentary for inclusion in the final report and providing valuable critique of written final version.

- **The role of the GDG** – The GDG is itself an expansion of the governor role as a real vehicle for monitoring, reviewing and changing the way in which the Trust Governance structure actually works. It was through discussion at GDG that the Deloittes review was initiated and directed leading to major changes in the Trust. The GDG is regarded as the key contributor to ensuring an appropriate response to the 2012 Act, Francis, Keogh and others in relation to a current definition of the Role of Governor and future development plans.

- **Individual governors' personal drive for service improvement** – a small number of individual governors have since 2008 developed a significantly greater role in determination of Trust policy and practice because of personal interest and commitment.

- **Food Reviews** – Governors are fully involved in the review of meal provision as a direct result of shared concerns about meal quality.

- **Frequent Ad-hoc roles** – for example the involvement of a governor in the panel to consider Artist submissions for the Organ Donation Celebratory Sculpture. Participating in Membership engagement activities e.g. design a poster competition

7. Structural matters

The Council's brief to the GDG was to explore the role of governors rather than the structural architecture of COG and its Committees. However, GDG propose to recommend that COG formally requires the GDG to review structures early in 2014, following a full 24 months operation under the new structure of Committees.

DRAFT

8. Conclusions and recommendations

The NHS Community's expectation of governors following the 2012 Act and reports from Francis and Keogh is clear. It is that the role of governor in Dudley should be enhanced to "*add value"* especially in the areas of Patient Safety, Patient Experience and Quality of Care. In the opinion of GDG, Council should adopt a formal framework to monitor the delivery of a number of structured changes that collectively will result in an enhanced role for governors. A suggested draft initial framework is attached at Appendix B**.**

This will require significant development, following discussion, including the proposed review of the Council of Governors and its Committee structure, over the next few months.

8.1 Council is recommended to embrace 5 key themes for the development of governors:

1. Patient and wider public engagement
2. Patient Experience and Quality
3. Improve information to Governors (information not data)
4. Improve Governors' feel for the organisation
5. Increase NED accountability to Governors

And to capture changes and improvements on a structured basis using the framework developed in Appendix B

8.2 Council is recommended to approve the specific recommendations of GDG which will provide early progress under these agreed development themes:

8.2.1 The Lead Governor and Chairman to agree CoG Agenda jointly, following consultation with GDG.

8.2.2 Governors to be invited to participate in all patient safety walkabouts.

8.2.3 Each Governor Committee Chair to agree with their lead Executive Director, the content of information provided to Committees, to improve the timeliness and relevance of information to that Committee's terms of reference and work programme.

Committee chairs to raise any issues with GDG as appropriate.

8.2.4 Regular Governor Only meetings will be encouraged.

8.2.5 Individual governor relationships with external health and social care organisations (with the approval of the Lead Governor) are to be encouraged. However, this must preclude voting member status.

DRAFT

8.2.6 The Trust will produce a Governance Handbook for all Governors to centralise information on;

- The Governor role description
- How, why, when and what… Governors are required to do to discharge their duties
- Terms of Reference for each Committee of the Council
- Governor Code of Conduct

8.2.6 The Board Secretary will arrange a regular series of NED update sessions, to answer Governors' questions on the work of the Board of Directors and its Committees and to give assurance in specific subject areas.

DRAFT

Governor Development Group
October 2013

Appendix A

Statutory Roles and Responsibilities of the Council of Governors		
Hold the Non Executive Directors, individually and collectively, to account for the performance of the Board of Directors		
Activity	**How**	**When**
Governors and Directors agree a regular process for holding Non Executives to account for the performance of the Board effectively throughout the year	Council and its Committees to receive specific performance monitoring information to an agreed timescale Option to require Directors to attend Governor's meetings Interaction opportunities and forums for Governors and Non Executives (NEDs) to allow debate and raise challenge on key items o NEDs assigned to Council committees o Attendance at Council/Board workshops o Attendance at full Council Governors to carefully consider reports from internal and external sources, particularly in fulfilling their duty to hold the NEDs to account for the performance of the Board	Established Further review by each CoG Committee with report back to full Council February 2014 In place Reviewed on an annual basis as part of CoG Effectiveness Monitoring. Reviewed as required by the GDG.

DRAFT

Represent the interests of the members of the Trust as a whole and the interests of the public		
Activity	**How**	**When**
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 Engagement opportunities for Governors to add value to existing Trust engagement activities **Patient Safety Walkrounds** All Governors need to be encouraged to be involved to give greater validity to the value of feed back. Why - Governor structure insight and understanding into the culture of the organisation Visibility of the environment Gaining direct feedback from our inpatients using a set question plan	Governors to contribute to development of Trusts Engagement Strategy to include; Maintain a calendar of Member events Annual Members Meeting Governor 'out there' initiative embedded and fully supported by the Trust to; o Raise awareness of the work of the Trust and the role of Governors o Develop relationships with local communities o Seek views of our community on the quality of care at DDGH o Recruit new members Directors and Governor to agree process and criteria Up to two governors involved per walk round and have direct patient contact Provide structured feedback direct into existing reporting process at the Trust and used to inform on success of delivery of Trust strategies and forward planning	Procedures and processes in place to be further considered by CoG Membership Engagement with a report to full Council in February 2014. Procedure agreed by GDG August 2013. Pilot extended for wider Governor participation with further report to CoG February 2014.
Opportunities for members and the wider community to provide feedback	Feedback mechanisms established to enable Governors to communicate the interests of the their members and the wider community rather than just their own personal views	Mechanisms in place to be reviewed by Lead Governor, Chairs of CoG Membership Engagement and

DRAFT

		Strategy Committees with Trust Deputy Chair with report to CoG February 2014.
Approve significant transactions, mergers, acquisitions, separations and dissolutions		
Activity	**How**	**When**
More than half the members of the full Council of Governors of the Trust voting need to approve the Trust entering into any significant transactions More than half the members of the full Council of Governor must approve any application by the Trust to merge or acquire another Trust, separate the Trust into two or more new NHS foundation trusts or to be dissolved	Directors and Governors to agree a process Trust to support Governors by providing appropriate information on proposed decisions. Governors will need to arrange a vote of the full Council and to inform Director of the outcome of the vote	Processes agreed by CoG
Decide whether the Trust's non-NHS work would significantly interfere with the Trust's principal purpose		
Activity	**How**	**When**
Council of Governors to consider elements of the Trust's forward plan containing information about any activity which is not providing goods or services for the purposes of the health service in England	Governors and Directors to agree process for Governor involvement with timescales Trust to support Governors by providing appropriate information on proposed decisions.	Annually
Approve amendments to the Trust Constitution		
Activity	**How**	**When**
Trust Constitution to be reviewed to reflect current legislation and regulatory guidance	Amendments to be presented to Members at Annual Members Meeting	Annually
Appoint and, if appropriate, remove the Trust Chair and other Non Executive Directors		
Activity	**How**	**When**
Maintain and support the appropriate Non Executive Directors and Chair as set out in the Trust constitution	Governors and Directors to agree process and establish criteria Appointments Committee is established as	Annually

DRAFT

	the working group comprised of Council and Governor members It is for the Council of Governors at a general meeting to appoint or remove the Chairman and other Non executive Directors. Director and Governor to agree Chair and NED appraisal process.	As required - Process established Process established and reviewed annually by CoG Appointments Committee.
Decide the remuneration and allowances and the other terms and condition of office of the Chair and other Non Executive Directors		
Activity	**How**	**When**
It may be necessary from time to time to review the remuneration and allowances and the other terms and conditions	Governors and Directors to agree process and establish criteria for triggering a review Remuneration Committee is established and comprises Council and Board members It is for the Council of Governors at a general meeting to approve at a general meeting	When required
Appoint, and if appropriate, remove the NHS Foundation Trust External Auditor		
Activity	**How**	**When**
Every Trust must have an auditor that is appointed by the Council of Governors	Governors and Directors to agree process and establish criteria for o Appointing the Auditor o Monitoring External Audit performance o Consider items for	Annually

DRAFT

Appendix B – review of existing arrangements and conversations with Director and Governors (individually and collectively) have agreed the following items as a starting point for the creation of a framework to take the Governor role forward.

The framework will be significantly developed following discussion over the next few months.

Key issues to be addressed by the Board of Directors and Council together		
Member/wider public engagement		
Activity	**How**	**When**
Patient Experience/Quality issues		
Activity	**How**	**When**
Supporting NEDs more proactively in Boards Quality Assurance processes and thereby maximize independent scrutiny		Agreed processes in place - GDG to give consideration to further development.
	Contribute to development of Trust Quality account	
Improve information to governors – information not data		
Activity	**How**	**When**
Desktop review of current reports/information/date provided to Council and it Committees	Establish Task Group Be more attentive to how meetings are reported – style, tone attributed etc.	Review of current agreed practices by Task Group to be established by GDG. Account to be taken of CoG Committee's own reviews of information and data.
Improve the 'feel and understanding' of the organisation		
Activity	**How**	**When**
Ward/service/area Walkrounds		
Increasing NED visibility to Governors		
Activity	**How**	**When**
'Select committee' Q&A from Governor to NEDs to increase assurance and enable	Process and format to be i)developed by Chair of Governance	

DRAFT

NEDs to gauge Governors response/support on individual issues.	Committee and Trust Deputy Chair. ii)trialled with Governors. iii)Final recommendation on way forward to BoD and CoG early 2014.	
Activity	**How**	**When**

DRAFT

Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors 7th November 2013

TITLE:	**Quality Metrics for Quality Account 2013/14**		
AUTHOR:	**Derek Eaves**	**PRESENTER**	**Denise McMahon**

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

SUMMARY OF KEY ISSUES:

Each year, the Board of Directors need to agree what three quality metrics will be publicised in the Quality Account for each of the three area of quality; Patient Experience, Patient Safety and Clinical Effectiveness.

That agreement needs to be minuted as it will be reviewed as part of the external audit of the Quality Account.

The attached paper indicates Monitor's requirements, the metrics used last year (2012/13) and it also includes a rationale for keeping in this year's report the same metrics used last year.

The Board of Directors are asked to agree with the above proposal.

IMPLICATIONS OF PAPER:

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

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

Decision	Approval	Discussion	Other
	Yes	**Yes**	

RECOMMENDATIONS FOR THE COMMITTEE:

To agree the quality metrics to be used in the Quality Account 2013/14.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Quality Metrics for Quality Account/Report

A. Introduction

As well as the requirement to have at least three quality priorities in the quality account (the Trust has 5 for 2013/14), Monitor mandates that in Part Three of the Account, Trusts should include three quality metrics for each of the three domains of quality. The Trust Board should agree these each year.

Monitor says that for those indicators selected by the Trust: ' *the report should refer to historical data and benchmarked data when available, to enable readers to understand progress over time and performance compared to other providers. References of the data sources for the indicators should be stated, including whether the data is governed by standard national definitions. Where these indicators have changed from the indicators used in the previous year's report, the Trust should outline the rationale for why these indicators have changed. Where the quality indicators are the same as those used in the previous year's report and refer to historical data, the data reported should be checked to ensure consistency with the previous year's report. Where inconsistencies exist, the Trust is required to include an explanatory note on any changes in the basis of calculation*.'

B. Last Year 2012/13

The Board will recollect that last year the Trust amended these metrics due to the introduction of a number of mandatory metrics together with the commencement of the 'Friends and Family' test, which meant there was some duplication with the chosen Trust metrics that had been used and published up to 2011/12.

Patient Experience Domain

It was agreed to use the results from three questions posed in the national patient survey (as opposed to the Picker results used previously) as these allow comparison with other Trusts.

The three topics/questions chosen were:

Inpatient survey question
Patients who agreed that the hospital room or ward was clean
Rating of overall experience of care
Patients who felt they were treated with dignity and respect

Patient Safety Domain

The three metrics chosen were:

Patients with MRSA infection/1,000 bed days
Number of cases of venous thromboembolism (VTE) presenting within three months of hospital admission
Never Events – events that should not happen whilst in hospital

Clinical Effectiveness Domain

The three metrics chosen were:

Readmission rate for Surgery
Number of cardiac arrests
% of elective admissions where planned procedure not carried out (not patient decision)

C. This year 2013/14

As the quote from Monitor above indicates, the Board needs to decide whether to continue using the above metrics or make any amendments.

It is worth noting that, following the recent reviews, in his National Overview Report (dated 16th July 2013) Sir Bruce Keogh said:

'I will ensure that the requirements for Quality Accounts for the 2014-15 round begin to provide a more comprehensive and balanced assessment of quality'.

In the light of last year's metrics being new and the imminent changes in 2014/15 indicated above, it is suggested that the Board agrees that last year's metrics are used again this year, 2013/14.

D. Eaves. 22nd October 2013

Enclosure 14

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 31st October 2013**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**Paul Assinder**

CORPORATE OBJECTIVE:

SG 06 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, but the 4 hours ED target remains a significant risk for Q3.**
- **Financially the Trust has incurred a significant deficit of £1m in September and is now forecasting a deficit of £0.5m for 2013-14.**
- **The Committee noted with some concern significant adverse trends in payroll costs caused by increased dependency on external nursing agencies and the continued slippage on some CIP schemes.**
- **C Diff trends were noted with concern and referred to CQSPE Committee for investigation**
- **The Committee approved the outline business case for an electronic health record and recommended approval to the Board.**

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in 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 31st October 2013

1. Background

The Finance & Performance Committee of the Board met on 31st October 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. Cost Improvement Programme

The Committee considered a report on the Trust's £12.4m Cost Improvements Programme (CIP). To date savings of £7.1m have been actioned. However this is already behind plan and a full year under delivery of CIP of £2.6m is forecast. Particular problem areas are the Directorates of Emergency & Specialist Medicine, Women & Children, where savings have not yet been identified; and Trust wide schemes, 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 Specialist Medicine. The Committee were presented with a revised set of proposals that were reported to have been agreed with local managers and which would deliver reductions in the forecast level of spending in this Directorate equivalent to the annual CIP target, if fully delivered.

The Committee received a further report from the Director of Operations on the progress of Emergency Medicine's CIP Programme. The AMU Business case was said to have yielded the opportunity to close 60% of GP places in ED. The AEC and Troponins schemes are ahead of plan and will yield savings of £76,000 and £10,000 respectively. Overall the CIP target of £306,000 is forecast to be met.

3. Progress with the Allocate staffing system roll out

The Committee received a report from the Deputy Director of Nursing on the roll out of the Allocate system. This was said to be on schedule to complete to timescale and budget with encouraging savings opportunities being identified from the early adopter wards.

4. Maternity data Management System

The Director of Operations presented a report which apprised the Committee of work to identify a proprietary computer system to provide the required maternity services data set. A business case for future investment will be submitted to the Committee in due course.

5. Plan to increase the compliance rate of staff appraisals

The Director of Operations presented a report which apprised the Committee of work to improve rates of staff appraisal in Directorates. It was noted that overall rates now exceed 80%. However a full investigation of the Surgical Directorate showed that many 'outstanding' appraisals related to new starters or staff on maternity leave etc who are not required to be appraised. The true rate is 92%. Improved reporting was commended.

6. 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. Remaining risks relate to Friends & Family in ED; Staff Survey results; Senior clinical reviews and reduction in falls.

7. Integrated Business Plan Process 2014-15

Mrs Morrey updated the Committee on the Plan Timetable and progress to date.

8. National Cancer Peer Review Report

The Director of Operations presented this report. The Committee noted a positive report on cancer services within the Trust.

9. 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 August is 3.77 % (3.88% previously) and was 4.02% in 2012. The 2013-14 target is 3.50% and YTD performance is 3.76%

b. Turnover
Turnover continues to remain consistent and within target at 7.77% (7.81%previously)

c. Pre-employment Checks
Pre-employment checks managed through the Centralised Recruitment Department perform at 100%, together with 93% for Medical Workforce recruitment.
Staff bank also performed at 88%.

d. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small improvement on previous months to 70.7%.
Appraisals have increased again this month to 84.22% (83.5% previously).

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

f. Vacancies
The current live vacancy rate has increased slightly to 264 FTE.

g. Employment Tribunal Summary
The Committee noted that the Trust had 5 live ET cases.

10. Outline Business Case for Electronic Health Record (EHR) Project Fusion

The Committee considered an outline business case for an EHR replacement system and associated functionality.

The Committee recommended to the Board the approval of the OBC; the commencement of work to produce a Full Business Case; and the commencement 'without commitment' of a procurement process under government framework contract arrangements.
The Committee also considered a report from Mr Walker on accounting treatment for the costs of termination of the current PFI IT agreement.

11. Financial Performance for Month 6 – September 2013

The Trust made a trading loss of £1m in September.. Although a much smaller loss was forecast, this figure is of concern due to the current trends in spending on pay, particularly on temporary staff. In the first 6 months of this year, the Trust has already spent more on agency nursing staff than in the whole of 2012-13.

For the 6 months period in total the trust is now recording a cumulative deficit of £219,000.

However, due to a number of factors the forecast for the year in total has deteriorated and an annual deficit of £0.5m is now forecast. Principle factors are:

- Continued confusion in the NHS commissioning leading to uncertainty of income and a significant loss of income in respect of maternity services.
- Slippage on the Trust's CIP programmes delivery.

- A continued deterioration in the ‘run rate’ of Trust spending, particularly on bank and agency nurses.

The Trust’s balance sheet and liquidity position remains strong.

Capital spending is now below phased plans due to slippage on I T 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 September. 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 Q2 was 96.7% However the Trust has made an ex tremely poor start to Q3 and R HH is under considerable pressure.

b) Diagnostic 6 week waits

The Trust fell marginally short in September (98.9% 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 l eave.. This is a not oriously difficult profession to recruit to due to a national shortage of trained staff.

c) Never Events

The Trust had no ‘never events’ in September.

.

d) DC Difficile Infections

The Committee has expressed concern about the ambitious nature of this target in 2013-14. We have now exceeded Monitor’s de minimus target of 12 for a full year and are considerably over trajectory for year to date (21 against a target of 18). The Committee wishes to refer the increase in C Difficile numbers in Q2 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)	1.11 (increased from 1.08)
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.

f) CQC Intelligent Monitoring Banding

The Committee noted the Trust's banding as 4 on the new CQC risk rating 6 point scale *(1 worst – 6 best).*

13. Monitor Risk Assessment Framework

The Committee noted Monitors new Risk Assessment Framework (RAF) and t he operation of the new Continuity of Service (COS) rating mechanism.

The Trust is rated 3 on the new scale (1 *high risk – 4 lowest risk).*

14. Monitor Q2 Compliance framework

The Committee approved Annual Plan Q" performance self-assessment ratings as:

financial risk rating of '3'

and governance rating of 'amber/green'

and approved appropriate declarations to Monitor.

15. AQP Service Profitability Reports

The Committee received profitability reports for Podiatry and Audiology services won under tender arrangement's in 2013-14.

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

The Board is asked to note:

a. **The recommendation for approval of the OBC for EHR replacement (para 10 refers)**
b. **The Committee's intention to refer the increase in C Difficile numbers in Q2 for consideration by the Clinical Quality Safety and Patients Experience Committee (para 12D refers)**

PA Assinder
Director of Finance & Information
Secretary to the Board

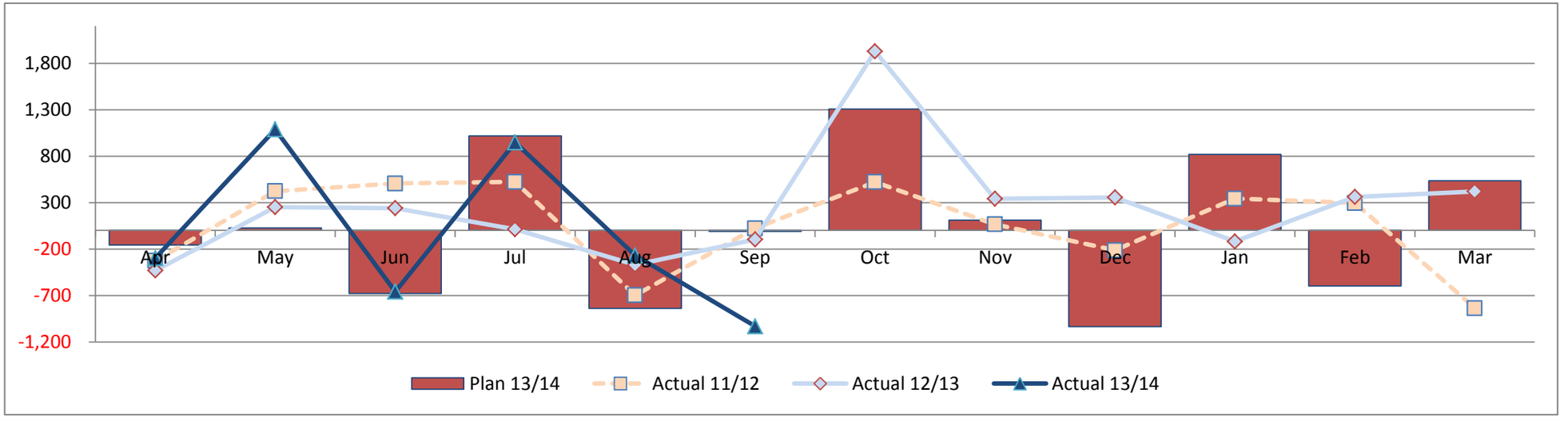
APPENDIX 1

THE DUDLEY GROUP NHS FOUNDATION TRUST

FINANCIAL SUMMARY **SEP 2013**

	CURRENT MONTH				CUMULATIVE TO DATE				YEAR END FORECAST			
	BUDGET £000	ACTUAL £000	VARIANCE £000			BUDGET £000	ACTUAL £000	VARIANCE £000		BUDGET £000	ACTUAL £000	VARIANCE £000	
INCOME	£26,613	£25,086	-£1,526	🔴	INCOME	£153,965	£154,280	£315	🟢	INCOME	£306,232	£307,173	£941	🟢
PAY	-£15,289	-£15,422	-£133	🟡	PAY	-£92,107	-£91,298	£809	🟢	PAY	-£183,970	-£183,317	£653	🟢
CIP	-£902	£0	£902	🟢	CIP	£1,459	£0	-£1,459	🔴	CIP	£5,276	£0	-£5,276	🔴
NON PAY	-£8,546	-£8,868	-£323	🟡	NON PAY	-£52,561	-£51,959	£602	🟢	NON PAY	-£104,190	-£101,636	£2,554	🟢
EBITDA	**£1,875**	**£796**	**-£1,079**	🔴	**EBITDA**	**£10,755**	**£11,023**	**£268**	🟢	**EBITDA**	**£23,348**	**£22,220**	**-£1,128**	🔴
OTHER	-£1,885	-£1,826	£59	🟢	OTHER	-£11,392	-£11,242	£150	🟢	OTHER	-£22,848	-£22,726	£123	🟢
NET	**-£10**	**-£1,030**	**-£1,020**	🔴	**NET**	**-£637**	**-£219**	**£418**	🟢	**NET**	**£500**	**-£506**	**-£1,006**	🔴

NET SURPLUS/(DEFICIT) 12/13 PLAN & ACTUAL **SEP 2013**



Key Comments

£1.030m deficit in September (£1.020m above planned deficit of £10k). Cumulatively this gives a £219k deficit (£418k ahead of planned deficit of £637k).

The income position to September is £1.526m behind plan. This reflects an adjustment for the maternity pathway tariff and Includes CCG transitional support of £1.5m, partially negated by a risk reserve of £505k (penalties and CQUIN). Other income also reduced, notably high cost drugs.

Pay costs are over budget in September by £133k but cumulatively under by £809k. Non pay spend in September is £323k over budget and cumulatively under by £602k. Spend has once again increased in September (following the dip in August).

Forecast now revised to a £506k deficit and continues to assume a degree of CCG flexibility regarding income (including £1m for Winter Pressures).

It is recommended that each Directorate is tasked with achieving an outturn that it is £1m lower than the current forecast to return the Trust to plan.

2013/14 EXPECTED RIGHTS AND PLEDGES FROM THE NHS CONSITUTION 2013/14

The Dudley Group NHS
NHS Foundation Trust

APPENDIX 2

Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	A&E	2% of revenue derived from the provision of the locally defined service line in the month of the under - achievement	A&E 4 hour wait	96.7%	95%	↑	●
5	Cancer		14 Day – Urgent GP Referral to Date First Seen	96.5%	93%	↓	●
5	Cancer		14 Day – Urgent GP Breast Symptom Referral	99.2%	93%	↓	●
5	Cancer		31 Day – Diagnosis to Treatment for All Cancers	99.4%	96%	↓	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs	100%	98%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Radiotherapy	-	-	-	-
6	Cancer		31 Day – 2nd/Subsequent Treatment – Surgery	100%	94%	→	●
6	Cancer		62 Day – Referral to Treatment after a Consultant upgrade	100%	85%	→	●
6	Cancer		62 Day – Referral to Treatment following National Screening	100%	90%	→	●
6	Cancer		62 Day – Urgent GP Referral to Treatment for All Cancers	86.5%	85%	↓	●
9-10	Diagnostics		Percentage of diagnostic waits less than 6 weeks	98.9%	99%	↑	●
-	MSA	Retention of £250 per day the patient affected	Mixed Sex Sleeping Accommodation Breaches	0	0	→	●
7	RTT	Deduction of 0.5% for each 1% under-achievement, to a max of 5%*	Admitted % Treated within 18 Weeks	96.4%	90%	↑	●
8	RTT		Non-Admitted % Treated within 18 Weeks	99.0%	95%	↓	●
7	RTT		Incomplete % waiting less than 18 Weeks	97.4%	92%	↓	●
	RTT	£5,000 per patient	Zero tolerance RTT waits over 52 weeks	0	0	↑	●
	A&E	£1,000 per breach	Trolley Waits in A&E >12 hours	0	0	→	●
-	Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payments*)	Failure to publish a Declaration of Compliance of Non-Compliance pursuant to clause 4.24. *Retention of monthly sums will continue for each month or part month until either a Declaration of Compliance or Declaration of Non-Compliance is published.*	Annual – Trust Compliant			●
-	Compliance		Publishing a Declaration of Non-Compliance pursuant to clause 4.26.				●
4	HCAI	Lesser of 1.5% of inpatient revenue or £50,000 per case above 38 threshold.	C Diff – Post 72 hours *(77 breaches allowed)*	6	3	↓	●
4	HCAI	Non-Payment of inpatient episode	Zero Tolerance for MRSA	0	0	→	●
11	Never Events - Recovery of costs of procedure and no charge to the commissioner for any corrective procedure.			0			
12-13	Monitor Summary Report		Governance Risk Rating	1			
14	Mortality Reports		2012/13 Qtr 3 SHMI	1.08		↓	
15-16	CQC Surveillance Model – Intelligent Monitoring October 2013:		Risk Rating Score & (Banding)	7 & (4)			

One month behind

⇩ Position Deteriorating ⇧ Position Improving ⇨ Position Unchanged

↑ Within Target ↑ Outside Target ↑ Position Unconfirmed

NEVER EVENTS

Description	Q1	Q2	Q3	Q4	YTD
Never Events : In hospital maternal death from elective caesarean section	0	0	-	-	0
Never Events : Inpatient suicide by use if no collapsible rails	0	0	-	-	0
Never Events : Intravenous administration of mis-selected concentrated potassium chloride	0	0	-	-	0
Never Events : Misplaced naso- or orogastric tube not detected prior to use	0	0	-	-	0
Never Events : Retained Instruments Post Operatively	0	0	-	-	0
Never Events: Air embolism	0	0	-	-	0
Never Events: Entrapment in bedrails	0	0	-	-	0
Never Events: Escape of a transferred Prisoner	0	0	-	-	0
Never Events: Failure to monitor and respond to oxygen saturation	0	0	-	-	0
Never Events: Falls from unrestricted windows	0	0	-	-	0
Never Events: Inappropriate administration of daily oral methotrexate	0	0	-	-	0
Never Events: Intravenous administration of epidural medication	0	0	-	-	0
Never Events: Maladministration of Insulin	0	0	-	-	0
Never Events: Misidentification of Patients	0	0	-	-	0
Never Events: Opioid overdose of an opioid-naïve Patient	0	0	-	-	0
Never Events: Overdoseof Midazolam during conscious sedation	0	0	-	-	0
Never Events: Severe scalding of Patients	0	0	-	-	0
Never Events: Transfusion of ABO-incompatible blood components	0	0	-	-	0
Never Events: Transplantation of ABO or HLA-incompatible organs	0	0	-	-	0
Never Events: Wrong gas administered	0	0	-	-	0
Never Events: Wrong Implant/Prosthesis	0	0	-	-	0
Never Events: Wrong route of Administration of Chemotherapy	0	0	-	-	0
Never Events: Wrong route of administration of oral/enteral treatment	0	0	-	-	0
Never Events: Wrong Site Surgery	0	0	-	-	0
Never Events: Wrongly prepared high-risk injectable medication	0	0	-	-	0

Never Event consequence (per occurrence)
In accordance with applicable guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care.

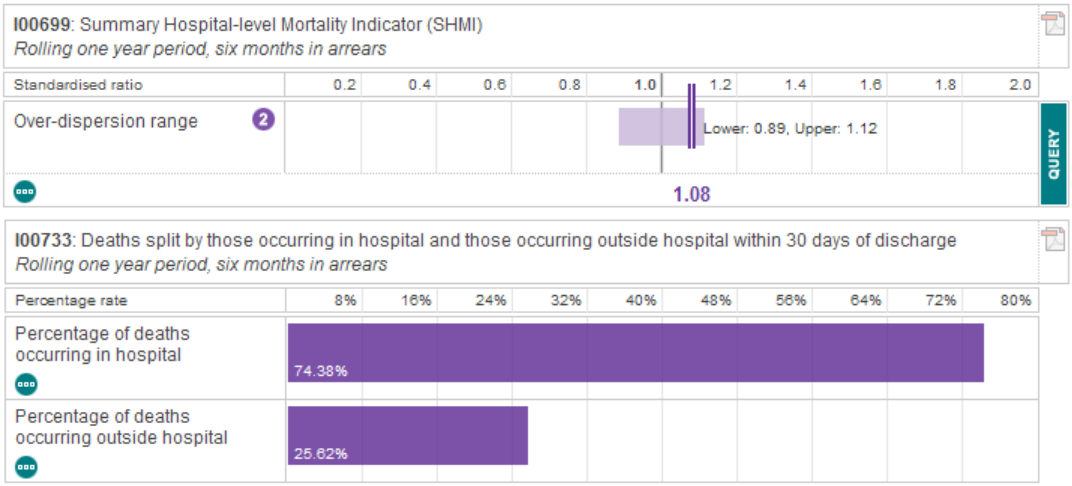
Method of Measurement
Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report.

APPENDIX 3

Dudley Group FT MORTALITY - SHMI
Quarterly KPI Report

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR - Next update 29th October 2013

Main SHMI value • January 2012 - December 2012



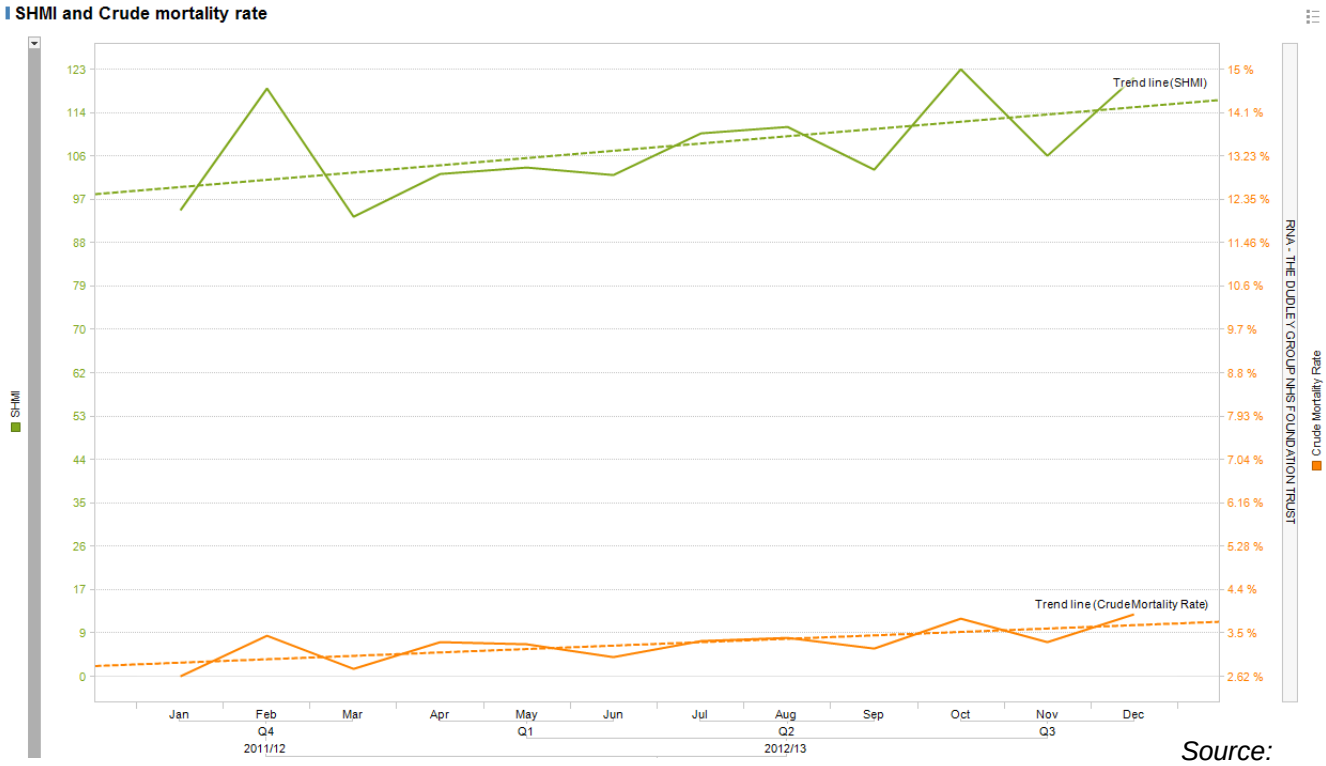
Source: NHS Choices

SHMI	Source	2012/13 Q1		2012/13 Q2		2012/13 Q3	
	NHS Choices	1.04		1.04		1.08	

Within over dispersion range

Within both Poisson and over dispersion range

The next set of experimental SHMI data will be published by the NHS Information Centre in October 2013.



Source: HED

APPENDIX 4

THE DUDLEY GROUP NHS FOUNDATION TRUST

CONTRACTUAL FINES NOTIFIED as at SEP 2013

	Q1	Jul	Aug	Sep	Q2	Q3	Q4	Cumulative	
National Quality									
MRSA >0	**£0**				**£0**			£0	
C Diff >38	**£0**				**£0**			£0	
RTT wait > 52 weeks	**£5,000**				**£0**			£5,000	
Ambulance Handover >30 Mins	**£0**				**£0**			£0	
Ambulance Handover >1 hour	**£77,000**	£12,000	£9,000		**£21,000**			£98,000	
Trolley Waits in A&E >12 hours	**£0**				**£0**			£0	
Urgent operation cancelled >1	**£0**				**£0**			£0	
Failure to publish Formulary	**£0**				**£0**			£0	
Duty of Candour	**£0**				**£0**			£0	
Operational Standards									
RTT Admitted > 18 weeks (90%)	**£10,439**	£3,442			**£3,442**			£13,881	
RTT Non Admitted > 18 weeks (95%)	**£5**				**£0**			£5	
RTT Incomplete > 18 weeks (92%)	**£867**				**£0**			£867	
Diagnostic Waits > 6 weeks (99%)	£0	£2,058			**£2,058**			£2,058	
A&E Waits > 4 hours (95%)	**£50,563**				**£0**			£50,563	
Cancer outpatient >2 weeks (93%)	£0				**£0**			£0	
Breast Symptoms >2 weeks (93%)	£0				**£0**			£0	
Cancer first treat >31 days (96%)	£0				**£0**			£0	
Cancer subseq surgery >31 days (94%)	£0				**£0**			£0	
Cancer subseq drugs >31 days (98%)	£0				**£0**			£0	
Cancer subseq radio >31 days (94%)	£0				**£0**			£0	
Cancer GP to treat >62 days (85%)	£0				**£0**			£0	
Cancer screen to treat >62 days (90%)	£0				**£0**			£0	
Cancer Cons. to treat >62 days (85%)	£0				**£0**			£0	
Mixed Sex Accommodation >0	£0				**£0**			£0	
Cancelled Ops re-book >28 days	£0				**£0**			£0	
TOTAL FINES	**£143,875**				**£26,500**	**£0**	**£0**	**£170,374**	

Board of Directors Members Profile.

Paula Clark – Chief Executive

As the Chief Executive, Paula leads the Executive Team to ensure that effective management systems are in place and that Directors and Senior Managers have clear objectives and are assigned well-defined responsibilities in line with the Trust's strategy and organisational objectives.

As a leader Paula provides visible examples of a positive culture for the Trust and drives the Trust Management executive to reflect a positive culture in their behaviour and decision making to continuously improve the Patient Experience within the Trust.

John Edwards – Chairman

Johns ensures that the Board and its committees function effectively and in the most efficient way: discharging their role of collective responsibility for the work of the Trust. John decides: on committee membership; ensures they have the correct Terms of Reference, assigns the appropriate committee's to deal with the key roles in running the Trust and ensures the Committee chairs report accurately to the Board in line with the relevant committees meeting cycle. John is also Chair of the Council of Governors and Chairs the Transformation Committee and the IT Project Board.

Paul Assinder – Director of Finance and Information

Paul provides strategic financial and business advice to the Board of Directors. He has lead responsibility for statutory accounts and audit as well as informatics, information technology, contracting, procurement and supplies. Paul is also Secretary to the Board of Directors and key liaison director for the FT regulator, Monitor.

Richard Beeken – Director Strategy, Performance and Transformation

Richard is responsible for developing the Trusts Long Term Strategy and for driving transformational change programmes within the organisation and local health economy. He provides leadership of the facilities and estates function via the PFI contract, in addition to security and health and safety management. In his role he also leads Emergency Planning and Business Continuity Planning for the Trust.

Denise McMahon – Director of Nursing

Denise provides professional leadership, management and direction for: Nursing and Midwifery Strategy, Education and Professional Conduct; Infection Prevention and Control and Integrated Governance. Denise also has collective corporate responsibility for strategic and operational performance as an Executive Director and member of the Trust Board.

Paul Harrison – Medical Director

Paul provides professional medical leadership for the organisation, including the role of Responsible Officer for revalidation. He contributes to the Boards strategic discussions by bringing perspective on clinical issues as a practising clinician. He is responsible for medical education, research and development and medical workforce issues. Paul and is also lead on Mortality and Morbidity issues.

Richard Cattell – Director of Operations

Richard is Executive Lead for operational management and delivery in clinical services on a day to day basis. He is responsible for the successful delivery of all national and local performance targets and quality standards, via each of the organisation's clinical directorates. Negotiation of and adherence to the contract the Trust has with our CCG commissioners is a vital part of his role.

Annette Reeves – Associate Director of Human Resources

Annette provides leadership and strategic management for the Human Rescources Directorate and gives advice to the Board on issues relating to functions under her control and their impact on the wider service issues to the Trust. She is responsible for developing strategies which meet NHS/legislative/best practise requirements and the needs of the Trust. She participates in the corporate management of the Trust, ensuring the Trust's strategic and operational objectives are met to facilitate the highest quality of services for patients.

David Badger – Non Executive Director, Deputy Chairman and Chair of the Finance and Performance Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act. David is Deputy Chair of the Trust and also Chair's the Finance and Performance Committee.

David is also responsible for the following:
Member - Clinical Quality Safety and Patient Experience Committee
Member - Risk and Assurance Committee
Member - Remuneration Committee
Member - Nominations Committee
Member - Transformation Programme Board
Member and link to Trust Board - Organ Donation Committee
NED liaison - Council of Governors
Assigned - Governor Development Group
Assigned - Governor Membership Engagement Committee
Attendee - Governor Appointments Committee
Board representative - Contract Efficiency Group

David Bland – Non Executive Director and Chair of the Clinical Quality, Safety and Patient Experience Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

David is also responsible for the following:
Chair of the Clinical Quality, Safety and Patient Experience Committee
Non Executive Director Lead for Patient Experience
Non Executive Director Lead for Patient Safety
Member of Risk and Assurance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Member of Charitable Funds Committee
Member of Council of Governors Committee
Member of the Dudley Clinical Services Limited (subsidiary of the Trust

Jonathan Fellows - Non Executive Director and Chair of the Audit Committee

As a Non Executive Director it is Jonathans responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Jonathan is also responsible for the following:
Chair of Audit Committee
Member of Finance and Performance Committee
Member of Charitable Funds Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Assigned to the Governors Governance Committee
Board representative - Contract Efficiency Group

Richard Miner – Non Executive Director and Chair of the Charitable Funds Comittee

As a Non Executive Director it is Richard's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Richard is also responsible for the following:
Chair of the Charitable Funds Committee
Non Executive Director Lead for Security Management
Member of Finance and Performance
Member of Audit Committee
Assigned to the Governors Governance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Chair of the Dudley Clinical Services Limited (subsidiary of the Trust)

Ann Becke – Non Executive Director and Chair of the Risk and Assurance Committee

As a Non Executive Director it is Ann's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Ann is also responsible for the following:
Chair - Risk and Assurance Committee
Member – Audit Committee
Member – Clinical Quality, Safety and Patient Experience Committee
NED Lead for Safeguarding
Board Representative – Dudley Children's Partnership
Non Executive Director Liaison for West Midlands Ambulance Service
Member – Remuneration Committee
Member – Nominations Committee
Member – Arts and the Environment Panel

Assigned – Governor Sub Committee Membership Engagement
Assigned – Governor Sub Committee Strategy
Member – Dudley Clinical Education Centre Charity