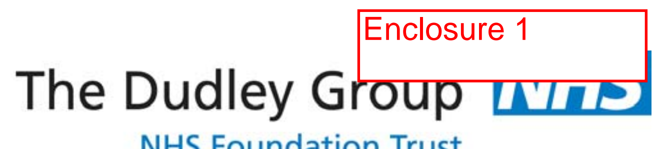
Board of Directors Agenda
Thursday 1st May 2014 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion/decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apols.**		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 April 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 3rd April 2014	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**		D McMahon	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D McMahon	To Note & Discuss	10.00
	7.2 Clinical Quality, Safety, Patient Experience Committee, Exception Report	Enclosure 5	D Bland	To Note & Discuss	10.10
	7.3 Assurance Report on Foetal Remains	Enclosure 6	R Cattell	To Note	10.20
	7.4 Report on Moving Patients Out of Hours	Enclosure 7	R Cattell	To Note	10.30
	7.5 Hard Truths Report	Enclosure 8	D McMahon	To Note	10.40
	7.6 Update on Nurse Staffing Tool	Enclosure 9	D McMahon	To Note	10.50
	7.7 Francis Report	Enclosure 10	J Cotterill	To Note	11.00
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 11	D Badger	To Note & Discuss	11.10
9.	**Date of Next Board of Directors Meeting** 9.30am 5th June, 2014, Clinical Education Centre		J Edwards		11.20
10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		11.20



Minutes of the Public Board of Directors meeting held on Thursday 3rd April, 2014 at 9:30am in the Clinical Education Centre.

Present:
John Edwards, Chairman
Ann Becke, Non Executive Director
Richard Miner, Non Executive Director
David Badger, Non Executive Director
Jonathan Fellows, Non Executive Director,
Richard Beeken, Director of Strategy, Performance and Transformation
Paula Clark, Chief Executive
Denise McMahon, Nursing Director
Paul Assinder, Director of Finance and Information
Paul Harrison, Medical Director

In Attendance:
Helen Forrester, PA
Elena Peris - Cross, Administrative Assistant
Liz Abbiss, Head of Communications and Patient Experience
Annette Reeves, Associate Director for Human Resources
Richard Cattell, Director of Operations
Julie Cotterill, Associate Director of Governance/Board Secretary

14/034 Note of Apologies and Welcome

Apologies were received from Mr Bland, Non Executive Director

14/035 Declarations of Interest

There were no declarations of interest.

14/036 Announcements

The Chairman made time adjustments to the Agenda and explained that item 7.10 would not be discussed in the public session as it related to an item in the private session and would be discussed in this part of the meeting instead. This item will then be reported back to the Public Board meeting in May.

14/037 Minutes of the previous Board meeting on 6th March, 2014 (Enclosure 1)

The Medical Director asked for the minutes to be amended at the bottom of page 7 where a full stop is required after the words; feedback process, with this change the minutes were agreed as a correct and true record of the meeting.

14/038 Action Sheet, 6th March 2014 (Enclosure 2)

14/38.1 Francis Report

The Trust is currently awaiting a response from Monitor and this will be reported at the May Board meeting.

14/038.2 Stroke Service Review Strategy

This is on the Agenda to be discussed.

14/038.3 CQSPE – WHO checklist in CQSPE exception report

14/038.4 Finance and Performance Report

The 4hr wait trajectory will be presented at the March Board meeting.

Letters to the CCG and LA can be found in the Chief Executives Report.

14/038.5 Keogh Action Plan

This will be reported back to the May Board meeting

14/039 Patient Story

The Director of Nursing presented a negative patient story for the Board to discuss. The main issues noted were around hospital gowns and the food.

The Chief Executive noted that the gown issue is a problem for us and we must revisit this.

The Board noted that a food review is underway and this patient has agreed to take part in menu tasting sessions.

The Director of Nursing explained that normally the gowns are checked before they are given to patients to ensure there are no rips or holes and patients should be given two in order to double the gowns up.

The Board noted that instructions for the gowns will soon be displayed in the waiting rooms.

The Chairman agreed that the gown issue is unacceptable in terms of patient dignity.

The Director of Performance, Strategy and Transformation confirmed that there is a food review taking place and there will also be a market test process.

The Chief Executive highlighted her concerns around food adding that there is no reason for staff to not understand what people with special dietary requirements can and cannot eat.

The Director of Performance, Strategy and Transformation assured the Board that he would follow this up with Interserve.

Ms Becke, Non Executive Director informed the Board that problems had been highlighted in a review of the gowns where bariatric patients had issues fitting into them and some patients had issues with waiting in public areas/ waiting rooms with only a gown on.

The Chief Executive assured the Board that there are a range of sizes of gowns for the larger patients; we need to ensure these are always accessible.

The Director of Nursing informed the Board that the issue of public areas would be difficult to rectify, we will have to look at the area patients are being asked to wait in as there would be flow issues if we moved them around too much.

The Chairman asked for the gowning issue to be reported back to the Clinical Quality, Safety and Patient Experience committee to ensure that staff are adopting the process that protects people's privacy and dignity and this can then be reported back to Board.

Director of Strategy, Performance and Transformation is to follow up the understanding of vegetarian options with Interserve.

Clinical Quality, Safety and Patient Experience Committee to discuss adopting a process for gowns that protects patient's privacy and dignity and report the discussion back to Board.

14/040 Chief Executive's Overview Report (Enclosure 3)

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

4 Hour ED wait target: The Trust failed the target as predicted; we continue to work with ECIST to improve the patient flow throughout the hospital. The Board noted that there is inconsistent performance However we are still keeping some of the winter schemes running and the walk in centre will be open until 10pm until June. The Chief Executive pointed out that we must maintain the flow at the back door as we still have a higher number of delayed transfers of care than desirable.

Friends and Family Test: The Board noted that the March position for the Friends and Family score is 81 which put the Trust back into the green. The A&E results have moved up to 67% and are also back in the green. We are currently looking at why the maternity scores have dropped.

CQC Visit: The Chief Executive informed the Board that the CQC planned visit went ahead as scheduled on the 26th and 27th of March. All staff demonstrated commitment to the Trust and passion for their work, we are currently waiting for the unannounced visit which could be at any time before the 10th April. The draft report will be released in the last week of May, with the Trust given opportunity to check for factual accuracy.. The Quality Summit will be held on 6th June .

The Chairman pointed out that the feedback he received around staff passion and commitment was very positive. He pointed out that the Trust has been on a journey of improvement for the past 2 ½ years. The Chairman explained that we continue to have positive leadership at all levels, and asked for the Governors and members of the public to be thanked for engaging with the inspection team.

14/041 Patient Safety and Quality

14/041.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Nursing Director presented the report given as enclosure 4 including the following points to note:

MRSA: Ms Pain, Matron reported that there had been 1 post 48hr MRSA case in the month of March. It is confirmed that this was not as a result of cross infection. Two 72hr meetings have been held by staff to discuss this issue. The patient's diagnosis has not yet been confirmed.

CDIFF: The Trust has had 43 cases of C.Diff at the year end; this is against a target of 38. This is the best recorded performance of the Trust and an improvement on 56 cases in the previous year. The new target for this year is 48. The infection prevention and control team have received new guidance and a local algorithm has been agreed with the commissioners to identify cases as either avoidable or unavoidable.. The new figures from use of this tool will be reported on the Trust website.

The Chairman pointed out that we received some good feedback from the CQC around the prescribing app.

The Chairman asked for an outcome report on the MRSA case to go back to the Clinical Quality, Safety and Patient Experience Committee and then back to Board.

The Board noted the contents of the report.

MRSA RCA outcome report to be presented to the Clinical Quality, Safety and Experience Committee and then back to Board.

14/041.2 Quality Account Priorities 2014/15 (Enclosure 5)

The Chief Executive presented the Quality Account priorities report given as Enclosure 5 explaining to the Board that this is in draft due to tight time restraints. The 1st draft has been sent to the CCG and other partners for their comments. The Board were asked to note that the top 5 priorities have been agreed and Mortality has been added as the sixth. The Board are now asked to endorse the detailed targets for each topic.

Patient Experience – The latest data shows the Trust has not yet hit the improvement needed around assistance for patients at meal times and therefore it is recommended we retain this as there is more work to do. The Board decided to keep the target around the call buzzer. The Community targets set were around single assessment process numbers and patients knowing how to raise a concern.

Mr Miner, Non Executive Director asked why the Infection Control trajectory fell toward the end of the year.

The Nursing Director confirmed that this is down to continued vigilance and changes to the way the infection control team work. There have been changes to the training of lead nurses and more focus on antibiotic guidelines, cleaning and hand hygiene. All these actions together consistently has given us results.

Mr Badger, Non Executive Director expressed his thoughts on the C.Diff framework of new targets and fines being a very strange situation and reminded the Board that we need to challenge ourselves to do as well as this year's target as a minimum.

The Nursing Director highlighted that experts say C.Diff levels have gone down to an irreducible level. C.Diff figures in the Community have risen and the targets are set cognisant of local levels, we are aiming to stay as low as we possibly can in C.Diff and have no post 48hr MRSA bacteraemia next year.

Mr Fellows, Non Executive Director asked if there was any sense in setting an avoidable pressure ulcer target.

The Nursing Director mentioned that she could not be sure of this before seeing the results of the new algorithm.

The Chairman highlighted the need to track and understand what the algorithm is telling us.

The Director of Finance and Information added that it would be useful to include the bed/day information

The Chairman asked that for the Quality Account Priorities we stick to the details in the report.

The Board endorsed the Priorities and noted that improvements will be made to the infection prevention and control report for Board.

The Board noted that we achieved the Grade 4 pressure ulcer target in which we achieved 0. Unfortunately we will miss the avoidable stage 3 score. Community will achieve the target of 25% reduction in grades 3 and 4 and the targets going forward should align with the CQUIN target.

The Board endorsed this recommendation.

The Board noted that we achieved 93% for the MUST scores in October/February. The average score is 90% which means we have narrowly missed the target.

The Nursing Director informed the Board we achieved 93% in the first 6 months of the year for the fluid balance charts and 90% throughout the whole year. The results have been mixed so we will retain the MUST scores target and there will only be one nutrition target due to the addition of the Mortality target. It has been decided to introduce the target of increasing the number of patients who have a weekly risk re-assessment regarding their nutritional status to raise the number of patients to at least 93% by the end of the year (March 2015). It has also been decided to include ensuring that on average throughout the year, 93% of patients' fluid balance charts are fully completed and accumulated at lunchtime.

The Board endorsed the recommendation to retain the same target.

The Board noted that the figures for Pressure ulcers should be 28%

The Board were informed that the following two mortality targets had been suggested:

Ensure that 85% of in hospital deaths undergo specialist, multidisciplinary review within 12 weeks by March 2015.

For congestive heart failure (Non- Hypertensive), reduce the nationally recognised mortality indicator SHMI to a number below 1, using the latest data available in March 2015.

The Medical Director highlighted to the Board that these were challenging but reasonable targets.

Mr Fellows, Non Executive Director asked if there was a risk of reporting against the 6 month old SHMI data.

The Medical Director informed the Board that we could use HED data which is more up to date.

The Chief Executive informed the Board that in terms of reassurance it's important to note that all notes are audited, however some are just not within 12 weeks.

Mr Badger, Non Executive Director pointed out to the Board that that the Clinical Quality, Safety and Patient Experience Committee received some very detailed reports on addressing mortality and asked if this proposal is consistent with these documents.

The Nursing Director confirmed that the six quality priorities are being agreed, SHMI will be in the Quality Accounts but just not in the summary document.

The Chairman recommended to the Board that the highest priority is that case note reviews are taking place. The priority – "For congestive heart failure (Non- Hypertensive), reduce the nationally recognised mortality indicator SHMI to a number below 1, using the latest data available in March 2015" – should not be a quality priority as it is reliant on data that lags by 6 months. We should therefore have one single mortality priority for case note reviews.

The Board endorsed the recommendations made.

14/041.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6).

Ms Becke, Non Executive Director presented the Report given as enclosure 6 including the following points:

Cancer Patient Experience Survey Action Plan: Matron Waldron had presented the Cancer Patient Experience Survey action plan to the Committee who have asked for a further update in two months.

Patient Safety Group: Baker Tilley held an internal audit which has highlighted some issues around the safety thermometer data, this is now resolved as the Trust now use's handheld devices to capture more consistent information.

Internal Safeguarding Board: The Board noted a significant improvement has been made around safeguarding training compliance and the learning disability CQUIN has been achieved.

Patient Experience Report and NHS choices: The Board noted that the Trust had received very good ratings from the National Survey Results.

Serious and Adverse Incident Monitoring report (January 2014): There were 7 new serious/adverse incidents however there is no trend and the Committee received assurance that all incidents were under investigation and had been reported correctly.

Quality Dashboard: All the Clinical indicators listed for January under NHS choices were within the acceptable range accept for Day Case issues such as hand surgery.

The Chairman and the Board noted the contents of the report.

14/041.4 Risk and Assurance Committee Exception Report (Enclosure 7):

Ms Becke, Non Executive Director presented the report given as enclosure 7, the Board noted the following points:

Assurance Reports: The Trust received the response from the LSAMO annual report and although three recommendations were made, overall, the Trust performed well. The Board also noted that the Maternity team have been recognised nationally by the Royal College of Midwifery for their Mom2Mom breastfeeding support project.

Surgery and Anaesthetics Risk Register: The Directorate presented their top 5 risks to the Committee.

The Chair thanked Ms Becke for the report and chairing the Risk and Assurance Committee for the past 3 years. The Board noted that this would be the last report of Risk and Assurance in this format.

14/041.5 Quarterly Safeguarding report (Enclosure 8)

The Nursing Director explained that the independent Chair of the Safeguarding Board and the Board requires reassurance on the recent issues; the Chief Executive presented the review at the last Pan Board Reassurance Group meeting. The police have reviewed the dossier given to the safeguarding Board and they have confirmed they have no reason to believe that our policies are not robust.

Training: Improvements have been made however there are still some areas in red, we are maintaining focus.

Mental Health Compliance: The compliance is now at 70.5%.

Learning Disability Strategy: There was a day dedicated to the learning disability strategy launch which was a very positive day.

The Chief Executive informed the Board that the PFI partners have now completed their safeguarding training.

The Mandatory Training issues will be discussed at the next Finance and Performance committee.

14/041.6 Organ Donation Report

The Board were joined by the Organ Donation Clinical Nurse Specialist who presented the report given as Enclosure 9.

Mr Badger, Non Executive Director, explained that this is a half year report on the work of the Organ Donation Committee.

The Board noted that this is a very positive overview, recognising that the Trust is better that the national average. Figures show a near 5% increase in register members.

The Organ Donation Clinical Nurse Specialist informed the Board that this Trust has always performed better than the national average; we have had the best performance in the last 3 years.

The Board were informed that planning permission went in last year and there are sufficient budgets for the ground works. The Board noted thanks to Summit for the help in funding the ground works.

Mr Miner, Non Executive Director suggested that the charitable funds monies are used to fund the training outlined in the organ donation plan.

The Organ Donation Clinical Nurse Specialist thanked Mr Miner and assured the Board that she would make a request to the charitable funds for this funding.

Mr Fellows, Non Executive Director noted that the performance and benchmarking were excellent. He went on to ask why we were below the national average for consent after cardiac deaths.

The Organ Donation Clinical Nurse Specialist explained that this is being worked on and the intensive care staff are being encouraged to contact the team for support.

Mr Badger, Non Executive Director told the Board that his granddaughter told him about one of her friends fathers who had died, the family were strong believers in organ donation and the wife had asked to speak to Mr Badger. She told him of the overwhelming experience she had with the Trust with every contact with staff being wonderful; she couldn't speak highly enough of the experience.

Offer of Charitable funding for training to be discussed at the next Organ Donation committee in April.

14/041.7 Research and Development Annual Report (Enclosure 10)

The Medical Director presented the report given as enclosure 10.

The Board noted page 2 as the summary and the point around reorginisation of the Comprehensive Local Research Networks which have been merged into one and is hosted by New Cross. There is some impact on potential funding as the funding now depends on research activity, Professor Kitas will work on ensuring we obtain a good share of this activity. We continue to perform well compared to other organisations and the Trusts publication and trials are noted in the papers.

The Board noted that Dr Neilson has been appointed as Deputy Research and Development Director as part of the succession planning process. Dr Neilson has previously been the chair of the research ethics committee.

MHRA inspection: The Trust received very positive results from this inspection.

Issues: The Medical Director informed the Board that there is an issue with storage for trials materials as we are obliged to keep copies of the records; this is being addressed by the team.

The Board also noted that Professor Ferry has retired and we have not yet got a replacement in place.

The Chairman noted the good progress against the recruitment target.

The Board noted the contents of the report.

14/041.8 Corporate Risk Register (Enclosure 11)

Mrs Cotterill presented the report given as Enclosure 11 explaining that this is the end of year report.

The Board noted 19 Corporate risks where 10 score 20 or above.

Mrs Cotterill explained that his report is continuously updated and there is a new risk relating to IBP, Board members noted gaps in control and assurance and the mitigating actions.

Mr Miner, Non Executive Director asked if the loss of experienced midwives risk has been reduced.

The Nursing Director explained that we must ensure this risk has reduced; a successful recruitment campaign has brought in a lot of middle grades.

The Chief Executive confirmed that this risk has been reduced.

Mr Badger, Non Executive Director confirmed that the Board have received assurance from Adrian Warwick.

The Chairman thanked the Director of Governance for the report and reminded the Board that we must understand the trend behind the risks.

The Board received and approved the corporate risk register.

1/041.9 Dementia Report (Enclosure 12)

The Director of Operations presented the report given as Enclosure 12 explaining to the Board that this is a brief update showing the key work strands that have previously been identified.

Improved Identification (and diagnosis) of patients with dementia: The Board noted that the performance around screening and identification of patients has improved and we are now above the target with a full assessment happening in every case.

Improved environment: we are now operating a frail elderly short stay unit.

Ensure appropriate support for carers: questionnaires have been given to carers as there are some lessons to be learnt.

The Board noted that this report will go to the Clinical Quality, Safety and Patient Experience Committee in the future.

Mr Badger, Non Executive Director pointed out that there is an issue with their not being a health economy wide dementia strategy.

The Director of Operations informed the Board that the biggest challenge is at night. He agreed that there is a need for a Dudley wide approach and this has been raised with the CCG

The Director of Strategy, Performance and Transformation explained that Dementia is explicit in the CCGs commissioning strategy however there is vagueness around a health economy wide approach.

The Chairman pointed out how far the Trust has come in a very short space of time.

The Board noted the positive trajectory and performance and asked for thanks to be passed back to all colleagues involved.

Future reports to be presented to the Clinical Quality, Safety and Patient Experience Committee.

14/041.10 Integrated Business Plan

This will be discussed in the Private Board meeting.

14/042 Finance

14/042.1 Finance and Performance Report (Enclosure 14)

Mr Badger, Non Executive Director presented the report given as enclosure 14, he informed the Board that there had been a very challenging Finance and Performance meeting last week and the main points from the meeting were as follows:

Bank and Agency spend: the Committee received a report from the Director of Operations on the report from PwC into the expenditure on bank and agency, the points of which can be seen in the report. The Board noted that there are issues within our control and we must address these as a matter of urgency.

Letters have been sent to the LA and the CCG to address the issues that are outside of the Trusts control; we are currently waiting for a response.

Appraisals: The Board noted a slight dip following some very good progress; the Committee sent some very clear messages to be passed down to the workforce committee. The Trust received very positive comments from the CQC on our levels of appraisals.

Financial Performance: The Trust has a modest trading surplus in February which is better than that planned. The Board noted that we are likely to end the year at a break even position. The Committee have concerns around the spend run rate as we are still spending too much into the New Year and there is concern that the corporate CIP programme could be at risk. Much work has been done to improve the financial position and Mr Davies, interim turnaround director shared his thoughts with the Committee.

IBP: The Committee received the IBP however it had concerns around the risks in the financial plans.

CIP: The Committee identified a sum of £10.2m as the realistic target for 2014/15 however it must be made clear that there is a minimum target and we must aim to get nearer to £16m. The Committee have approved the CIP programme for 2015/2016.

RTT Admitted waits: The Trust is at risk on the RTT admitted waits target and therefore the Committee have asked for proposals to address this.

Monitor Governance rating: The Board noted a green rating for Quarter 3.

The Board noted the issues, in particular, the financial pressures and the spending rate issues.

14/043 Any Other Business

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

13/033 Date of Next Meeting

The next Board meeting will be held on Thursday, 1st May, 2014, at 9.30am in the Clinical Education Centre.

Signed ……………………………………………………………………………………

Date ………………………………………………………………………………...........

Enclosure 2

Action Sheet
Minutes of the Board of Directors Public Session
Held on 3 April 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/041.6	Organ Donation	Offer of Charitable funding for training to be discussed at the next Organ Donation Committee in April.	DB	April 14	Done
13/083.4	Francis Report	Update on the response from Monitor on the Role of the Governor Report to be included in the Chief Executives Report.	JC	1/5/14	Awaiting response from Monitor
14/008.3	Keogh Action Plan	Update on AUKUH Tool to future Board.	DM	1/5/14	On Agenda
14/039	Patient Story	Director of Strategy, Performance and Transformation to follow up understanding of vegetarian option with Interserve.	RB	1/5/14	
		Clinical Quality, Safety, Patient Experience Committee to discuss adopting a process for gowns that protects patients privacy and dignity and report back to Board.	DM	5/6/14	
14/030.3	Quarterly Complaints and PALS Report	Future Reports to include quarter on quarter data.	DM	5/6/14	
14/041.1	Infection Control	MRSA RCA outcome report to be presented to the Clinical Quality, Safety, Patient Experience Committee and then back to Board.	DM	5/6/14	
14/041.9	Dementia Report	Future reports to be presented to the Clinical Qualilty, Safety, Patient Experience Committee.	RC	Ongoing	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 1st May 2014

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- 95% Hospital/Emergency Department 4 Hour Wait Target
- Friends and Family Test Performance

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

Chief Executive Update – May 2014

95% Hospital/Emergency Department 4 Hour Wait Target:
The Trust continues to have real pressures in terms of capacity resulting in our inability to move patients from ED in a consistent and timely manner to meet the target. Despite extensive plans having been put in place to cope with the inevitable pressures over the Easter weekend we had extremely poor performance which built from Saturday into Sunday, Monday and Tuesday and pressure remained unabated into Easter week. The Emergency Care Intensive Support Team were in the Trust for two days and they will be giving us a report on their findings.

Friends and Family Test:
The returns from the wards are very pleasing as we go through April with a slight dip in week 3. Reponses from patients regarding their experience have maintained a high level of satisfaction.

ED had a difficult two weeks in early April at just below the required 15% footfall which was disappointing and the team have been reminded of the importance in gaining patient feedback.

	APRIL 14 WK 1	APRIL 14 WK 2	April 14 WK3
	01.04.14	07.04.14	14.04.14
Date range	06.04.14	13.04.14	20.04.14
Number of eligible inpatients	388	433	452
Number of respondents	173	165	118
Ward FFT score	82	81	87
Ward footfall (min'm 15% required)	45%	38%	26%
Number of eligible A&E patients	889	982	962
Number of respondents	127	137	186
A&E FFT Score	50	62	76
A&E footfall (min'm 15% required)	14%	14%	19%
TRUST FFT Score	68	72	81
TRUST footfall	23%	21%	21%

Paper for submission to the Board of Directors on 1st May 2014 - PUBLIC

TITLE:	Infection Prevention and Control Exception 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 – Score: 16
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:**	Outcome 8 – Cleanliness and Infection Control
	NHSLA	N	**Details:**	
	Monitor	Y	**Details:**	Compliance Framework
	Equality Assured	Y	**Details:**	
	Other	Y/N	**Details:**	

ACTION REQUIRED OF BOARD:

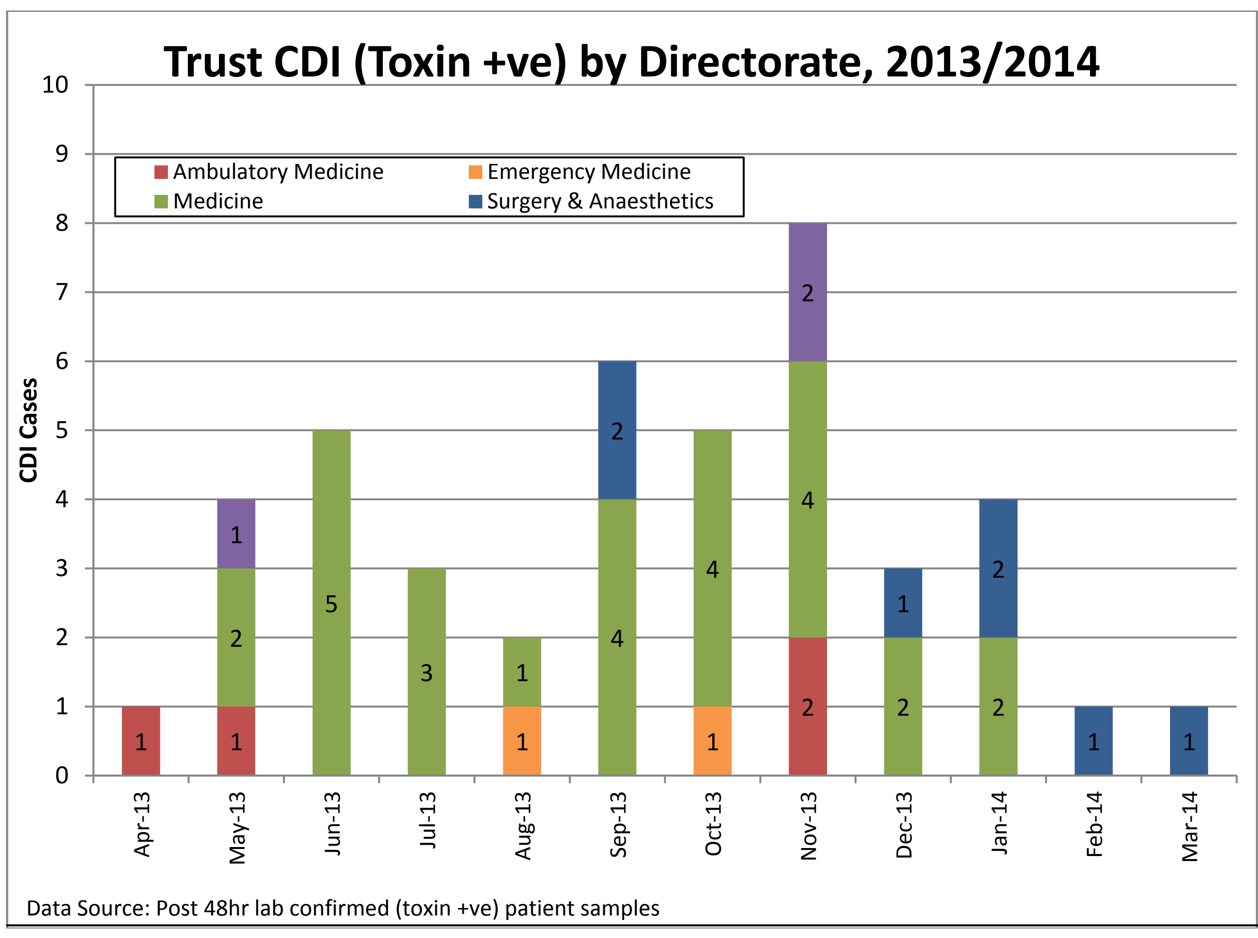
Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive the report and note the content.

Clostridium Difficile

The target for 2014/15 is 48 cases, equivalent to 20.5 CDI cases per 100,000 bed days. At the time of writing we have 3 post 48 hour cases recorded in April 2014 against a trajectory for the month of 4 cases. At the end of each quarter it will be possible to give an estimate of an annual equivalent number of cases per 100,000 bed days. During this last month we have identified a period of increased incidence of CDI on C3. Meetings have been arranged and an action plan being developed. An algorithm to review all post 48 hour cases is in progress and awaiting formal approval from the CCG. Below is a graphical representation of last years' figures and location of cases by current directorate descriptions.



MRSA – Annual Target 2 (Post 48 hrs)

There have been no post 48 hour MRSA bacteraemia cases so far this year.

CPE

New national guidance on the control of carbapenamase producing enterobacteriaceae (CPE) has been released. These are organisms, for example E.coli or Klebsiella oxytoca, which are resistant to the majority of antibiotics currently available for treatment of severe infections. The guidance is designed to ensure the best quality of care to patients who are

colonised/ have an infection with a CPE and also to protect other patients from harm. The primary mechanism of control is to identify and then screen those patients who are identified as being at highest risk of harbouring these organisms. An action plan is being developed to address this guidance for completion by June 2014.

Norovirus

The Norovirus situation has now settled down and there are currently no wards closed within the Trust.

Infection Prevention and Control Team

Following the departure last year of the Consultant Nurse in Infection Control we have looked to recruit to a Matrons post in Infection Prevention and Control. We have succeeded in appointing a senior Infection Control Nurse currently leading the team in the Walsall and Dudley Mental HealthTrust to this post. We are grateful for the work done by the existing team in providing cover over the last 6 months and look forward to welcoming Angela Murray back to DGFT later this Summer.

Glossary of new terms:

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

References:

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

(N13) Clostridium difficile infections

Monthly number of C.diff cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	Cumulative % Over/Under Target	Trust Total	Health Economy
Apr-14	3	4	-25.0%	3	4	-25.0%	3	6
May-14		4			8			
Jun-14		4			12			
Jul-14		4			16			
Aug-14		4			20			
Sep-14		4			24			
Oct-14		4			28			
Nov-14		4			32			
Dec-14		4			36			
Jan-15		4			40			
Feb-15		4			44			
Mar-15		4			48			
FY 2014-15	3	48	-93.8%				3	6

The CCG target for Cdiff is 48 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.

The Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.

The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-14	-	0	0.0%	-	0	0.0%	-
May-14		0			0		
Jun-14		0			0		
Jul-14		0			0		
Aug-14		0			0		
Sep-14		0			0		
Oct-14		0			0		
Nov-14		0			0		
Dec-14		0			0		
Jan-15		0			0		
Feb-15		0			0		
Mar-15		0			0		
FY 2014-15	-	0	-				-

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

MSSA infections		
Month / Year	Total	Cumulative
Apr-14	1	1
May-14		
Jun-14		
Jul-14		
Aug-14		
Sep-14		
Oct-14		
Nov-14		
Dec-14		
Jan-15		
Feb-15		
Mar-15		
FY 2014-15	1	

Monthly number of MSSA cases

E.coli infections		
Month / Year	Total	Cumulative
Apr-14	4	4
May-14		
Jun-14		
Jul-14		
Aug-14		
Sep-14		
Oct-14		
Nov-14		
Dec-14		
Jan-15		
Feb-15		
Mar-15		
FY 2014-15	4	

Monthly number of E.coli cases

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 1st May 2014

<table>
<tr><td>TITLE:</td><td colspan="3">Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 13th March 2014</td></tr>
<tr><td>AUTHOR:</td><td>Julie Cotterill
Governance Manager</td><td>PRESENTER:</td><td>David Bland (NED)
CQSPE Committee Chair</td></tr>
<tr><td colspan="4">CORPORATE OBJECTIVES:
SGO1: Quality, Safety & Service Transformation, Reputation, SGO2: Patient Experience
SGO5: Staff Commitment</td></tr>
</table>

Cardiac Arrest Trolley Audit Report - The Committee was advised that Cardiac Arrest Trolleys were checked daily and weekly. Photographs are now taken to confirm the items that should be in the trolleys. The Committee received the Cardiac Arrest Trolley Audit Results for January 2014 and noted that some areas had scored 75% and some 50%. Action plans were in place to address this.

Cervical Screening QA Team Visit Report - Mr Warwick presented the Cervical Screening QA Team Visit Report. He informed the Committee that this was an arranged visit and part of the triennial review of cervical cytology screening services undertaken across the West Midlands by the West Midlands QA team. The action plan had been reviewed with the visiting team. The QA team collect colposcopy and laboratory data for the DoH (KC65) showing all colposcopy national standards to be achieved. For quarter 3 all indicators were green.

Friends and Family Report - The Trust would be undertaking a staff Friends and Family survey in April 2014. Every member of staff would be asked to complete the survey twice yearly and would be required to answer two questions. The A&E score was green for February and the Inpatient score amber. Maternity data showed an increased score for antenatal care and post natal community, but a drop in score for birth and postnatal ward putting them in the red this month. The Committee referred to the National/Regional position (January 2014) and advised that the Trust had scored well in some categories. It was accepted that reviewing the lessons learned was an area that needed to be reconsidered.

Patient Experience Strategy Action Plan – The Committee received an update from the strategy approved by the Board in January. The availability of Volunteers had improved significantly and the Volunteer Co-ordinator had recently undertaken a recruitment drive for volunteers and recruited 51 in 1 day. Dr Rees had completed some work with Ms Fleetwood to streamline the Occupational Health testing as there had previously been a delay with tests. The summary heading in the strategy had been formulated from the patient experience data received each year including the Patient Journey work. A feedback system was being trialled in the outpatient department and the feasibility of huddle boards would be investigated as part of that work. There would be two reporting groups into the Patient Experience Group; these were the Complaints Review Group and the Dementia Group.

National Staff Survey Results 2013 - the response rate had improved but was still just below the national average with 36% last year and 48% this. 2300 staff had completed the survey. The results would be shared with Clinical Directors, General Managers and Matrons. The largest group of responses was from registered nurses at 83 questionnaires (21%) followed by admin and clerical at 17%. The Trust had improved since 2012 for Key Finding 24 "Staff recommendation of the trust as a place to work or receive treatment." This also featured amongst the top most improved scores. The overall staff engagement score had improved since 2012 at 3.73 and was now almost at the national average (3.74).The Committee discussed the Summary of Results and the difference in scores between last year and this.

Quality Dashboard for Month 10 (January) 2013/2014 - there were 4 confirmed C.Diff cases in January. New guidance had been published which indicated that the Trust did not have to report negative samples nationally but had to show these on the web site. The Trust would therefore have two sets of figures in the future. CDiff cases had gone up to 48. The TAL indicator had increased slightly to 48% in January, against the 80% required performance. This had been scrutinised by the Out patients Steering Group and the Trust was hoping to achieve a figure of 65% for February. Both of the maternity quality indicators (Breast feeding and Smoking in Pregnancy) remained below target. There were no red rated Nursing Care Indicators or Protected Mealtime measures. Four wards were red for Think Glucose – B4, B6, C5 and C7 and four wards – A1, A3, B6 and C5 were red for Protected Mealtime: Assistance. Overall the Trust was rated as amber. Two areas were red for the Saving Lives: Renal Dialysis Insertion - Renal Unit were green with 100% however, Critical Care had omitted to input any data and showed overall red.

The Trust had achieved the Band 4 CQC Risk score following a successful challenge of the elevated risk for

dermatological conditions which was removed.

Mortality Report - the SHMI was outside of the expected range (July 2012-June 2013) of 1.13, however it was expected to drop within the expected range at 1.07 with a containing downward trend. The HSMR remained within the expected range at 101.68. The Trust had received a further alert from the CQC on the 8th November 2013 with regard to the skin and subcutaneous condition group. The Mortality reports were shared with the CCG and CSU at the Clinical Quality Review Meeting (CQRM). The Committee discussed the impact of end of life care provision in the community and the CQCs role in inspecting.

AHRQ Patient Safety Culture Survey Results and Actions - all directorates had provided responses with the highest numbers from CSIC (61) nursing directorate (51) and surgery and anaesthetics (51). Comparisons were made with the last survey in 2009. A number of strengths emerged from the results:

- Over 75% of respondents either agreed or strongly agreed we are actively doing things to improve patient safety
- Most respondents rated patient safety in their area as either very good or excellent (74% or 177)

A number of areas for improvement emerged from the results (the majority of results were as expected):

- Most respondents said they did not have enough staff to handle the workload (53.2% or 143)
- 45.6% of respondents either agreed or strongly agreed that we work in 'crisis mode' trying to do too much too quickly.

Serious and Adverse Incident Monitoring Report (February 2014) - 7 new incidents were reported (1 Delay in obtaining test, 1 Slip/Trip/Fall-Hazard (Staff), 1 Stillbirth (pre-delivery), 3 Patient Fall resulting in Fracture and 1 Confidentiality Breach). There was consistent reporting of falls resulting in a fracture with 3 incidents reported in February 2014 in older people and Trauma and Orthopaedics. These occurred on 3 different ward areas B2, C5 and B4. Trends were addressed at the monthly Falls Prevention and Management Group Meeting. There remained a consistent reporting of confidentiality breaches with 1 incident reported in February 2014. Faxing still appeared to be an issue. There were 39 open general SI's in total (15 undergoing investigation, 17 awaiting assurance that all actions identified from the RCA investigation had been completed and 7 recommended for closure). In February 2014 there was one breach in the 2 days from identification of the incident and reporting and there were no breaches to complete the investigation in agreed time scales.

Patient Safety Group (4th February 2014) highlighted the following:

- **Diabetes Task and Finish Group –** this was established in response to three serious incidents that occurred in the Trust relating to mismanagement of diabetes. The Diabetes Team reviewed all incidents quarterly where diabetes management was a concern. Diabetes training was problematic with some group's being small with poor attendance. Junior Doctor training was mostly complete. Diabetes training would be included in a rolling programme of clinical skills medicine management.
- **Trailing Cables and Wires –** The Trust had opted to use Wi-Fi. Clinical areas would inform estates of all trailing wires to raise a variance for this work.
- **Medication incidents -** Of the total number of medication incidents reported, approximately 70% related to medicines reconciliation. The prescribers name was not recorded by pharmacists who identified the incident making it difficult to identify the individual or patterns or trends. The Trust was planning to change the treatment chart to provide space for a signature stamp for each prescription.
- **Resuscitation Training Department Report -** Problems remain with non-attendance and under utilisation of places. With regard to the NCCA and DNAR Audit a significant increase in Arrest numbers had been noted for the end of 2013.
- **Maternity and Children's Directorate Risk Management Group –** A new Risk Assessment had been produced "Lack of Phlebotomy Service in ANC". This related to Down's screening.

Infection Prevention and Control Forum (12th December 2013) – the Committee noted that currently RCAs were not carried out for E. coli and MSSA infection and the Trust was not currently required to do so. There were new targets and a new way of managing these. The Committee **noted** the key issues from the Infection Prevention and Control Forum.

Internal Safeguarding Board (20th February 2014) - the Adults Safeguarding Board was under scrutiny publicly and was awaiting feedback. The Trust was launching a Learning Disability Strategy on 28th March 2014. A live theatre performance would highlight some of the needs of people with learning disabilities when they access hospital care. The formal launch of the strategy would also include the findings of Patient Summits for people with a learning disability. An average of 40 patients per day required 1:1 additional

observations. The Clinical Nurse Specialist for Older People was collating a report for the Older People's unit.

Drugs and Therapeutics Committee (8th January 2014) highlighted the key work areas:

• Oversee the implementation of NICE technological appraisals (TAs) including a costing statement for each TA (October to December 2013).
• Review and sign off Patient Group Directions (PGDs) for Trust staff.
• Ratify the minutes of the Safe Medicines Group (SMP) and the Antimicrobial Steering Group and disseminate information from the Area Medicines Management Committee (AMMC).
• Review and approve a new electronic template prescription for use in the Emergency Department.

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 13th March 2014 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 7

Paper for submission to the Board of Directors
on Thursday 1st May 2014

TITLE:	Report on moving patients out of hours		
AUTHOR:	Richard Cattell Director of Operations	**PRESENTER**	**Richard Cattell** **Director of Operations**
CORPORATE OBJECTIVE: SG02: To provide the best possible patient experience			

SUMMARY OF KEY ISSUES:

Following a letter from the Chief Medical Officer the Board is asked to 'review practices within the organisation to ensure that transfers made for reasons other than clinical ones are minimised and that established good practice is followed where such moves are necessary. This includes ensuring that such moves are properly explained to patients and relatives.

- DG NHS FT has a current policy '**TRANSFER AND HANDOVER OF PATIENT CARE POLICY'** agreed in November 2013**.**
- The policy states under - **Transferring Patients Out of Hours**
  - This policy applies throughout the 24 hour period although out of hours transfers (2200-0800) must be avoided unless the patient's condition or operational demands of the organisation dictate. If the required escorts are unavailable due to lower staffing numbers the Clinical Site coordinator must be informed for advice, before the patient transfer is commenced. If an unsafe or out of hours transfer occurs, this must be documented in the nursing notes and an incident report (DATIX) completed. Transfers of older people at night should be avoided wherever possible as this can increase the risk of delirium.
- The Clinical Site Coordinators who operate 24/7 take the lead on the operation of the policy.
- The policy states under - **Informing the Patient**
  - A member of the ward staff must inform the patient and their relatives (if possible) where they are being transferred to and why the transfer is necessary. If a transfer is happening against relatives wishes the reasons will be documented in the patient's medical records.
- The organisations current policy is in line with the NHS England expectations

IMPLICATIONS OF PAPER:

RISK	**Y/N**	**Risk Description:**

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS COMMITTEE:

To receive this briefing

Enclosure 8

Paper for submission to the Board of Directors on 1st May 2014

<table>
<tr><td>TITLE:</td><td colspan="3">Hard Truths Commitments Report</td></tr>
<tr><td>AUTHOR:</td><td>Denise McMahon
Director of Nursing</td><td>PRESENTER:</td><td>Denise McMahon
Director of Nursing</td></tr>
<tr><td colspan="4">CORPORATE OBJECTIVE: See below
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</td></tr>
<tr><td colspan="4">SUMMARY OF KEY ISSUES:

The ‘Hard Truths Commitments’ issued on 30th March 2014 set out a set of expectations, this paper covers the Trust position against these.</td></tr>
</table>

<table>
<tr><td colspan="4">IMPLICATIONS OF PAPER:</td></tr>
<tr><td rowspan="2">RISK</td><td colspan="2">Y/N</td><td>Risk Description:</td></tr>
<tr><td colspan="2">Risk Register: Y</td><td>Risk Score:</td></tr>
<tr><td rowspan="5">COMPLIANCE and/or LEGAL REQUIREMENTS</td><td>CQC</td><td>Y</td><td>Details:</td></tr>
<tr><td>NHSLA</td><td>Y/N</td><td>Details:</td></tr>
<tr><td>Monitor</td><td>Y</td><td>Details:</td></tr>
<tr><td>Equality Assured</td><td>Y/N</td><td>Details:</td></tr>
<tr><td>Other</td><td>Y/N</td><td>Details:</td></tr>
</table>

<table>
<tr><td colspan="4">ACTION REQUIRED OF THE BOARD:</td></tr>
<tr><td>Decision</td><td>Approval</td><td>Discussion</td><td>Other</td></tr>
<tr><td></td><td>✓</td><td>✓</td><td></td></tr>
<tr><td colspan="4">RECOMMENDATIONS FOR THE BOARD OF DIRECTORS

For discussion and approval.</td></tr>
</table>

Hard Truths Report

Background

Hard Truth commitments regarding the publishing of staffing data was issued on 31st March 2014 and authorised by Jane Cummings, Chief Nursing Officer and Mike Richards, Chief Inspector of Hospitals. This guidance applies to Inpatient areas including acute, community, mental health, maternity and learning disability.

Expectations

The expectations are that:

Expectation 1: A Board report describing the staffing capacity and capability, following an establishment review, using evidence based tools where possible. To be presented to the Board every six months.

Our Position: The safer hospital staffing tool has been repeated. The National database tool was available on 10th April 2014 and we are currently inputting our data. The results will be available within one month.

Expectation 2: Information about the nurses, midwives and care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level.

Our Position: This is displayed on 'huddle boards' and data recorded for audit purposes.

Expectation 3: A Board report containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month. To be presented to the Board every month.

Our Position: This information is collected and will form part of a nurse staffing exception paper to the Board.

Expectation 4: The monthly report must also be published on the Trust's website and Trusts will be expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices.

Our Position: This exception report can be made available for the Trust's website and NHS Choices.

Next Steps

Boards must, at any time, be able to demonstrate to their commissioners that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient to provide safe care.

All NHS Trusts are accountable to the NHS TDA[1] and, as stated in the Accountability Framework 2014-15, will be expected to provide the NHS TDA with assurance that they are implementing the NQB[2] staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk. Monitor approves development of this guidance and expects Foundation Trust to have the right staff, in the right place at the right time. The Care Quality Commission will be looking for compliance with all the actions outlined as part of their inspection regime. Monitor will act where the CQC identifies any deficiencies in staffing levels in Foundation Trusts.

[1] TDA – Trust Development Agency
[2] NQB – National Quality Board

Hard Truths Commitments Regarding the Publishing of Staffing Data

Timetable of Actions

	Action Required by Trusts:	By When:	Periodicity:	Trusts Comments
A	The Board receives a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in NQB report page 12 and reflects a realistic expectation of the impact of staffing on a range of factors. This report: • Draws on expert professional opinion and insight into local clinical need and context • Makes recommendations to the Board which are considered and discussed • Is presented to and discussed at the public Board meeting • Prompts agreement of actions which are recorded and followed up on • Is posted on the Trust's public website along with all the other public Board papers	June 2014	Every six months	On plan
B	The Trust clearly displays information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. This should be visible, clear and accurate, and it should include the full range of patient care support staff (HCA and band 4 staff) available in the area during each shift. It may be helpful to outline additional information that is held locally, such as the significance of different uniforms and titles used. To summarise, the displays should: • Be in an area within the clinical area that is accessible to patients, their families and carers • Explain the planned and actual numbers of staff for each shift (registered and non-registered) • Detail who is in charge of the shift • Describe what each member of the team's role is • Be accurate	From April and by June 2014 at the latest	Each shift	Delivered

	Action Required by Trusts:	By When:	Periodicity:	Trusts Comments
C	The Board: • Receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis • Is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap • Evaluates risks associated with staffing issues • Seeks assurances regarding contingency planning, mitigating actions and incident reporting • Ensures that the Executive Team is supported to take decisive action to protect patient safety and experience • Publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly 'safe staffing' area on a Trust website).	From April and by June 2014 at the latest	Monthly	On plan
D	The Trust will ensure that the published monthly update report specified in Row C [i.e. the Board paper on expected and actual staffing] is available to the public via not only the Trust's website but also the relevant hospital(s) profiles on NHS Choices. The latter can be achieved either by placing a link to the report that is hosted on the Trust website on the relevant hospital(s)' newsfeed on their NHS Choices webpage or by uploading the relevant document to the relevant hospital(s)' NHS Choices newsfeed. For Trusts with multiple hospital sites that have their own NHS Choices webpages, this will require the separate posting of the Trust Board report to each hospital newsfeed. However, this is likely to reach more patients given that patients tend to review hospital, not Trust, NHS Choices webpages. This approach will also allow you to highlight hospital-specific plans and achievements, which may be of particular interest to a public audience. Given these requirements, the update reports should be written in a form that is accessible and understandable to patients and the public. This is likely to include ensuring that the information on staffing is not embedded within hundreds of pages of other Board papers.	By June 2014	Monthly	On plan

	Action Required by Trusts:	By When:	Periodicity:	Trusts Comments
	Your own NHS Choices web editor(s), who already provide your Trust and hospital-specific content to NHS Choices, will be able to advise you further on their preferred mechanism for making these documents available on NHS Choices – either via a link or by uploading a .pdf of the Board paper. NHS Choices will also be liaising directly with each Trust's web editors with further information.			
E	The Trust: • Reviews the actual versus planned staffing on a shift by shift basis • Responds to address gaps or shortages where these are identified • Uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care	Immediate	Each Shift	Delivered

KEY:

	Not Delivered
	Off Plan
	On Plan
	Delivered

Paper for submission to the Board of Directors on 1st May 2014

TITLE:	Update on Nurse Staffing Tool		
AUTHOR:	Denise McMahon Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:

SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation

SGO2: Patient experience - To provide the best possible patient experience

SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude

SUMMARY OF KEY ISSUES:

In addition to undertaking an additional skill mix review has been undertaken and the safer staffing tool is nearing completion. This involves peer review, professional judgement and the safer staffing Alliance recommendation of one Registered Nurse to eight patients. This has involved individual meetings with every matron and completed a basic data set (Appendix 1).

Using ward bed numbers (not yet adjusted for occupancy rate) this data has been considered to deliver the minimum ratio of one Registered Nurse to eight patients in general ward areas over a 24 hour period.

The Care Support Worker ratio has been defined to meet the needs of the specialty and this ranges from 1:10 to 1:6.

The indicative costings have been completed by the Finance Department and this is being cross referenced with the ALLOCATE rostering system.

This output will then be confirmed by each matron and a final report will be available for the next Finance and Performance Committee and Trust Board Meeting.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF THE BOARD:

Decision	Approval	Discussion	Other
			✓

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive the update regarding the Nurse Staffing tool.

Appendix 1

STAFFING ESTABLISHMENT

Ward/Area:.. Matron: ....

Registered Nurse

By band	Funded Establishment	Expenditure Against FE	Vacancy against band	Maternity Leave	Long Term Sick
7					
6					
5					

Bank (WTE) ....

Why: ....

....

....

Clinical Support Worker

By band	Funded Establishment	Expenditure Against FE	Vacancy against band	Maternity Leave	Long Term Sick
4					
3					
2					
Cleanliness					
Nutritional					

Bank (WTE) ....

Why: ....

....

....

Comments:

....

....

....

....

....

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 6th February 2014

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

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

SUMMARY OF KEY ISSUES:

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

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

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

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.					
4	Clarity of values and principles	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21	Board	Whilst the NHS Constitution underpins the core values and principles of the Trust, these will be re-visited and re-considered in light of the report and recommendations made.	**Open**
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings					
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance	The Health and Safety Manager role is currently vacant and is being recruited to as part of a restructuring of the F&E function within the Trust. Whilst arrangements for reporting RIDDOR incidents remain sound, the review of this recommendation will have to be deferred until the appointment of a new Health and Safety Manager for the Trust.	**Open**
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing	We will work with the HSE to meet any new requirements.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
	Nursing					
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the:	23	Director of Nursing and Human Resources		
		– Possession of the appropriate values, attitudes and behaviours;			An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation. Local value question agreed ready for implementation by 31st March 2014 **Implemented**	**Closed**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		– Regular, comprehensive feedback on performance and concerns;			Nurses referred to NMC report to be taken to the Board.	**Open**
		Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23	Associate Director of Human Resources	An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation. **Implemented**	**Closed**
	Caring for the elderly - Approaches applicable to all patients but requiring special attention for the elderly					
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:	25			
		• All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.		Director of Nursing	Matron and Lead Nurse availability will be posted on ward boards. This is being trialled in Paediatrics and will then be rolled out across the Trust.	**Closed**
		• Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients		Director of Ops /Director of Nursing	Every ward has an area that is confidential to converse with patients and visitors.	**Closed**
		• The NHS should develop a greater willingness to communicate by email with relatives		Director of Ops/Medical Director /Director of Finance & Information	All e-mails from patients relatives and nurses are responded to by the Executive team. Ward level will require more process.	
		• The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered			The trust plans to move to an Electronic Patient Record system in the future and will include this requirement in the system specification In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved discharge letter functionality specified by Francis in Autumn 2014.	
		• Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.		Director of Ops/Medical Director	Care plans available at the bedside. Communication with relatives/visitors sheet being trialled on C7. **Rolled out to all wards**	**Closed**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations	i) Late night discharge reports to be provided to clinical teams routinely to enable peer review and challenge ii) Review of the criteria for and protocol supporting patient moves at night as a requirement of managing bed capacity during periods of high escalation levels Discharge lounge is now appropriately staffed and furnished to provide care for patients awaiting discharge. Further work is being undertaken to improve the uptake of the service provided by the discharge lounge	**Open**
242 243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director/ Director of Finance & Information	Not currently possible to record electronically. This functionality is specified in a replacement EPR solution being procured by the Trust In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014.	**Open**
					Paper charts are at each bedside.	
					Compliance with charts is audited via Nursing Care Indicators.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Information					
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	26	Director of Finance & Information	The requirements outlined here will be considered when reviewing the electronic Patient Information Systems. In October 2013 the Board of Directors approved an Outline Business Case for investment in a new Electronic Patient Record system that it is estimated will provide improved functionality specified by Francis in Autumn 2014. Information is currently shared and available via the manual systems in place across the Trust.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress
		• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.			

Enclosure 11

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meetings held on 24h April 2014**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: S06 Enabling Objective			

SUMMARY OF KEY ISSUES:

- **The unaudited management accounts for March show the Trust out turning the year with a small operating surplus of £351,000, marginally worse than plan.**
- **The Committee noted with some concern some further significant deterioration in the spend rate in March, particularly on pay related expenses.**
- **Headcount and agency costs achieved new record levels in March**
- **CIP delivered only 75% of the £12.4m Plan**
- **The Trust failed to meet waiting time standards in ED in March, Quarter 4 and the year in total.**

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Failure to achieve the 4 hours A&E target in Q4 & Q1 and risk for Q3** **Risk to C. Diff target**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **The Trust has rated itself 'Green' for Governance & '3' (good) for Finance at Q4. The Trust remains on quarterly monitoring by Monitor.**
	Other	**N**	**Details:** **Significant exposure to performance fines by commissioners in 2014-15**

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
			X

NB: Board members have been provided with a complete copy of agenda and papers for this meeting.

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the small financial surplus generated in 2013-14 but also the Committee’s major concern about the level of overspending in the Trust which is jeopardising financial stability in 2014-15.

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

Finance and Performance Committee Meeting held on 24th April 2014

1. Background

The Finance & Performance Committee of the Board met on 24th April 2014. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports. The Committee noted in particular the following matters:

2. Allocate Nurse Rostering Project

The Committee considered a report from the Deputy Director of Nursing on progress with the roll out of this project. The technical roll out of this project has been completed but there now remains for the revised budget information to be populated in the establishment modules and a wholesale switch to centralised recruitment. The Committee supported increasing project resource at this crucial 'switch over' period.

The Committee requested regular monthly progress reports with financial benefits clearly articulated.

3. Turnaround Programme Progress report

Mr Davies, Interim Turnaround Director, reported upon progress to date against the critical path presented to the previous Board of Directors Meeting. The first iteration of the productivity plan (CIP) will be published by the end of April and the first week in May will see the formal launch of the Turnaround Programme.

Mr Davies said that the Committee would see the level of expenditure begin to fall in May (week 9-13 of the Plan).

The QIA approval process for vacant posts had commenced and started very well.

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

4. Performance Targets and Standards

The Committee noted the following matters:

a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for March was 91.5% and for Quarter 4 it is 90.4% and full year 93.7%, against a 95% target. The Trust has failed 4 of the last 5 quarters' targets.

b) Never Events

The Trust had no 'never events' in March.

c) C Difficile Infections

C. Diff infections for 2013-14 totalled 43 against a target of 38. However the Regulator has expressed interest only in 'avoidable' infections which fall well within the target tolerance.

d) Mortality Indices

The Committee noted that the Standardised Hospital Mortality indicator for period July 2013 to September 2013 had reduced to 1.11 previously to 1.13 and now falls within the expected range

e) RTT 18 weeks waits

This target was fully achieved by the Trust in 2013-14 but the wait for admitted care had increased such that only 90.4% of patients met the 18 weeks target (target 90%). Achieving this target in April and Q1 of the new year is a significant risk.

5. RTT 18 weeks waits recovery plan

Mr Cattell reported that the main reasons for deterioration in this target were increases in emergency surgical activity and medical outliers causing elective surgical cancellations and an 8% increase in referrals. Theatre staffing issues are a further concern

Particular pressures had been analysed in Urology & T&O due to consultant vacancies. Short term waiting list sessions will correct the position with a more structured transfer of additional beds to surgery planned in 2015.

The Committee requested a full specialty analysis at its May meeting.

6. Nurse staffing business case

The business case is linked to a Keogh recommendation to strengthen front line qualified nursing. The detailed Plans have been costed and the Business case is expected to be presented to the Board in June.

7. Bank & Agency Expenditure reductions

Mrs McMahon, Director of Nursing, reported on this plan to reduce growing spending trends in bank & agency nursing. It was noted that reductions to Band 2 recruits will save c£48,000 per week.

Mr Cattell reported on additional controls over medical staffing. He was asked to bring a more detailed report to the next meeting.

8. A&E 4 Hours recovery plan

Mr Cattell reported on the progress achieved in delivering the recommendations of the ECIST following their visit to RHH last week. The 'perfect weekend' concept was discussed and Mr Cattell was asked to provide full details of costs and benefits to the Committee prior to arranging.

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 February is 3.85% (3.63% previously) The 2013-14 target is 3.50% and YTD performance is 3.69%.

b. Turnover
Turnover continues to remain consistent and within target at 8.02% (7.98%)

c. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small increase on previous months to 78.05%. No red rated subjects.
Appraisals have decreased this month to 77.26% (80% target).

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

The Committee noted that the Trust had 4 live ET cases submitted during the year.

10. Financial Performance for April 2013 to March 2014

The Trust made a small trading surplus of £752,000 in March, mainly due to additional one off income received from local commissioners. Expenditure levels in March reached the highest on record and are wholly unsustainable in future months.

The major problems were the level of pay expenditure, particularly agency spending, which is now running at unprecedented levels, despite the Trust never employing so many people and a continued failure to deliver CIP savings plans.

For the year in total the Trust reported an operating surplus of £351,000, £149,000 below plan. In addition restructuring expenses were charged (below the line) of £2.7m.

The Committee noted with concern that at £16.4m, the March pay spend was the highest ever recorded by the organisation and exceeded budget by £1,039,000.

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

Capital spending was behind annual plan by c 15% at £5.7m outturn.

The Committee noted the work of an experienced Turnaround Director and PwC to support the identification of additional CIP opportunities in short order.

11. Monitor Q4 Submission

Under delegated authority this submission was approved as:

Continuity of service (finance) rating of 3
Governance rating of Green.

12. Bad debts write off

Under delegated authority the Committee approved the write off of 5 cases exceeding £500 per case, with a combined value of £22,688.81.

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

a. **The Committees continued concern about the trends in overspending should be noted by the Board**

PA Assinder
Director of Finance & Information

THE DUDLEY GROUP NHS FOUNDATION TRUST

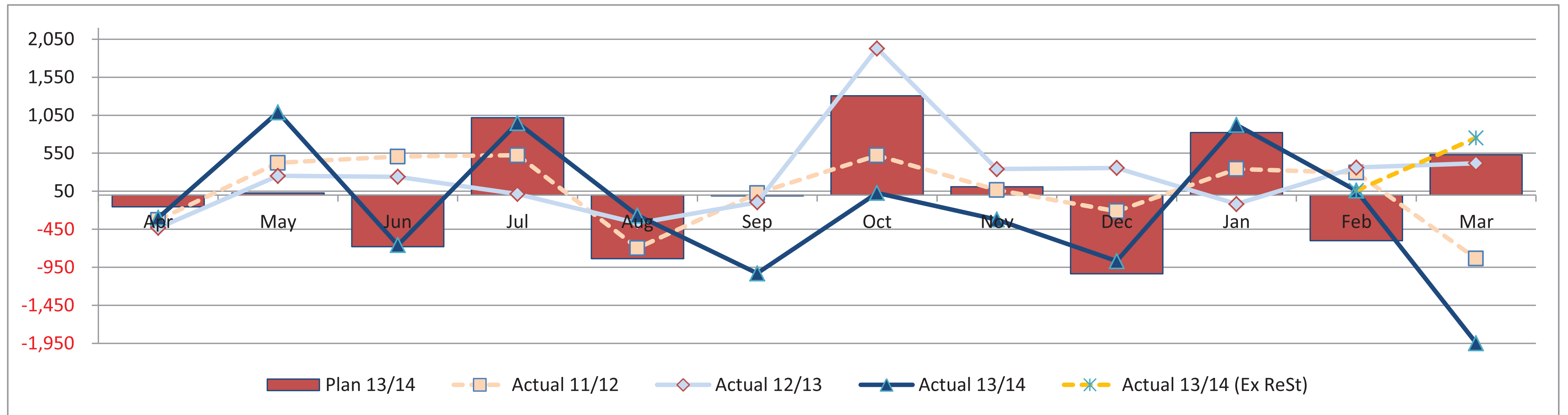
FINANCIAL SUMMARY **MAR 2014**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£26,276	£28,770	£2,494
PAY	-£15,367	-£16,406	-£1,039
CIP	£218	£0	-£218
NON PAY	-£8,668	-£10,420	-£1,752
EBITDA	**£2,459**	**£1,944**	**-£515**
OTHER	-£1,926	-£3,892	-£1,965
NET	**£532**	**-£1,948**	**-£2,480**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£309,700	£316,189	£6,489
PAY	-£184,795	-£186,218	-£1,424
CIP	£3,082	£0	-£3,082
NON PAY	-£104,639	-£107,746	-£3,107
EBITDA	**£23,348**	**£22,225**	**-£1,123**
OTHER	-£22,848	-£24,574	-£1,725
NET	**£500**	**-£2,349**	**-£2,849**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£309,700	£316,189	£6,489
PAY	-£184,795	-£186,218	-£1,424
CIP	£3,082	£0	-£3,082
NON PAY	-£104,639	-£107,746	-£3,107
EBITDA	**£23,348**	**£22,225**	**-£1,123**
OTHER	-£22,848	-£24,574	-£1,725
NET	**£500**	**-£2,349**	**-£2,849**

NET SURPLUS/(DEFICIT) 12/13 PLAN & ACTUAL **MAR 2014**



Key Comments

-**Deficit of £1.948m** in March (planned for £532k surplus so £2.480m over plan). **Cumulative deficit of £2.349m** (£2.849m behind plan).

- However, March position includes £2.7m for restructuring (Siemens Termination provision and MARS). Without these one-off below the line costs, the Trust would have returned a surplus in March of £752k and a cumulative surplus of £351k.

- The year end outturn is £519k better than forecast at month 11. This is largely due to additional income agreed with Dudley CCG as part of the year end settlement and a postive change to the PDC charge negated by a significant increase in expenditure (both pay and non-pay costs represent the highest value this year). The income settlement improved by £1.4m from previous assumptions and the PDC benefit equated to £0.7m. Other factors have thus deteriorated by £1.6m from previous forecasts (including £0.6m on pass through items).

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

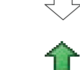
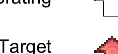
Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	A&E	2% of revenue derived from the provision of the locally defined service line in the month of the under - achievement	A&E 4 hour wait	91.5%	95%	⬆ (red)	● (red)
5	Cancer		14 Day – Urgent GP Referral to Date First Seen	97.7%	93%	⬆ (green)	● (green)
5	Cancer		14 Day – Urgent GP Breast Symptom Referral	97.8%	93%	⬇ (green)	● (green)
5	Cancer		31 Day – Diagnosis to Treatment for All Cancers	100%	96%	➡ (green)	● (green)
5	Cancer		31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs	100%	98%	➡ (green)	● (green)
5	Cancer		31 Day – 2nd/Subsequent Treatment – Radiotherapy	-	-	-	-
6	Cancer		31 Day – 2nd/Subsequent Treatment – Surgery	100%	94%	➡ (green)	● (green)
6	Cancer		62 Day – Referral to Treatment after a Consultant upgrade	100%	85%	➡ (green)	● (green)
6	Cancer		62 Day – Referral to Treatment following National Screening	100%	90%	➡ (green)	● (green)
6	Cancer		62 Day – Urgent GP Referral to Treatment for All Cancers	87.0%	85%	⬇ (green)	● (green)
9-10	Diagnostics		Percentage of diagnostic waits less than 6 weeks	99.6%	99%	⬇ (green)	● (green)
-	MSA	Retention of £250 per day the patient affected	Mixed Sex Sleeping Accommodation Breaches	0	0	➡ (green)	● (green)
7	RTT	Deduction of 0.5% for each 1% under-achievement, to a max of 5%*	Admitted % Treated within 18 Weeks	90.1%	90%	⬇ (green)	● (green)
8	RTT		Non-Admitted % Treated within 18 Weeks	98.6%	95%	⬇ (green)	● (green)
7	RTT		Incomplete % waiting less than 18 Weeks	93.1%	92%	⬇ (green)	● (green)
	RTT	£5,000 per patient	Zero tolerance RTT waits over 52 weeks	3	0	⬇ (green)	● (green)
	A&E	£1,000 per breach	Trolley Waits in A&E >12 hours	0	0	➡ (green)	● (green)

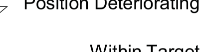
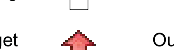
One month behind (applies to the Cancer rows)

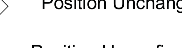
Page	Area	Breach Consequence	Measure	Month Actual / Month Target		Monthly Trend	Year End Forecast
-	Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payments*)	Failure to publish a Declaration of Compliance of Non-Compliance pursuant to clause 4.24. *Retention 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			● (green)
-	Compliance		Publishing a Declaration of Non-Compliance pursuant to clause 4.26.				● (green)

Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	HCAI	Lesser of 1.5% of inpatient revenue or £50,000 per case above 38 threshold.	C Diff – Post 72 hours	1	3	➡ (green)	● (red)
4	HCAI	Non-Payment of inpatient episode	Zero Tolerance for MRSA	1	0	⬇ (red)	● (red)

Page	Item	Measure	Actual	Trend
11	Never Events - Recovery of costs of procedure and no charge to the commissioner for any corrective procedure.		0	
12-13	Monitor Summary Report (*based on Q3 2013/14)*	Governance Risk Rating		
14-15	Mortality Reports	2013/14 Qtr 1 SHMI	1.11	⬆ (green)
16	CQC Surveillance Model – Intelligent Monitoring March 2014:	Risk Rating Score & Banding	7 & 4	
	Dr Foster – Hospital Guide 2013	HSMR	100.7	

 Position Deteriorating  Position Improving Position Unchanged

 Within Target  Outside Target Position Unconfirmed



NEVER EVENTS

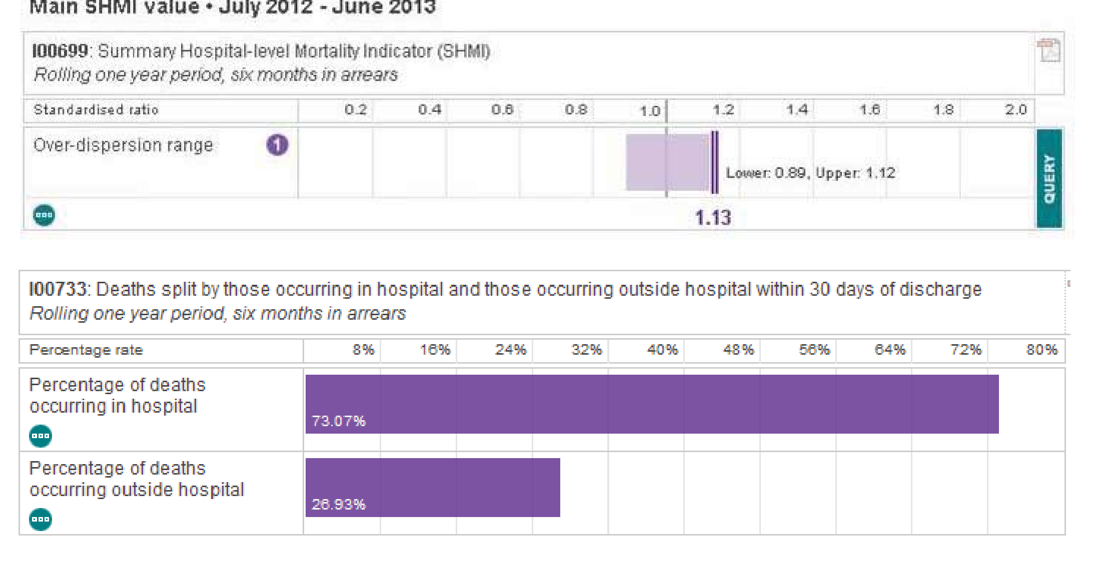
Description	Q1	Q2	Q3	Q4	YTD
Never Events : In hospital maternal death from elective caesarean section	0	0	0	0	0
Never Events : Inpatient suicide by use if no collapsible rails	0	0	0	0	0
Never Events : Intravenous administration of mis-selected concentrated potassium chloride	0	0	0	0	0
Never Events : Misplaced naso- or orogastric tube not detected prior to use	0	0	0	0	0
Never Events : Retained Instruments Post Operatively	0	0	1	0	1
Never Events: Air embolism	0	0	0	0	0
Never Events: Entrapment in bedrails	0	0	0	0	0
Never Events: Escape of a transferred Prisoner	0	0	0	0	0
Never Events: Failure to monitor and respond to oxygen saturation	0	0	0	0	0
Never Events: Falls from unrestricted windows	0	0	0	0	0
Never Events: Inappropriate administration of daily oral methotrexate	0	0	0	0	0
Never Events: Intravenous administration of epidural medication	0	0	0	0	0
Never Events: Maladministration of Insulin	0	0	0	0	0
Never Events: Misidentification of Patients	0	0	0	0	0
Never Events: Opioid overdose of an opioid-naïve Patient	0	0	0	0	0
Never Events: Overdoseof Midazolam during conscious sedation	0	0	0	0	0
Never Events: Severe scalding of Patients	0	0	0	0	0
Never Events: Transfusion of ABO-incompatible blood components	0	0	0	0	0
Never Events: Transplantation of ABO or HLA-incompatible organs	0	0	0	0	0
Never Events: Wrong gas administered	0	0	0	0	0
Never Events: Wrong Implant/Prosthesis	0	0	0	0	0
Never Events: Wrong route of Administration of Chemotherapy	0	0	0	0	0
Never Events: Wrong route of administration of oral/enteral treatment	0	0	0	0	0
Never Events: Wrong Site Surgery	0	0	0	0	0
Never Events: Wrongly prepared high-risk injectable medication	0	0	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.

Dudley Group FT MORTALITY - SHMI
Quarterly KPI Report

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR - Next update April 2014



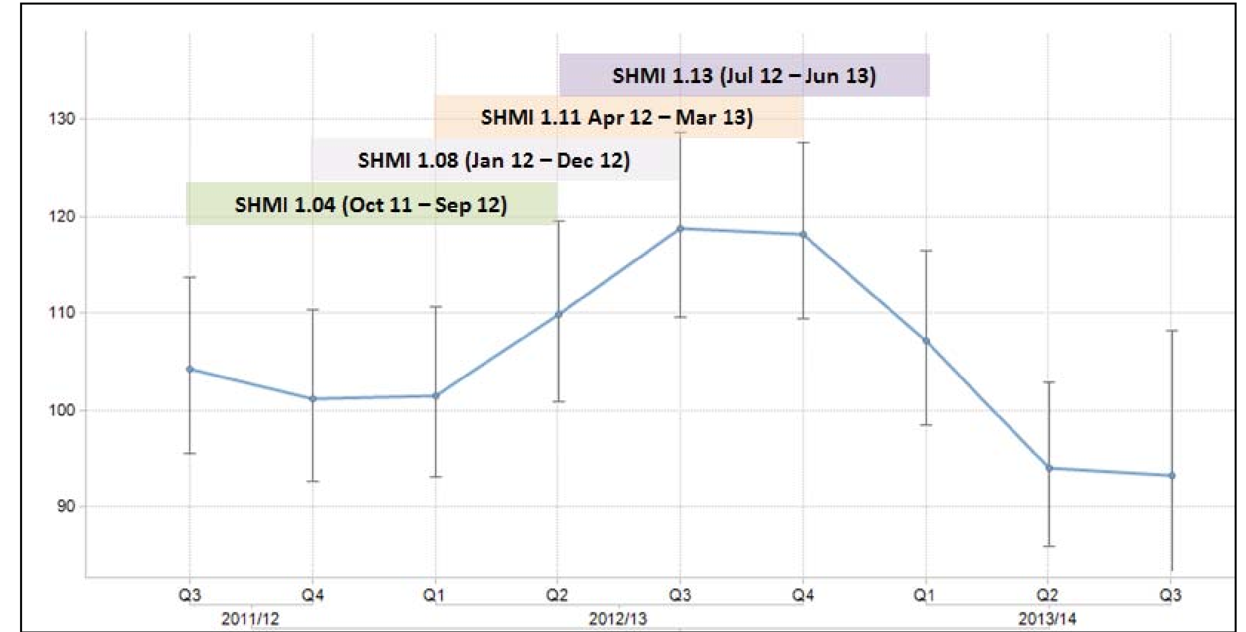
Source: NHS Choices

SHMI	**Source**	**2012/13 Q3**		**2012/13 Q4**		**2013/14 Q1**	
	NHS Choices	1.08	🟡	1.11	🟡	1.13	🔴

🟡 *Within over dispersion range*

🔴 *Outside of both Poisson and over dispersion range*

Graph showing the impact of the 2012/13 Quarter 3 & 4 winter period and the associated increase in death on the last three publications of the SHMI.
Looking at the quarterly SHMI figures for the 2013/14 Quarters 1 to 3 we would expect the SHMI to return back with the expected range within the next one or two reporting periods.



THE DUDLEY GROUP NHS FOUNDATION TRUST

INCOME & EXPENDITURE SUMMARY 2013/14 as at MAR 2014

Current Month Plan £000	Current Month Actual £000		Annual Plan £000	Plan to Date £000	Actual to Date £000	Variance to Date £000
		Income				
23,934	26,723	NHS Clinical Revenue	285,336	285,336	290,931	5,594
9	8	Private Patient	113	113	74	(38)
990	328	Other Non Mandatory	7,377	7,377	6,490	(887)
50	73	Research & Development	1,026	1,026	1,069	43
710	787	Education & Training	8,638	8,638	9,136	498
38	41	Car Parking	454	454	553	99
11	11	Accommodation	122	122	123	1
318	390	Non Patient Services to Other Bodies	3,594	3,594	3,764	170
216	410	Miscellaneous Other	3,039	3,039	4,050	1,010
26,276	**28,770**	**Total Income**	**309,700**	**309,700**	**316,189**	**6,489**
		Expenditure				
(2,404)	(2,725)	Drug Costs	(27,592)	(27,592)	(26,948)	644
(2,075)	(2,851)	Clinical Supplies	(24,989)	(24,989)	(28,224)	(3,235)
(370)	(540)	Non-Clinical Supplies	(4,309)	(4,309)	(4,682)	(373)
0	0	Secondary Commissioning	0	0	0	0
(15,182)	(14,950)	Employee Benefits (Permanent)	(182,268)	(182,268)	(175,033)	7,235
(115)	(1,366)	Employee Benefits (Agency/Locum)	(1,660)	(1,660)	(10,177)	(8,517)
(72)	(101)	Research & Development	(1,279)	(1,279)	(1,180)	99
(48)	(19)	Education & Training	(624)	(624)	(471)	153
(9)	(340)	Consultancy Expense	(437)	(437)	(987)	(550)
(1,754)	(2,007)	Miscellaneous Other	(19,315)	(19,315)	(19,482)	(167)
(2,930)	(2,930)	PFI Unitary Payment	(38,123)	(38,123)	(38,123)	0
1,311	1,311	IFRIC12 PFI Adjustment	17,059	17,059	17,059	0
(387)	(308)	Other PFI Expenses	(5,897)	(5,897)	(5,716)	181
218	0	CIP Requirement	3,082	3,082	0	(3,082)
(23,817)	**(26,826)**	**Total Expenditure**	**(286,352)**	**(286,352)**	**(293,964)**	**(7,613)**
2,459	**1,944**	**Surplus/(Deficit) EBITDA**	**23,348**	**23,348**	**22,225**	**(1,123)**
		Other				
0	(5)	Profit/(Loss) on Disposal	0	0	(10)	(10)
0	0	Impairment	0	0	0	0
0	(2,700)	Restructuring	0	0	(2,700)	(2,700)
(799)	(762)	Depreciation	(9,336)	(9,336)	(9,183)	154
0	7	Donated Assets	0	0	198	198
17	11	Interest Receivable	200	200	134	(66)
(1,144)	(442)	Interest Payable	(13,712)	(13,712)	(13,013)	699
(1,926)	**(3,892)**	**Total Other**	**(22,848)**	**(22,848)**	**(24,574)**	**(1,725)**
532	**(1,948)**	**Net Surplus/(Deficit)**	**500**	**500**	**(2,349)**	**(2,849)**

Note 1: Adverse variances are shown in brackets and red; Income/Surplus = positive; Expenditure/Deficit = negative;

Note 2: R&D Expenditure includes both pay and non-pay

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

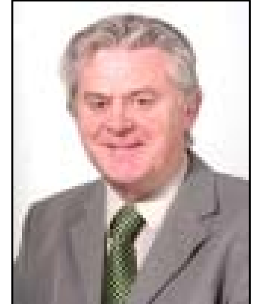
Richard is Executive Lead for operational management and delivery in clinical services on a day to day basis. He is responsible for the successful delivery of all national and local performance targets and quality standards, via each of the organisation's clinical directorates. Negotiation of and adherence 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