The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 3rd April 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 Apologies – D Bland**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 6th March 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 6th March 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 Quality Account Priorities 2014/15	Enclosure 5	D McMahon	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety, Patient Experience Committee, Exception Report	Enclosure 6	A Becke	To Note	10.20
	7.4 Risk and Assurance Committee Exception Report	Enclosure 7	A Becke	To Note	10.30
	7.5 Quarterly Safeguarding Report	Enclosure 8	D McMahon	To Note	10.40
	7.6 Organ Donation Recognition Project	Enclosure 9	D Badger	To Note	10.50
	7.7 Research and Development Annual Report	Enclosure 10	P Harrison	To Note	11.00
	7.8 Corporate Risk Register	Enclosure 11	J Cotterill	To Note	11.10
	7.9 Dementia Half Yearly Report	Enclosure 12	R Cattell	To Note	11.20
	7.10 Integrated Business Plan	Enclosure 13	R Beeken	To Note	11.30
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 14	D Badger	To Note & Discuss	11.40
9.	**Date of Next Board of Directors Meeting**		J Edwards		11.50
	9.30am 1st May, 2014, Clinical Education Centre				

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		11.50

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 6th March, 2014 at 9:30am in the Clinical Education Centre.

Present:
John Edwards, Chairman
David Bland, 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

14/023 Note of Apologies and Welcome

Apologies were received from Ann Becke.

14/024 Declarations of Interest

There were no declarations of interest.

14/025 Announcements

No announcements made.

14/026 Minutes of the previous meeting on 6th February, 2014 (Enclosure 1)

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

14/027 Action Sheet, 6th February, 2014 (Enclosure 2)

14/027.1 Chief Executive's Report – Mortality

The update on mortality had been presented at the last Clinical Quality, Safety, Patient Experience Committee. The item should have the Medical Directors initials against it on the action sheet.

The Committee exception report was covered on the agenda at item 7.2.

14/027.2 Emergency Plans Assurance

Update provided at the last Finance and Performance Committee.

14/027.3 Francis Report

Awaiting response from Monitor on the Role of Governor Report.

14/027.4 Stroke Service Review

A conference call was taking place following the Board meeting. An update will be provided to the April Board.

Update on the Stroke Service Review to the April Board.

14/027.5 Clinical Quality, Safety, Patient Experience Committee – WHO Checklist

To be reported at the March Clinical Quality, Safety, Patient Experience Committee with an update to the April Board.

To be reported at the March Clinical Quality, Safety, Patient Experience Committee with an update to the April Board.

14/028 Patient Story

A patient story video was shown to Board members. The story was from a female patient on B1.

The Nursing Director commented that it showed the importance of GP around choice and also highlighted the multi-disciplinary team.

Board members noted the positive comments around answering call buzzers.

The Director of Finance and Information asked how patients are selected to record their stories. The Head of Communications and Patient Experience confirmed that the Communications Team approach patients on the wards and ask if they are prepared to have their stay recorded.

The Director of Operations confirmed that the patient had described the enhanced recovery service which reduces days from the length of stay.

David Badger, Non Executive Director, suggested we could ask people who had done a written complaint if they would like to record their story.

The Board noted the positive story.

14/029 Chief Executive's Report (Enclosure 3)

The Chief Executive presented her report including:

- **95% 4hr Hospital/ED target:** This had been discussed during the earlier Clinical Director's presentation. Board members noted that the Emergency Care Intensive Support Team had visited the Trust the previous week to review length of stay. The Trust was also working with its partners around discharging to assess.

- **Friends and Family Report:** Board members noted the continued good performance. Jonathan Fellow, Non Executive Director, asked why the A&E results are on trend when we are missing the four hour target. The Chief Executive confirmed that the team are working hard around patient experience.

- **Keogh Action Plan:** Discussed with Monitor who are now content to close down the monthly reporting.

- **Nurse Establishment Progress:** Nurses from Spain and Portugal have now started to arrive at the Trust and feedback has been positive. The nurses from Romania are due to commence in April. David Badger, Non Executive Director, commented that we need to support the nurses so we do not lose any of them. The Nursing Director confirmed that there is a 24 hour on call service for them and they have also been buddied with a colleague. David Badger asked when the Trust can expect to see a reduction in bank costs. The Nursing Director confirmed that there is a four week induction period before they become operational. The Chief Executive commented that there is still a big gap in nurse vacancies. David noted this but stated that we still need to see an impact on premium costs.

- **Professor Briggs Visit:** Reviewing our Orthopaedic Services. The Team were very impressed with the service, outcomes and team working. They were also very impressed with the RTT 18 weeks performance.

- **Contract Negotiations:** The Heads of Agreement with the CCG had now been agreed.

14/030 Patient Safety and Quality

14/030.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Nursing Director, presented the Infection Prevention and Control Exception Report given as Enclosure 4, including:

- **C.Diff:** The report identifies 41 cases. There had been one case in February and the total now stood at 42 cases. No periods of increased incidence had occurred. Board members noted the target for next year is 48 cases.

  Last year the Trust's outturn was 56 cases, there is now a confidence that we will finish the year much lower than last year which will be the Trust's best ever performance for C.Diff. The C.Diff action plan is available on the shared drive.

  The Chairman asked why cases were so low in February. The Nursing Director said the reason was not clear and Board members noted that there had been no cases in February last year.

  The Nursing Director confirmed that the C.Diff algorithm was being agreed with partners.

- **Norovirus:** High incidence of cases in the community but the Trust is continuing to manage cases with a few admissions but no transmissions. The Chief Executive asked if there had been an upturn of cases in ED with Norovirus. The Nursing Director confirmed that there had and the Trust was working with GPs and public health to manage this although most cases were self-presenting.

The Chairman noted the good performance and that the C.Diff target for next year was being agreed with the Trust's partners and also noted the continued upward trend in the Community.

14/030.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5)

David Bland, Committee Chair, presented the exception report given as Enclosure 5, including the following issues:

- **Mandatory Training:** It was pleasing to note the highest level of compliance ever achieved.

- **Patient Safety Group – Pressure Ulcer Report:** Pleasing to see actions now embedded across the organisation.

- **NICE Guidance Update:** Good performance with a 17% decrease in the 'not yet assessed overdue' category.

The Medical Director commented that it was positive to note the mentoring process for Consultants.

The Chief Executive raised NHS Choices and confirmed that the numbers of comments are incredibly high and this is as a result of asking people in our correspondence and through the use of hand out cards to leave feedback.

Board members noted the positive actions.

14/030.3 Quarterly Complaints and PALS Report – October to December 2013 (Enclosure 6)

The Nursing Director presented the Complaints Report for Quarter three, given as Enclosure 6, including the following highlights:

- **Listening into Action Events:** Meetings held with complainants, three key themes for actions:

    - Complainants wanting more meetings: meetings now offered before the investigation commences.
    - Named individual: this is now in place.
    - Feedback on what changes have been put in place: This is now included in all letters.

- **Number of Complaints:** Clinical care is the top category with 24 complaints. Board members noted that future reports will show quarter on quarter results. When a complaint is received a risk category is identified and these are detailed in the report.

Future Complaints Reports to include quarter on quarter data.

- **Action Taken as a Result of Complaints or Concerns:** The Trust captures all changes that have happened as a result of a complaint and this is detailed on page six. Board members that there had been two issues relating to agency nurses and the respective agencies had been notified of the investigation. The Chairman asked if the Trust still pays for agency nurses where there is an issue with competency. The Nursing Director confirmed that is depends on the case but generally no.

David Badger, Non Executive Director, asked about the clinical negligence claims on page two of the report. There were eight cases detailed and it was be useful to see the period of the claims identified in the report.

Board members noted the complaints relating to Ophthalmology and the delays in clinics which were an organisational issue. The Director of Strategy, Performance and Transformation, confirmed that demand in Ophthalmology is very high and not all concerns are as a result of staffing issues. Board members noted that a new prioritisation system for follow ups is being implemented and triangulation of actions can be seen. David Badger, noted the actions but commented that the Trust should also investigate clinic timings. The Director of Strategy, Performance and Transformation confirmed that the Trust was reviewing clinics and was also recruiting two further Ophthalmic Surgeons.

The Chairman noted the positive report and confirmed that more trend information would be helpful in future reports.

14/030.4 Quality Accounts (Enclosure 7)

The Nursing Director presented the Quality Accounts Report for Quarter Three, given as Enclosure 7, including the following headlines:

- **Review of Q3 Performance:**

  - Patient Experience: Two targets for hospital and community, performance was mainly on track.

  - Pressures Ulcers: Very good performance.

  - Infection Control: MRSA well met. C.Diff discussed earlier on the agenda. Jonathan Fellows, Non Executive Director, asked when the Quality Accounts are produced, will we differentiate between the avoidable and unavoidable C.Diff cases. The Nursing Director confirmed that this will be included once the algorithm has been signed off.

  - Nutrition and Hydration: Three targets, very high thresholds. Slightly off course with one target and two targets on track.

  - Outline Statutory Responsibility for Statutory Assurance: Deloitte have audited for content, consistency and data testing. Last year the Board agreed to data test the 62 day cancer waits and C.Diff. Last year the Council of Governors chose patient experience for testing, this year it had been proposed to choose a nutrition indicator for the internal auditors.

- **Proposed Quality Priorities 2014/15:**

  There had been an initial proposal to include an extra priority around Diabetes but it has since been agreed that nationally mortality is the area that has the highest focus and therefore the Board is asked to agree to continue with the existing five topics with the addition of mortality as the sixth indicator.

The Chairman raised Professor Nick Black's recent comments around mortality indicators from earlier in the week. The Medical Director confirmed that the comments related specifically to HSMR and Professor Black had said that patients should not use this as an indicator of quality. The Trust needs to be cognisant that it is using an indicator that does not have academic worth. The Nursing Director confirmed that this point would be made in the accounts.

The Chairman noted the point around the wording of the mortality indicator in the accounts. The Board approved the recommendations for the testing of indicators by external audit and the quality priorities for 2014/15.

14/031 Finance

14/031.1 Finance and Performance Report (Enclosure 8)

David Badger, Non Executive Director and Chair of the Finance and Performance Committee, presented the overview of the February meeting given as Enclosure 8, including the following highlights:

- **Workforce KPIs:** Mandatory training discussed earlier on the agenda. Concern was noted around appraisals following a drop in the completion rate. Board members confirmed that 100% of all eligible staff should receive an appraisal and the target should be increased to 85% and the warning level increased from 50%. The Associate Director for Human Resources confirmed that appraisal reporting will be reviewed at the new Workforce Committee.

- **Financial Performance – Month 10:** Board members noted with concern that the Trust was now forecasting a £1.6m deficit. This was as a result of three factors: increased permanent staffing levels ; slippage on CIP and deterioration in run rate due to higher than previous year spend on bank and agency nurses.

  The Trust is operating in a pernicious contractual environment. C.Diff had generated fines although the Trust had achieved its best performance ever. Board members noted that the C.Diff target for 2014/15 would be higher than the current year. There had been substantial ambulance fines which were based on non-validated data and the Trust had expressed its concerns to the CCG that this data should be validated. It is clear that drastic action is required.

  A turnround specialist had been working with the Trust to identify CIP initiatives for 2014/15.

  The balance sheet and liquidity position remains solid but the Trust must arrest its overspending against budget.

- **Performance:** The Committee has requested a recovery plan and trajectory for four hour waits to its next meeting. Letters would be sent to the CCG and Local Authority around their contribution to the situation and the response would be discussed at the April public Board meeting.

Four hour wait trajectory and recovery plan to the March Finance and Performance Committee.
Letters to be written to the CCG and LA regarding their contribution to the situation and response discussed at the April public Board.

David Badger confirmed that it had been a challenging meeting and confirmed that the Board IBP meeting is critical in relation to the Trust meeting its two year plan.

In relation to feedback on appraisals The Medical Director confirmed that there is a built in feedback process for Consultant's good performance.

The Chairman confirmed that there needs to be a detailed look at outcomes at the next Board workshop. The financial benchmarking report had clear messages and the Trust needs to resolve maternity issues, PFI costs and non-tariff income.

The Director of Finance and Information provided an update on the turnround position. Steve Benger, turnround specialist had confirmed that the challenge is the identification and delivery of CIP opportunities and the Trust needs to focus on what it can influence on terms of internal efficiency. It needs to achieve upper quartile performance and it is evident that the Trust has fallen behind its competitors and it must identify and deliver savings opportunities.

The Chairman asked about the work being undertaken by PWC. The Director of Finance and Information confirmed that they had given the Trust's own CIP work some impetus and had put together a more robust range of opportunities.

David Bland, Non Executive Director, asked if data was available from other Trusts. The Director of Finance and Information confirmed that benchmarking information was not readily available and that is how PWC have been assisting the Trust.

The Chairman commented that our reference costs are lower but the Trust is struggling to deliver sustained financial performance.

The Chairman asked about mortality and the peak in the SHMI and whether the Trust had now seen any reduction in the numbers. The Medical Director confirmed that it had fallen significantly in the latest figures but he could not accurately predict when the Trust will be back in range.

The Board noted the excellent performance in Appendix two with the exception of C.Diff, 4 Hour target and the never event.

The Board received and noted the report.

14/032 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, 3rd April, 2014, at 9.30am in the Clinical Education Centre.

Signed …….

Date ……..

Enclosure 2

The Dudley Group NHS
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Action Sheet
Minutes of the Board of Directors Public Session
Held on 6 March 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
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	6/2/14	Awaiting response from Monitor
13/083.8 & 13/027.4	Stroke Service Review Strategy	Executive Team to enter into discussions with other local providers regarding the Stroke Strategic Review and feedback to the Board in March.	RB	6/3/14	Update to the April Board. On Agenda
14/008.1 & 13/027.5	Clinical Quality, Safety, Patient Experience Committee – WHO Checklist	Benchmarking information for WHO checklist to be included in the March Chief Executives Report.	CE	6/3/14	Included in the CQSPE Exception Report
14/031.1	Finance and Performance Report	Four hour wait trajectory and recovery plan to the March Finance and Performance Committee. Letters to be written to the CCG and LA regarding their contribution to the situation and response discussed at the April public Board.	RC PC	27/3/14 3/4/14	On Agenda In Chief Executive's Report
14/008.3	Keogh Action Plan	Update on AUKUH Tool to future Board.	DM	1/5/14	To the May Board
14/030.3	Quarterly Complaints and PALS Report	Future Reports to include quarter on quarter data.	DM	5/6/14	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 3rd April 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
- CQC Inspection

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive Update – April 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. Work continues to be focused on the "back door" and to ensure patients are not delayed once medically optimised. Plans are in place to cope with the inevitable pressures over the Easter weekend and the winter pressures schemes are continuing into April to assist.

Friends and Family Test:

		Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	preliminary Mar 14 as at 25/3
Maternity - Antenatal	Score	58	65	76	58	76	89
	Response rate	29% (of 294)	27% (of 242)	20% (of 258)	21% (of 252)	24% (of 217)	9%
Maternity - Birth	Score	76	86	85	88	78	83
	Response rate	15% (of 386)	30% (of 350)	9% (of 362)	26% (of 354)	23% (of 294)	23%
Maternity - Postnatal ward	Score	78	81	83	84	74	77
	Response rate	15% (of 383)	29% (of 350)	9% (of 361)	25% (of 353)	23% (of 292)	20%
Maternity - Postnatal community	Score	75	85	79	88	95	80
	Response rate	13% (of 315)	22% (of 300)	19% (of 262)	16% (of 299)	25% (of 257)	17%
Combined	Score	65	80	80	81	81	81
	Response rate	21%	27%	13%	22%	24%	18%

% of footfall (response rate)	<15%	15%+

Antenatal	80+	76-79	<76	FFT Scores key	Top 20% of Trusts (based on Dec 13 scores)
Birth	89+	85-88	<85		Between Trust Dec 13 score and top 20%
Postnatal ward	78+		<78		Below Trust Dec 13 score
Postnatal community	84+	79-83	<79		

CQC Inspection:

The planned CQC inspection took place at the end of the month. Many thanks to all the staff right across the organisation who worked hard to prepare for the inspection. At the time of compiling the report we are still awaiting the unannounced visits to take place. These should be completed by Friday 10th April in line with CQC practice. The report is expected at the end of May in readiness for the Quality Summit which will take place on 6th June. At that time the rating for the organisation will be made public.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd April 2014 - PUBLIC

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

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

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Infection Prevention and Control	
	Risk Register: Y		**Risk Score:**	IC010 – 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/N**	**Details:**	
	Other	**Y/N**	**Details:**	

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

GLOSSARY OF INFECTIONS

MSSA

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

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

MRSA

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

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

E Coli

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

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

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

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

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

C difficile

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

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

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

SUMMARY OF WARDS AND SPECIALTIES

Area	Speciality
A1	Rheumatology & Pain
A2	Rehabilitation
A3	Stroke Rehabilitation
A4	Acute Stroke
B1	Orthopaedics
B2	Hip & Trauma Orthopaedics
B3	General Surgery
B4	Mixed Colorectal & General Surgery
B5	Female Surgery
B6	Ear, Nose and Throat, Maxillo-Facial & Urology
C1	Renal
C3	Elderly Care
C4	Georgina Unit/Oncology
C5	Respiratory
C6	Respiratory/ Gastro Intestinal Medicine (GI Medicine) Overflow
C7	Gastro Intestinal Medicine (GI Medicine)
C8	Acute Medical Unit/Short Stay Unit
CCU/PCCU	Coronary Care Unit/Post Coronary Care Unit
Critical Care Unit	Critical Care
EAU	Emergency Assessment Unit
ED	Emergency Department
GI Unit	Gastro Intestinal Unit
MHDU	Medical High Dependency Unit
OPD	Out Patients Department
SHDU	Surgical High Dependency Unit

Report to: Board of Directors

Subject: Infection Prevention & Control Report

Summary:

Clostridium Difficile - The target for 2013/2014 is 38 cases; at the time of writing the report 43 cases have been recorded.

C. Difficile Cases Post 48 hours – Ward breakdown:

Ward	April '13	May '13	June '13	July '13	August '13	September '13	October '13	November '13	December '13	January '14	February '14	As of 25th March '14	Totals so far 13/14
A2	0	1	0	1	1	1	1	0	1	0	0	0	6
A3	0	0	0	0	0	1	1	0	0	0	0	0	2
A4	0	0	0	0	0	1	0	0	0	1	0	0	2
B2	0	1	0	0	0	0	0	2	0	0	0	0	3
B3	0	0	0	0	0	1	0	0	0	0	0	1	2
B4	0	0	0	0	0	1	0	0	0	0	0	0	1
B5	0	0	0	0	0	0	0	0	0	1	0	0	1
B6	0	0	0	0	0	0	0	0	1	1	1	0	3
C1	1	1	0	0	0	0	0	2	0	0	0	0	4
C3	0	1	1	1	0	1	1	0	1	0	0	0	6
C4	0	0	0	0	0	0	0	0	0	1	0	0	1
C5	0	0	2	0	0	0	1	2	0	0	0	0	5
C7	0	0	0	0	0	0	0	1	0	0	0	0	1
C8	0	0	0	0	1	0	1	0	0	0	0	0	2
MHDU	0	0	1	1	0	0	0	0	0	0	0	0	2
CCU/PCCU	0	0	1	0	0	0	0	1	0	0	0	0	2
Total	**1**	**4**	**5**	**3**	**2**	**6**	**5**	**8**	**3**	**4**	**1**	**1**	**43**

See Appendix 1 – Board Report (2013/2014)

MRSA – Annual Target 2 (Post 48 hrs) – There has been 1 case of post-48 hrs MRSA bacteraemia within the Trust. A 72 hour meeting has been held with all relevant internal staff and outside agencies and an action plan produced and the PIR process commenced.

C. Difficile – We have had 43 cases against an annual target of 38 to date. The ongoing Infection Control and C.Difficile Recovery Plan is being followed and actions completed in a timely manner.

The Trust's C.Difficile objective for next year is 48 cases. This is 10 higher than the current 2013/14 year. There has been acknowledgement from the Department of Health that whilst NHS organisations have continued to deliver a year on year reduction in C.Difficile cases this has slowed over recent years. Experts have advised that the time has arrived when organisations may be approaching their irreducible minimum level of cases. The objectives have been modified based on each individual organisation's performance over the preceding year but is intended to reflect an achievable target.

In order to learn from cases to continue to show improvement each organisation is being encouraged to assess each CDI case to establish whether there is a link with a lapse in the quality of care. This should help identify if cases are considered avoidable. The sanctions imposed on organisations failing to meet their targets can then, with agreement with commissioners, be modified in light of the above methodology. These avoidable/ unavoidable cases will be published on Trust website but are not nationally reported. The intention is to ensure relevant lessons are learned promptly and to provide a basis upon which we can target further improvement to increase patients' safety.

Using local benchmarking data it is clear that many Trusts have struggled with their target this last year and this is reflected in the objectives for 2014/15.

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

Appendix 1

(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-13	1	3	-66.7%	1	3	-66.7%	4	6
May-13	4	3	33.3%	5	6	-16.7%	10	11
Jun-13	5	3	66.7%	10	9	11.1%	6	6
Jul-13	3	3	0.0%	13	12	8.3%	9	11
Aug-13	2	3	-33.3%	15	15	0.0%	8	11
Sep-13	6	3	100.0%	21	18	16.7%	12	17
Oct-13	5	4	25.0%	26	22	18.2%	9	17
Nov-13	8	3	166.7%	34	25	36.0%	15	16
Dec-13	3	4	-25.0%	37	29	27.6%	5	6
Jan-14	4	3	33.3%	41	32	28.1%	6	9
Feb-14	1	3	-66.7%	42	35	20.0%	2	6
Mar-14	1	3	-66.7%	43	38	13.2%	1	2
FY 2013-14	43	38	13.2%				87	118

The CCG target for Cdiff is 38 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.

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

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

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-13	-	0	0.0%	-	0	0.0%	-
May-13	-	0	0.0%	-	0	0.0%	-
Jun-13	-	0	0.0%	-	0	0.0%	-
Jul-13	-	0	0.0%	-	0	0.0%	-
Aug-13	-	0	0.0%	-	0	0.0%	-
Sep-13	-	0	0.0%	-	0	0.0%	-
Oct-13	-	0	0.0%	-	0	0.0%	-
Nov-13	-	0	0.0%	-	0	0.0%	-
Dec-13	-	0	0.0%	-	0	0.0%	1
Jan-14	-	0	0.0%	-	0	0.0%	-
Feb-14	-	0	0.0%	-	0	0.0%	-
Mar-14	1	0	100.0%	1	0	100.0%	1
FY 2013-14	1	0	100.0%				2

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.

Monthly number of MSSA cases

MSSA infections		
Month / Year	**Total**	**Cumulative**
Apr-13	6	6
May-13	6	12
Jun-13	-	12
Jul-13	6	18
Aug-13	7	25
Sep-13	4	29
Oct-13	9	38
Nov-13	2	40
Dec-13	6	46
Jan-14	8	54
Feb-14	12	66
Mar-14	-	66
FY 2013-14	66	

Monthly number of E.coli cases

E.coli infections		
Month / Year	**Total**	**Cumulative**
Apr-13	25	25
May-13	13	38
Jun-13	14	52
Jul-13	22	74
Aug-13	32	106
Sep-13	17	123
Oct-13	22	145
Nov-13	15	160
Dec-13	17	177
Jan-14	19	196
Feb-14	33	229
Mar-14	4	233
FY 2013-14	233	

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd April 2014

TITLE:	**Quality Account Priorities for 2014/15**		
AUTHOR:	Derek Eaves Quality Manager	**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.

SUMMARY OF KEY ISSUES:

In March 2014 the Board agreed to continue in 2014/15 with the same priority topics as 2013/14. These are:

- Patient Experience
- Infection Control
- Pressure Ulcers
- Nutrition
- Hydration

In addition, it was agreed to add Mortality as a sixth topic

It was noted at the time that the specific targets associated with each of these topics would have to be agreed at a later date further towards the end of the financial year when it was clear how we had progressed with the 2013/14 targets. Generally, we are now at the point when we are in a position to know whether we have or are likely to have achieved the 2013/14 targets. The attached paper outlines our position and suggests the targets for 2014/15. A decision on these is required now as the agreed targets have to go into the 2013/14 Quality Account which is already in draft form and has been sent to commissioners, Healthlink, Governors etc for their comments with the final version required by 26th April.

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IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details**:
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Quality Report requirements
	Equality Assured:	**Y**	**Details:** Better Health Outcomes Improved Patient Access and Experience
	Other	**Y**	**Details**: DoH Quality Account requirements

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
✓		✓	

RECOMMENDATIONS FOR THE BOARD: To note the present position with the 2013/14 targets and agree the targets for 2014/15.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Quality Account Priorities for 2014-15

Introduction

In March 2014, the Board of Directors agreed that the topics for the quality priorities in 2014/15 should remain the same as 2013/14. These are:

Patient Experience Infection Control Pressure Ulcers Nutrition Hydration

In addition, following the Keogh review, it was agreed to add a sixth topic: Mortality.

There is now a need to agree the detailed targets for each topic for the forthcoming year now that we either know for definite or have a reasonable idea on whether we have or are likely to achieve the majority of the actual targets set for 2013/14.

1) Patient Experience

a) Hospital

Quality Priority hospital (a)	**Q1**	**Q2**	**Q3**	**Q4** as at 24.03.14	**YTD** as at 24.03.14
Maintain an average score of 85 or above throughout the year for patients who report receiving enough assistance to eat their meals	77.3	77.6	81.2	91.2	81.5
Number of patients who felt that they sometimes or never get the help that they needed	3 (out of 326 surveyed)	9 (out of 429 surveyed)	3 (out of 359 surveyed)	2 (out of 280 surveyed)	17 (out of 1394 surveyed)

Quality Priority hospital (b)	**Q1**	**Q2**	**Q3**	**Q4**	**YTD** as at 24.03.14
By the end of the year at least 80 per cent of patients will report that their call bells are always answered in a reasonable time	89.2	89.1	89.4	77.8	88.5

It can be seen that the latest data indicates that, although there has been a recent improvement in the figures, the Trust has not met the target relating to patients perception of receiving enough assistance to eat their meals (target 85 with actual YTD (year to date) figure of 81.5). It is therefore suggested that this target is retained in 2014/15.

With regards to the call bell target, this has been achieved for the year as a whole and so it is suggested to replace this with the only question in the Trust's national survey of adult inpatients results that is in the category of 'worse' than other trusts – the rating of hospital food. Therefore the following two targets are suggested:

(a) Maintain an average score of 85 or above throughout the year for the patients who report receiving enough assistance to eat their meals on our real-time surveys.

(b) Increase the rating of hospital food from 4.3 in the 2013 national survey of adult inpatients. and
Show trend of improvement on the rating of hospital food in our local real-time surveys.

a) Community

The two targets set for 2013/14 were:

a) Increase the number of patients who use their Single Assessment Process folder/Health and Social Care Passport to monitor their care from 49.4 per cent to 80 per cent by the end of the year.

b) Increase the number of patients who would know how to raise a concern about their care and treatment if they so wished from 86.8 per cent to 90 per cent by the end of the year

The results of the 2013/14 community survey are not available at this time to assess what the position is with the above two targets. However, it is suggested that the Single Assessment Process folder priority be removed for 2014/15 as this remains outside the control of the Trust as this is a multi-agency document and there have been delays in the implementation of an updated version due to the number of organisations involved.

The following suggested topics for 2014/15 are based on the latest year's available results (2012/13) lowest scoring questions, subject to not yet knowing the figures for 2013/14 and consistent with the Trust's wish to encourage patients to provide feedback on the service provided:

a) *Equal or improve the percentage of patients who state they were informed who to contact if they were worried about their condition after treatment.*
b) *Equal or improve the percentage of patients who state they know how to raise a concern about their care and treatment if they so wished.*

2) Infection Control

The Trust has not met its zero target of MRSA bacteraemias having had one case on March 21st 2014 just prior to the end of the year and has not met its C. Difficile target for 2013/14 (no more than 38 post 48hr cases). At the time of writing this paper (25th March), the Trust has had 43 C. Difficile cases. These targets were the ones set on a national basis. It is suggested that the 2014/15 targets for the quality account are again the same as those set nationally. The targets therefore would be:

Reduce our MRSA and Clostridium difficile rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C. difficile is no more than 48 post 48hr cases in 2014/15.

3) Pressure Ulcers

The Trust will achieve its hospital pressure ulcer target of a 50 per cent reduction of avoidable stage 4 ulcers from 2012/13 (In 2012/13 there were 31 stage 4 pressure ulcers and at the end of Dec Trust had zero).

The Trust will not achieve its hospital pressure ulcer target of a 25 per cent reduction of avoidable stage 3 ulcers from 2012/13 (In 2012/13 there were 21 stage 3 pressure ulcers and at 28th March the Trust has had 15).

The Trust will achieve its community pressure ulcer target of a 25 per cent reduction of avoidable stage 3 and 4 ulcers from 2012/13 (In 2012/13 there were 18 stage 3 and 4 pressure ulcers and at 28th March the Trust has had 3).

The targets in 2013/14 paralleled the CQUIN target and so it is suggested that the Board agree that the quality account targets in 2014/15 for pressure ulcers also reflect the CQUIN targets:

a) Hospital

No avoidable grade 4 hospital acquired pressure ulcers.

Reduce avoidable grade 3 hospital acquired pressure ulcers in 2014/15 so that the number is less than the number in 2013/14

b) Community

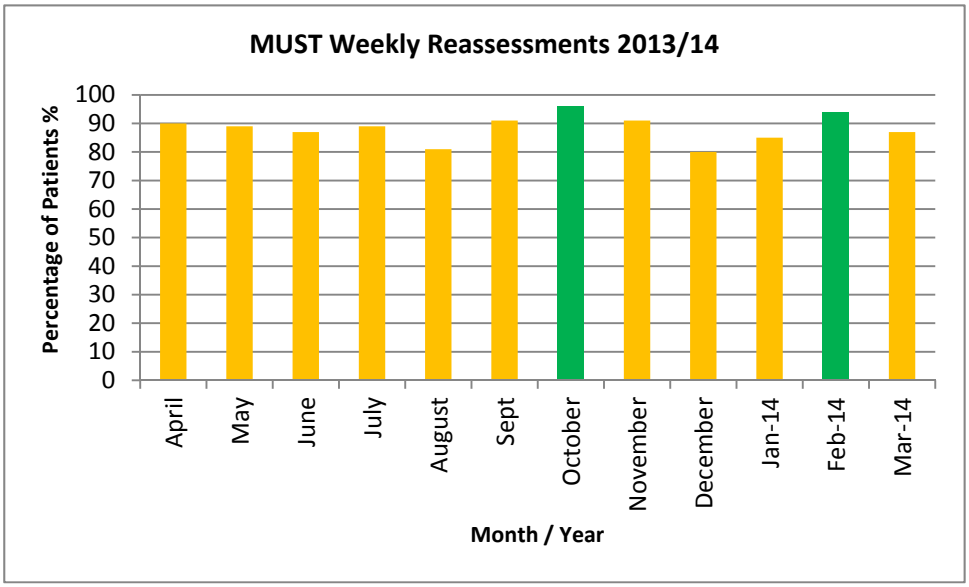
No avoidable grade 4 hospital acquired pressure ulcers.

Reduce avoidable grade 3 hospital acquired pressure ulcers in 2014/15 so that the number is less than the number in 2013/14

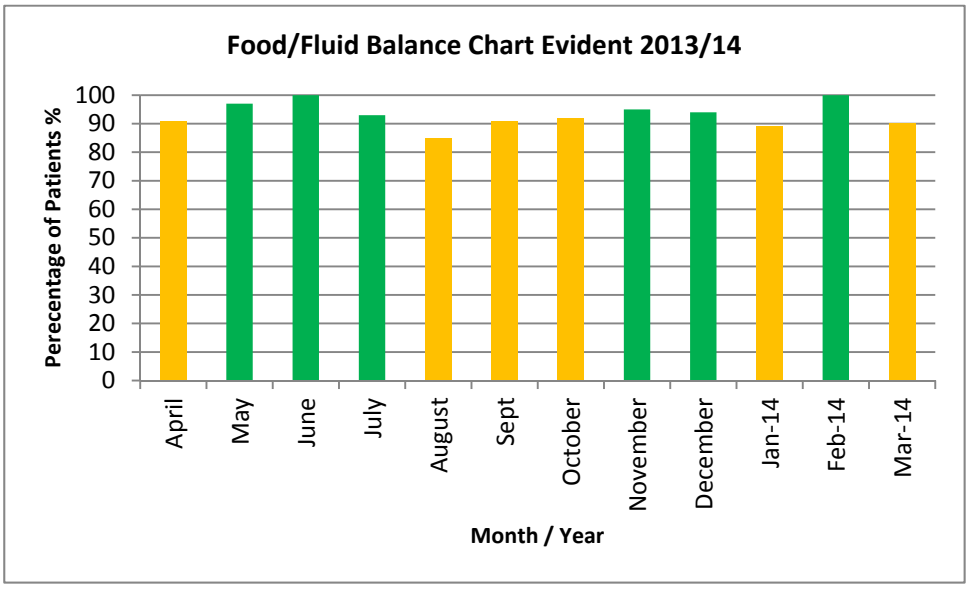
4/5) Nutrition/Hydration

The graphs below shows the overall Trust results for 2013/14:

Nutrition

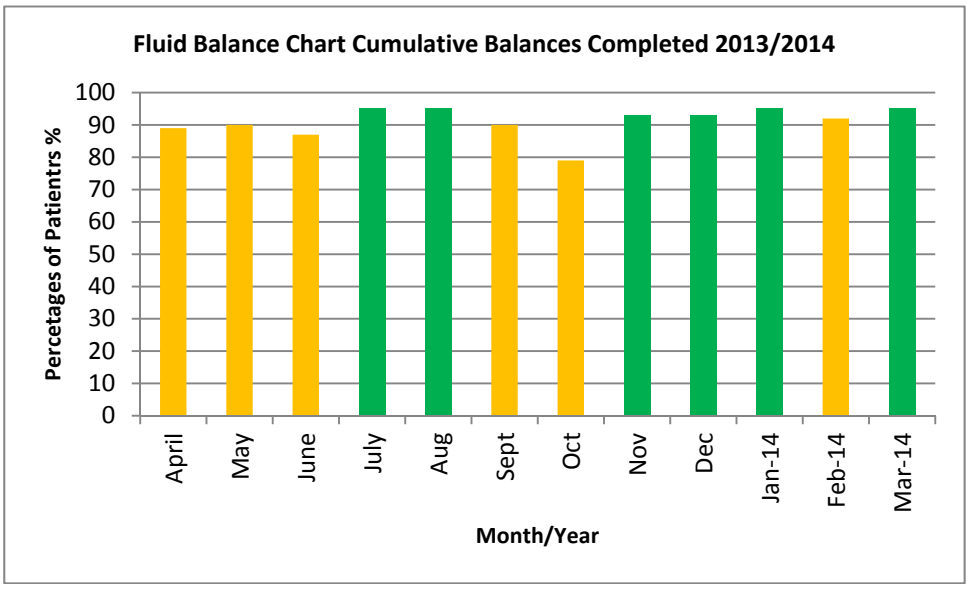


Results for the weekly reassessments of the MUST scores show that although 93% or over was achieved in October and February unfortunately the average of 90% throughout the year has not been met (average was 88%). In March the figure attained was 87% and so the 93% end of year target was not met.



Results for patients identified at risk having both a fluid balance and food monitoring chart in place show that 93% or over was achieved in six of the months and the average of 90% throughout the year has been met (average was 93%). In March the figure attained was 90% and so the 93% end of year target was not met.

Hydration

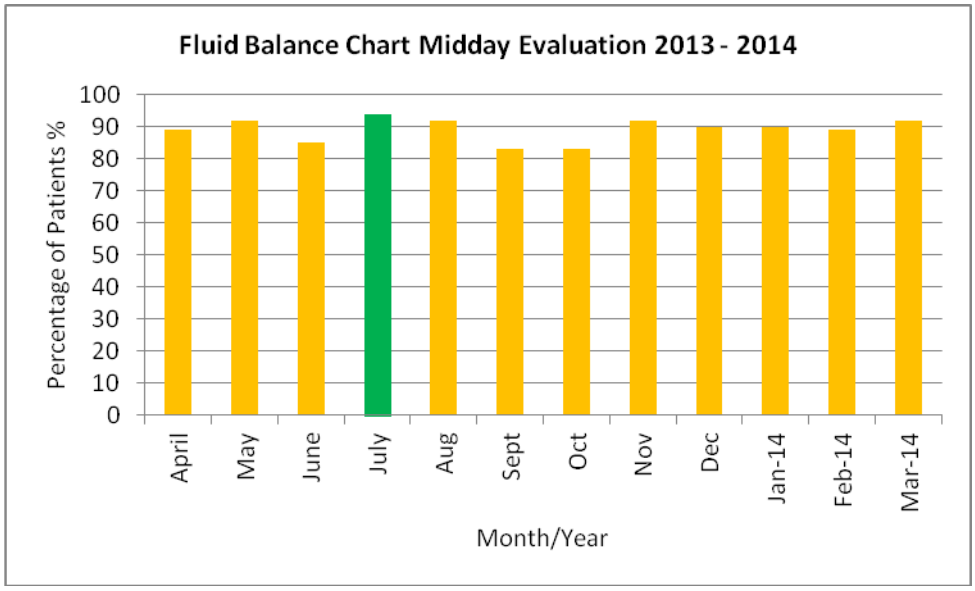


Results for patients having their fluid balance charts completed show that 93% or over was achieved in six of the months and the average of 90% throughout the year has been met (average was 91%). In March the figure attained was 95% and so the 93% end of year target was met.

It can be seen that the results have been rather mixed. With regards to undertaking the weekly re-assessments of the MUST we didn't achieve the 90% average target (actual figure 88%) or the end of year target of 93% (actual figure 87%) and so it is suggested that we retain this target for 2014/15. Due to adding in a sixth priority topic this year (Mortality - see below) and as we achieved an average of 93% in our second nutrition target it is suggested that we have just one nutrition target in 2014/15. With regards to hydration, we achieved both elements of that target, with nurses ensuring that they completed patients' fluid balances at the end of the day. As it is important that nurses not only monitor and total the fluid balance at the end of the day but monitor

input and output continually we have introduced that the balance should also be calculated and documented at midday. These lunch time evaluations are vital in ensuring that any hydration issues are identified early so interventions and active management can be implemented to halt any deterioration of the patient.

In 2013/14, the average monthly completion of these midday accumulations was 89% (see below) and so our new hydration target for 2014/15 is that this should average 93% like we achieved in 2013/14 with the end of the day accumulations.



It is therefore suggested that the following targets are introduced:

Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90% of patients will have the weekly risk assessment completed and this will rise to at least 93% by the end of the year (March 2015).

Ensure that on average throughout the year 93% of patients' fluid balance charts are fully completed and accumulated at lunchtime.

6) Mortality

The following two targets are 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.

Rationale for Inclusion

- Feedback from the Keogh Review in May 2013 indicated that the Trust should consider including Mortality as a Quality Priority

- The Keogh Report highlighted the importance of detailed and systematic case note review as the way forward in learning from hospital deaths and therefore the Trust needs to ensure that this is undertaken regularly in all specialties.

- A high SHMI is a trigger for hospitals to investigate and understand where performance may be falling short in specific areas. Congestive Heart Failure (Non-Hypertensive) has been an outlying area for at least 3 years.

Current status

At present, the Trust has an average of 70.6% of in hospital deaths undergoing specialist multidisciplinary review within 12 weeks. The details by speciality are below:

Meeting 85% Target **At or above Trust Average** **Below Trust Average**

Specialty	% audited within 12 weeks	Specialty	% audited within 12 weeks
Cardiology	80.6	Clinical oncology	63.6
Gastroenterology	65.1	Haematology	50
General Medicine	64.5	Medical oncology	33.3
Medical Assessment	82	Care of the Elderly	79.3
Orthogeriatrics	100	ENT	66.7
Rehabilitation	70.6	General Surgery	62.8
Respiratory	95.5	Urology	30
Stroke Medicine	85.9	Vascular Surgery	47.4
Diabetes	88.9	T&O Rehabilitation	100
Endocrinology	100	Trauma and Orthopaedics	96.3
Renal	32.1	Neonates	100
Rheumatology	100	Gynaecology	100

For the diagnostic group Congestive Heart Failure (CHF); nonhypertensive the latest SHMI figure available (for November 2012-October 2013) is 1.38

Developments planned for 2014/15

- Cardiology review of all cases of CCF identified on admission
- Cardiology Team to undertake quarterly audit to identify areas/clinicians of poor heart failure diagnosis.
- Directorate Mortality and Action Plans Reviewed Quarterly
- Monthly mortality meeting to be held by Medical Director, Information and CCG to review:
    - Mortality Indices,
    - Mortality Tracking System Performance
    - Review action plans
    - Provide exception reports where necessary to board.

De/qualityaccountargetpaperapr14

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 3rd April 2014

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 13th February 2014		
AUTHOR:	Julie Cotterill Governance Manager	**PRESENTER:**	David Bland (NED) CQSPE Committee Chair

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

SUMMARY OF KEY ISSUES:

Cancer Patient Experience Survey Action Plan - Matron Waldron presented the report and RAG rated action plan which confirmed completion dates and time scales and the work undertaken by the Task and Finish Group. Regular meetings with the Commissioning Manager for planned care and the GP Cancer/Palliative Care Lead were now in place. The Committee considered the appropriateness of sharing the detail of the action plan, themes and timeline with Macmillan. The Committee also discussed the improvements outlined by Matron Waldron and the potential cost implications and funding of these. The Committee requested a further update in two month's time.

Reports from Reporting Group

New Interventions Group - The group received three applications in the last quarter:

- **Extracorporeal Shock Wave Therapy (ESWT) for Chronic Achilles Tendinopathy and Chronic Plantar Fasciitis:** (this controls inflammation).
- **Transperineal Template Biopsy of Prostate:** This procedure is used for failed transrectal biopsy of the prostate. The Group asked for more information regarding safety and how patients were selected.
- **Laparoscopic and Percutaneous Renal Cryoablation for Small Renal Mass:** This procedure is proposed for renal tumours <4cm in patients who are unfit for nephrectomy. The Group was awaiting additional information before granting approval.

Patient Safety Group - held on 10th January 2014 highlighted the following:

- **Safety Express Group** – An internal audit undertaken by Baker Tilley had highlighted inconsistencies between the Safety Thermometer hard copy data collection and electronic information submitted. The Trust now uses hand held devices to capture the information electronically across all areas.
- **Cardiac Arrests and Cardiac Arrest Trolley Audits -** The cardiac arrest trolley daily checks in November 2013 identified 7 areas that were not 100% and 5 areas in December.
- **Serious and Adverse Incident Monitoring Report -** 7 new General SI's were reported in December 2013. Concerns highlighted from the General SI's were the upward trend in the reporting of Unexpected Deaths which was partly attributed to positive reporting.
- **Ambulatory Medicine (20 December 2013) -** There was a rise in incidents regarding leaks from waste pipes in the Renal Unit. The drains required rodding every two/three weeks.

Internal Safeguarding Board – The Deputy Director of Nursing highlighted the key issues from the meeting held on 30th January 2014 and focussed on the improvement in safeguarding training compliance. Safeguarding Adults compliance was 82.4% against the target of 90% and would continue to be monitored monthly. Safeguarding Children Foundation level compliance was 83.2%, Intermediate level: 54.1%. Mental Health compliance was 65.2% against the target of 90%. The Clinical Nurse Specialist for Older People was meeting with Learning and Development to review the staff groups requiring this training. The PFI partners had achieved Foundation and Intermediate level for those who needed it e.g. Porters and Security. The Learning Disabilities CQUIN target had been achieved. The Deputy Director of Nursing outlined the process to identify patients requiring 1:1 supervision and the reviews by the Mental Health Team to ensure that observations and mental health and Dols assessments were completed. The Committee was advised that the Dudley Safeguarding Adults Board had commenced a review including the Trust restraint issues.

Children's Services (14rh January 2014) - The Deputy Director of Nursing presented the summary of issues and referred to the training compliance rates in theatres. Paediatric resuscitation training had increased to 73%. Extra sessions had been provided to achieve this. Safeguarding training compliance in theatres had also increased from 38% to 70%. The Theatre Manager and the Named Nurse for Safeguarding Children would continue to work closely to increase the compliance rate further. The West Midlands Quality Review of Standards for the Critically Ill/Injured Child undertaken on 21st January 2014 was very positive and no major concerns had been identified. The final report was due at the end of February.

Friends and Family Report - the Trust had not maintained the high Inpatient and A&E scores seen in December but remained above the national average. The Maternity scores were reported for the first time. These were very high and the Trust was the top in the region in December.

Patient Experience Report & NHS Choices - the Patient Experience CQUIN indicators focused on the Friends and Family Test and include implementation in outpatients, day case and community. There will also be a staff Friends and Family Test. National Maternity Survey Results were received during the quarter and Trust comparisons show that "Labour and birth" and "Staff" were "about the same", "Care in hospital after the birth" was "Better". The Committee will receive a quarterly report on the Patient Experience Strategy Action Plan.

Serious and Adverse Incident Monitoring Report (January 2014) – 7 new incidents were reported (1 delay in obtaining test, 1 stillbirth (pre delivery), 3 patient falls resulting in fracture which occurred in different areas, 1 no beds/treatment room available, 1 confidentiality breach which related to a fax intended for a GP surgery that went to a garage in Dudley; the telephone number was correct however the dialling code was incorrect). The Committee received assurance that all incidents were under investigation and had been reported appropriately.

There were 39 open general SI's in total (12 undergoing investigation, 23 awaiting assurance that all actions identified from the RCA investigation had been completed and 4 recommended for closure). The CCG considered the previous retrospective reporting of pressure ulcers as unacceptable and had requested a change in the process. From 01/03/2014 all Grade 3 or 4 pressure ulcers acquired in acute or community care must be reported 'real time' within 48 hrs of the incident being reported to DATIX.

For January 2014 there were no breaches in the 2 days from identification of the incident and reporting and there were no breaches to complete the investigation in agreed time scales.

The Committee were requested to support the closure of 4 Serious Incidents

- 2013/33414 - **CONFIDENTIALITY BREACH -** District Nurse's car was broken into on staff members drive and work laptop stolen. The Committee agreed to close this incident.
- 2013/30345 - **CONFIDENTIALITY BREACH**. A member of staff wilfully accessed the OASIS system in order to establish information relating to a work colleague. The Committee agreed to close this incident.
- 2013/31834 - **BOGUS HEALTH WORKER.** The Committee agreed to close this incident**.**
- 2013/29260 - **PATIENT FALL RESULTING IN FRACTURE** on Ward C4 – Documentation (falls bundle not maintained risk assessments not completed when required. Nursing actions not taken (no chair/bed alarms sought). The Committee agreed to close this

Aggregated Incident Report – (quarter 3) - there were 4079, 3271 patient incidents and 808 non clinical incidents reported in the quarter and only 90 in the same quarter in 2010/2011.This was a reflection of the improved incident reporting culture. The Committee considered the incident categories showing an increased trend, including medication incidents. The severity of the incidents showed that 99% of these were no harm/near misses. These incidents were raised by the ward Pharmacists and addressed immediately. The Patient Falls, Injuries and Accidents category continues to be an area of consistently high reporting with an increase in Falls from Bed, Fall from Chair/Toilet/Commode and Patient Falls Resulting in a Fracture. These occurred in different areas with different conditions and there was no evidence of a trend. Any identified trends would be addressed at the monthly Falls Prevention and Management Group Meeting. There were 260 records, communications and information incidents reported in Quarter 3 of which 83 were in the subcategory Delay in Obtaining Medical Record. The Health Records Manager was aware of this data and was continuing with the actions reported in November 2013 which included monitoring the full roll out of the RoAR (Retrieval of all Records) system. An update had been requested but was awaited. The Committee **noted** the key issues identified. No further actions were identified for follow up or to be taken by other reporting groups.

Mortality Report - Dr Harrison presented the Quarterly Mortality Report Action Log highlighting 2 red actions "repeat successful training to improve recording of primary cancer in first admitting episode for relevant CCS groups" and "investigate possibility of improving mortality performance by preventing a change of admitting episode between acute medical wards." He advised that as the timeline for both actions was scheduled for May 2014 and work was in progress, these actions should be shown as amber and not red. The Committee was referred to the reduction in crude mortality showing the impact of correct primary diagnosis on the indicator, together with a thematic review of cases referred to the Mortality Review Panel. The Committee **received** the Mortality Report and **approved** the action plan and **noted** the progress on the

agreed actions

Quality Dashboard for Month 9 (December) 2013/2014 - there were 3 confirmed C.Diff cases signed off to ICNET in December. With January figures the Trust had exceeded the years target of 38. The TAL indicator had increased to 44.8% in December, against the 80% required performance. The Out Patients Department had established a SteeringGroup with speciality split for OPD and Ophthalmology and was reviewing this. There were no red rated Nursing Care Indicators or Protected Mealtime measures, but the Saving Lives: Enteral Feeding KPI was just under the warning level. Three wards were currently showing red for Think Glucose – B6, C6 and C8 and the same three wards and B3 were in the red with Protected Mealtime: Assistance. Two areas were red for the Saving Lives: Enteral Feeding - Critical Care and MHDU. The two wards with the most red rated Nursing Care Indicators were C5 having 6 and B6 with 4.
All the clinical indicators listed for January under NHS Choices were within the acceptable range except the day case rate for patients who had surgery for Dupuytren's Contracture where there was a high likelihood of the patients staying overnight. This had improved but was now slipping. The Trust was in the acceptable range for all of the other indicators. The Committee **noted** the quality dashboard looking at the performance trends and variances against target for NCIs.

Nursing Care Indicators - 16 ward areas had reported a reduction in the previous quarter results. The Committee was encouraged by the results and challenged the consistency of performance. The Deputy Director of Nursing confirmed that the numbers requiring escalation were small in comparison to the overall position and assured the Committee that escalation processes were stringently followed.

Safety Thermometer – The Deputy Director of Nursing presented the Safety Thermometer Report for quarter 3 and confirmed that between 620 and 650 in-patients and approximately the same number of community patients were audited monthly. The issues arising related to low numbers of patients. The following were reported between Oct – December 2013:

- 12 new pressure ulcers
- 8 falls with harm.
- 14 Catheter Acquired Urinary Tract infections were identified.
- 2 VTEs.

The Committee **received** the report and **noted** the position as of 31st December 2013. No actions requiring further review were identified.

Quality Account Update including Priority Targets - The Deputy Director of Nursing presented the Quarterly Quality Account Report for the third quarter (October 2013 – December 2013) and outlined the actions in progress to achieve the five quality priorities. She confirmed that there were two hospital and two community targets for the patient experience targets. The latter two were based on an annual survey and could not be reported at this stage. The Committee **noted** the position with regards to the quality priority targets at the end of the third quarter.

Nursing Strategy Update (3rd Quarter 2013/14) - The Deputy Director of Nursing advised that 34 of the 49 actions were green rated, 10 amber, 3 red and 2 blue (i.e. unknown as based on an annual survey). Of the 3 red rated actions, one was due to delays by Dudley CCG and one was delayed due to changes in the End of Life Care Programme. The third red rated action was one of the Trust's Quality Priorities and related to the survey results of whether or not patients perceive they receive enough assistance to eat their meals. The Committee discussed the use of red trays and utilisation of volunteers for assisting patients and queried whether patients asked for help when they needed it. The Deputy Director of Nursing advised that it was the patients perception of whether or not they had received the assistance they required when they needed it. 3 patients out of 359 interviewed said they did not get the help they needed.

WHO Checklist - The Deputy Medical Director presented the WHO Surgical Checklist Report outlining the results of the audit for November and December 2013. The report confirmed the completion level of checklists and exception reports for each theatre area. The majority of exceptions related to "Sign out not indicated as completed". It was thought that this occurred when the notes were returned to the wards with the patients.

ALLOCATE Report - The Committee received an update on the ALLOCATE Project and were advised that the roll out of ALLOCATE was progressing in accordance with the project plan. All rostered areas currently on SMART would be transferred across by 31st March 2014. Previously raised concerns regarding underutilised hours on Ward A4 were discussed. The Committee received assurance that this occurred one month but was not repeated in the following month.

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 13th February 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

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 3rd April 2014

TITLE:	**Summary of Key issues from the Risk & Assurance Committee held on 28th January 2014 and 17th March 2014**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Ann Becke (NED)** **CQSPE Committee Chair**

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

SUMMARY OF KEY ISSUES (28th January 2014)

Assurance Reports – Response to the Local Supervising Authority Midwifery Officer's (LSAMO) Annual Report April 2012 – March 2013 - Ms Punter presented the Response to the LSAMO Annual Report and advised that the action plan arising from the 2011/12 Assurance Report was complete and archived. She confirmed that the current report was a statutory requirement to monitor local Supervising Authority performance and compare key clinical, activity and workforce information across the West Midlands. Three recommendations were made:

- Statutory appointment of a named Supervisor of Midwives (SoM) for every practicing midwife.
- Ensure SoM are integral to influencing the provision of a safe midwifery service by involvement in the Directorate governance and business agenda.
- To promote the new NMC midwives rules and standards (2013) and ensure embedding into practice of supervision of midwives practice across the cluster.

The Trust performed well when benchmarked against other organisations and there were few areas for improvement. A lot of work had been undertaken in 2013 to improve the birth to midwife ratios. The Committee received assurance that the team were reviewing staffing on a monthly basis.

The maternity team had been recognised by the Royal College of Midwifery for their Mom2Mom breastfeeding support project led by midwife Lucy Johnson and piloted by the community midwives. The project, which encourages support from family members, was announced as the winner of the JOHNSON'S® Baby Award for Evidence into Practice at a ceremony in London.

Surgery and Anaesthetics risk register - Ms Muraszewski (General Manager – Surgery and Anaesthetics) and Dr Sonksen (Clinical Director - Surgery and Anaesthetics) attended the committee meeting to present the Surgery and Anaesthetics Risk Register. The Committee focussed on the top 5 directorate risks:

- SO13 – Junior Doctor Cover (Score 25) - the Committee received assurance that this was high on the directorate agenda. The appointment of Physician Assistants and an Advanced Nurse Practitioner along with Clinical Fellows would help to mitigate some of the risk. A transformation project around the surgical emergency pathways would offer alternative pathways and would also reduce the pressure on beds.
- VAS003 – Inadequate Staffing arrangements to support phase 2, Vascular Hub (Score 25) - Ms Muraszewski outlined the issues identified at the time of the contract and referred to a subsequent gap analysis undertaken by Directors. She assured the Committee that the service was clinically safe.
- SO07 – Cancellation of elective surgical patients due to excessive emergency admissions from medicine, trauma or surgery (Score 20) - Ms Muraszewski outlined the background to the risk and work in progress.
- MAT032 – Second obstetric emergency case could be delayed more than 30 minutes due to the designated out-of-hours emergency Inpatient Theatre and the Obstetric Theatre already being engaged in a case – The Committee discussed whether this risk was corporate or directorate and received assurance that no mothers and babies had ever been put at risk.
- SO020 – There are currently 1800 patients who have not had a follow-up appointment at the interval previously determined by the clinicians at the patients last appointment – The Committee was advised that this was a global problem and the Directorate was looking overseas to recruit Junior Doctors. A series of mitigating actions had been taken but additional staff were required. The implications of this situation were discussed in detail.

The Committee **received** and **noted** the summary of key issues for the Trauma and Orthopaedics Directorate.

Policy Group Recommendations - 55 policies/guidelines had been drafted/revised and reviewed by the Policy Group. These were recommended to the Committee for formal ratification. The full documents were available for review on the Directors shared drive prior to the meeting. Nine policies had already been approved with slight amendments. The Deputy Medical Director referred the Committee to the End of Life Care Guideline which replaced the Liverpool Care Pathway to support staff. An End of Life Care Strategy was in development and would be ratified at the Extra Ordinary meeting. In future each Board Committee would be responsible for ratifying policies appropriate to their terms of reference. The Committee **reviewed** the schedule of Policies and Guidelines and **ratified** all 55 documents listed noting that an extra ordinary meeting would be required to ratify outstanding documents.

Corporate Risk Register - 8 of the 21 risks on the register scored 20 or above and reflected the areas discussed previously as part of the Board Assurance Framework. Updates were requested. The Committee **received** and **approved** the Corporate Risk Register and **noted** the assurance received to date.

Operations Directorate Risk Register and Community Services and Integrated Care Risk Register
The Committee considered the directorate risks and noted the assurance recorded.

Transformation and Estates Risk Register - the following key issues were highlighted and discussed:

- Service Improvements
- PFI Contract
- Cost Management
- EBME PFI Contracts

The Committee noted that a number of action plan dates had expired and challenged the position with regard to these and the impact on risk mitigation / management. Updates were requested.

Nursing Directorate Risk Register - the following risks were discussed including the management actions and current position of each:

- IC010 – Risk of Infection outbreak or high numbers above contract levels (Score 16)
- IC006 – Non-compliance with NHS NPSA Guidance (Score 12) - this risk could be removed.
- G012 – Staff not receiving appropriate Manual Handling Training (Score 9) – This risk could be archived.
- HS008 – Care Management of the Bariatric Patient (Score 8) - this was a low risk.
- G005 – Sub-optimal care provided by Locums/Agency and Bank Staff (Score 8) - this risk could be archived
- G013 – Increased Capacity, use of registered staff within the Professional Development Team whose current roles do not involve regular clinically-based activity to work in clinical areas (Score 8) - this risk could be archived

Finance, Information and IT Directorate Risk Report - there were two Directorate risks. The management actions and current position of each was discussed:

- F011 - Implementation of new Maternity Pathway System (Score 20)
- IT007 - Potential risk that not all Radiological Examinations are being recorded on Soarian. As a consequence X-ray reports have not been transferred from CRIS System to Soarian (Score 4)

Human Resources Risk Register - there were 5 risks on the register which had been previously reported. The following issues were highlighted:

- WO12 Management of Doctors in Training Rotas - this risk would be closed,the policy was in place.
- HG007 Inability to prove the review of CRB (now Disclosure and Barring DBS) check – the risk score had been reduced from four to two since October 2013.
- HR015 Recruitment end to end process – The risk score had been reduced from ten to eight. NHS Jobs 2 would be launched on 4th March 2014
- W013 Measles Vaccination
- W014 Nurse Clinical Skills Training – work was continuing with Matrons.

Medical Directorate - there were 2 risks on the register scoring 12. Mitigating actions were discussed.

- M031 - Not all Medical on-call SpR's are signed off as being competent - the risk end date was 30th November 2013. Actions were appropriate.
- M033 – Failure to successfully revalidate Doctors

Compliance with NPSA Safety Alerts - one alert (non luer needles) had breached the closure date of

01/04/13. As previously reported, this problem was shared with many organisations and the position had not changed since the last report.

Health and Safety Group – the following issues were highlighted and discussed:

- **Smoking Policy** –smoking permitted on hospital sites in designated smoking shelters.
- **Operator Chairs** – Some office chairs in the Trust were unsuitable and aggravating back weaknesses due to the lack of support.
- **Trailing Wires** – Trailing television wires on some wards was still an issue.
- **Security Management** – Use of Datix incident reporting system to be reinforced
- **Sharp Instruments in Healthcare Regulations 2013** – New regulations considered
- **First Aid Training** –the Trust does not provide First Aid training.
- **Winter Gritting and Snow Clearing Plan**

The Committee also discussed the reporting of RIDDORS and the current system for handling these in the organisation. It was agreed that all RIDDORs should be reviewed by the Health and Safety Manager before submission to the HSE.

Equality and Diversity Group (5th November 2013) - Equality and Diversity Training for staff remained green. An e-learning package to help staff complete equality impact assessments was being designed and staff were working with Ophthalmology to design a training session for staff on visual awareness. The Committee **received** the summary of issues.

Research and Development Directorate Report - The Committee was advised of new studies taking place within the Dudley Group and the risk levels of these. The Committee approved the Terms of Reference for the Scientific Protocol Review Sub-Committee.

SUMMARY OF KEY ISSUES (17th March 2014)

The Committee considered all outstanding matters arising and confirmed where actions would be considered in the future. The remainder of the agenda focussed on the recommendations arising from the Policy Group.

111 policies/guidelines had been drafted/revised and had been reviewed by the Policy Group. These were recommended to the Committee for formal ratification. The full documents were available for review on the Directors shared drive prior to the meeting. The committee discussed the progress of policies, consultation and review arrangements and dates. The future arrangements for ratification of policies following the restructure of Board Committees was also discussed. The Committee **reviewed** the schedule of Policies and Guidelines and **ratified** all 111 documents listed.

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE BOARD: To note the key issues arising from the Risk & Assurance Committee held on **28th January 2014 and the Extra – ordinary meeting held on 17th March 2014** and refer to the full minutes for further details.

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

portfolio and the provision of assurance to the Board of Directors on the adequacy and effectiveness of the risk management arrangements across the Trust and in the Community.

The Dudley Group NHS Foundation Trust

Enclosure 8

Paper for submission to the Trust Board on 3rd April 2014

TITLE:	**Safeguarding Report to Trust Board – March 2014**		
AUTHOR:	**Pam Smith Acting Deputy Director of Nursing**	**PRESENTER**	**Denise McMahon Nursing Director**
CORPORATE OBJECTIVE: SGO1, SGO2 and SGO6			

SUMMARY OF KEY ISSUES:

1. CONCERNS RAISED BY INDEPENDENT CHAIR OF SAFEGUARDING BOARDS

Concerns were raised by the Independent Chair regarding the allegations of unlawful restraint of adults and children which were raised in the media by an ex-employee of the Security Company contracted by the Trust; the areas for consideration identified by Scrutiny programme regarding the Trust's section 11 audit action plan; the appropriateness of the application of mental capacity assessments and Deprivation of Liberty Safeguard situations which were identified in the Safeguarding Adults Board Peer Review action plan.
A Pan Board Reassurance group has been convened to ascertain the quality of all aspects of adult and children safeguarding within the Trust. This has been attended by the Chief Executive, the Deputy Director of Nursing and the Acting Deputy Director of Nursing. The Section 11 audit action plan has been remitted back to the Scrutiny panel of the Children's Board and the Stoke Peer Review action plan has been remitted back to the Adults Board.
The Trust has commissioned an Independent review of the Restraint issues by an external security manager. The Chief Executive presented the review at the last Pan Board Reassurance group meeting. Additional cases passed to the Police held by the Police have been shared with the Chief Executive and the review has been extended to include these.
A further meeting is scheduled to take place following the Care Quality Commission hospital inspection on the 26th and 27th March 2014.

2. SECTION 11 AUDIT ACTION PLAN

The Section 11 audit has been updated and presented to the Pan Board Reassurance Group meeting and this has been remitted back to the Scrutiny Committee of the Safeguarding Children's Board. The Scrutiny Committee is due to meet again in April 2014.

3. TRAINING

a. Safeguarding Children compliance

Safeguarding Children Foundation training compliance is now at 86%. Intermediate training compliance is now at 58.7%.

The following areas remain in red:

- Surgery/Anaesthetics
- Emergency Medicine
- Women's and Children's

The Named Nurse for Safeguarding Children is obtaining a breakdown of the staff groups that are outstanding so that targeted training could be implemented.

b. Safeguarding Adults compliance

Safeguarding Adults training compliance is now at 85.4%. 510 staff have been identified as still having to complete training.

c. Mental Health compliance

Mental Health training compliance is now at 70.5%. 614 staff have been identified to complete training.

d. Learning Disabilities CQUIN

The Learning Disability Liaison Nurse is in the process of identifying the remaining 3% of staff in admission areas to be targeted for training; 4 staff have been identified to complete training.

e. Safeguarding Maternity Compliance

Foundation training compliance is now at 99%. Maternity Intermediate training compliance is now at 76%. Adults Safeguarding training is now at 88%.

f. Training for Medical Staff

Training for the 5th year medical students had been arranged 3 times year in addition to the existing training programme for FY1 doctors.

IMPLICATIONS OF PAPER:

Risk Management	**Risk Register: N**		
	Risk Register: CSO11 Score 6		Lack of Safeguarding Children Intermediate Training
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Compliance with Care Quality Standards Outcome 7
	NHSLA	**Y**	**Details:** CNST Maternity standards
	Monitor	**Y**	**Details:** Ability to maintain at least level 1 NHSLA
	Equality Assured	**Y**	**Details:** Better Health outcomes Improved Patient access and Experience
	Other	**N**	**Details:** Safeguarding

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE: To note the key issues arising from the Safeguarding Report to Trust Board and identify any actions for follow up.

The Dudley Group NHS
NHS Foundation Trust

SAFEGUARDING REPORT TO TRUST BOARD
MARCH 2014

1. CONCERNS RAISED BY INDEPENDENT CHAIR OF SAFEGUARDING BOARDS

The Independent Chair of the Adults and Children's Safeguarding Board raised concerns regarding the allegations of unlawful restraint of adults and children which were raised in the media by an ex-employee of the Security Company contracted by the Trust; the areas for consideration identified by Scrutiny programme regarding the Trust's section 11 audit action plan; the appropriateness of the application of mental capacity assessments and Deprivation of Liberty Safeguard situations which were identified in the Safeguarding Adults Board Peer Review action plan.
A Pan Board Reassurance group has been convened to ascertain the quality of all aspects of adult and children safeguarding within the Trust. This has been attended by the Chief Executive, the Deputy Director of Nursing and the Acting Deputy Director of Nursing. The Section 11 audit action plan has been remitted back to the Scrutiny panel of the Children's Board and the Stoke Peer Review action plan has been remitted back to the Adults Board.
The Trust has commissioned an Independent review of the Restraint issues by an external security manager. The Chief Executive presented the review at the last Pan Board Reassurance group meeting. Additional cases passed to the Police held by the Police have been shared with the Chief Executive and the review has been extended to include these.
A further meeting is scheduled to take place following the Care Quality Commission hospital inspection on the 26th and 27th March 2014.

2. CQC/OFSTED ASSESSMENT

This unannounced inspection is still awaited. The local Authority has requested that all agencies are prepared for this unannounced visit.

3. SECTION 11 AUDIT

The Section 11 audit has been updated and presented to the Pan Board Reassurance Group meeting and this has been remitted back to the Scrutiny Committee of the Safeguarding Children's Board. The Scrutiny Committee is due to meet again in April 2014.

4. LEARNING DISABILITY

4.1 Learning Disability Strategy

The Learning Disability Strategy has been ratified. This is due to be launched on 28th March 2014. The aim of the launch is to ensure that the Trust offers safe and Appropriate care for patients with learning disabilities and make reasonable adjustments, understanding the needs of people with learning disabilities when they access healthcare within the Trust. Staff from all staff groups across the Trust have been invited to attend as well as the members of the Dudley Adults and Children Safeguarding Board, the Learning Disabilities Partnership Board, the health sub group of the Learning Disabilities Partnership Board.

5. TRAINING

5.1 Safeguarding Children compliance

Safeguarding Children Foundation training compliance is now at 86%. 467 staff have been identified to complete training. Intermediate training compliance is now at 58.7%. 509 staff have been identified to complete training.
The following areas remain in red:

- Surgery/Anaesthetics - 167 staff have been identified to complete training.
- Emergency Medicine – 109 staff have been identified to complete training.
- Women's and Children's – 98 staff have been identified to complete training.

The Named Nurse for Safeguarding Children is obtaining a breakdown of the staff groups that are outstanding so that targeted training could be implemented.

5.2 Safeguarding Adults compliance

Safeguarding Adults training compliance is now at 85.4%. 510 staff have been identified as still having to complete training.

5.3 Mental Health compliance

Mental Health training compliance is now at 70.5%. 614 staff have been identified to complete training. The Clinical Nurse Specialist for Older People is setting up a meeting with Learning and Development to review areas identified in red.

The Mental Health CQUIN requires 100% compliance by quarter 4 – 2014/15.

5.4 Learning Disabilities CQUIN

The Learning Disability Liaison Nurse is in the process of identifying the remaining 3% of staff in admission areas to be targeted for training; 4 staff have been identified to complete training.

5.5 Safeguarding Maternity Compliance

Foundation training compliance is now at 99%. Maternity Intermediate training compliance is now at 76%. Adults Safeguarding training is now at 88%.

5.6 Training for Medical Staff

Training for the 5th year medical students had been arranged 3 times year in addition to the existing training programme for FY1 doctors.

Pam Smith
Acting Deputy Director of Nursing
27.03.14

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 3rd April 2014

TITLE:	**Organ Donation Committee Report**		
AUTHOR:	Rebecca Timmins, Specialist Nurse-Organ Donation Dr Julian Sonksen, Clinical Lead Organ Donation	**PRESENTER**	Rebecca Timmins, Specialist Nurse-Organ Donation Dr Julian Sonksen, Clinical Lead Organ Donation
CORPORATE OBJECTIVE: SGO2. Patient experience.			

SUMMARY OF KEY ISSUES:

- Report Trust performance in nation key performance indicators monitored by NHS Blood and Transplant.
- Trust performance benchmarked against national average performance for comparison.
- Update on Donor Recognition Project

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

RISK			**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	√	**Details: Outcomes 1,4,6.**
	NHSLA		**Details:**
	Monitor		**Details:**
	Equality Assured		**Details:**
	Other		**Details: Organ Donation Taskforce**

			Recommendation

ACTION REQUIRED OF COMMITTEE: .

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD

- ***To support and advocate the Specialist Nurse-Organ Donation to be involved in all approaches to the family for organ donation where this is possible, in line with best practice and national guidance(NICE CG135).***

STRATEGIC OBJECTIVES : ***(Please select for inclusion on front sheet)***		
SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a “can do” attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

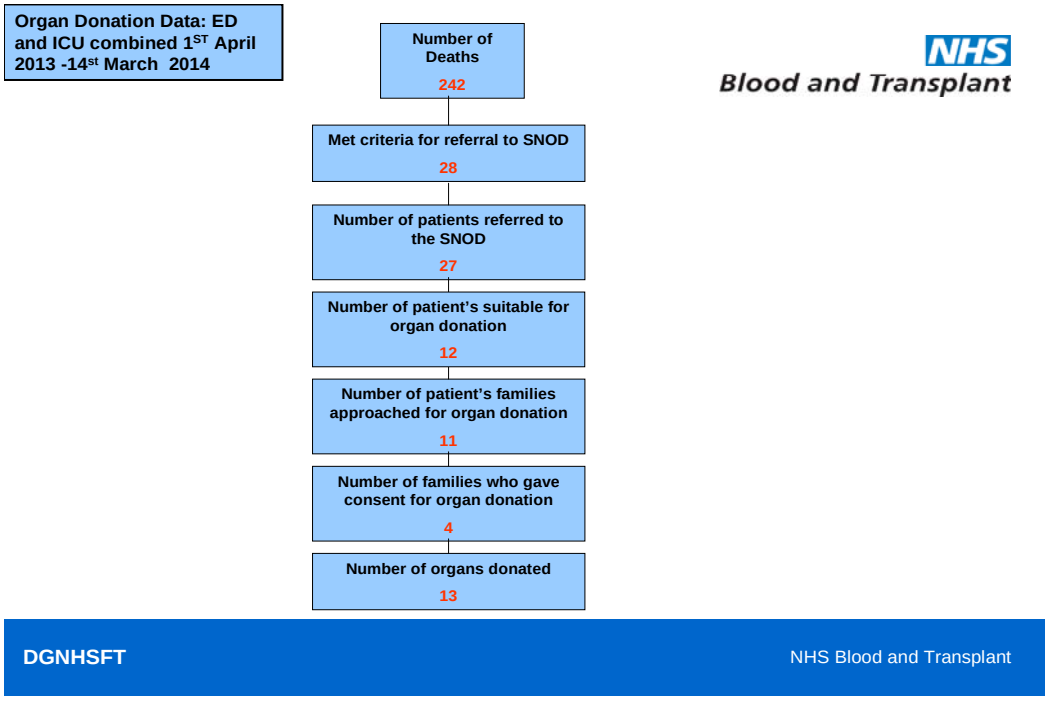
The Dudley Group NHS
NHS Foundation Trust

PAPER FOR SUBMISSION TO TRUST BOARD

Title:	**Organ Donation Committee Report**
Summary:	This report from the Organ Donation Committee to the Trust Board will outline the Trust's Organ Donation Data, and progress with Dudley Group NHS Foundation Trust Annual Organ Donation Plan 2013-14. Section 1 – Organ Donation Data Section 2- CQC data Section 3 - Issues arising from PDA data and actions planned Section 4 - Donor Recognition Project Appendix 1- DGNHSFT 2013-14 Organ Donation Data Appendix 2- Progress with 2013-14 Annual Organ Donation Plan Appendix 3- Donor Recognition Project/Celebratory Sculpture: Plans for Groundwork's Appendix 4- Donor Recognition Project/Celebratory Sculpture Plans
Action required of Trust Board	The Trust Board is asked to: (a) Support action plans to address Organ Donation Data (b) Support actions planned as part of 2013-14 Annual Organ Donation Plan and Donor Recognition Project
Corporate objective ref:	Quality strategy
CQC Essential Standards	Outcome 1, 4, 6.
Author:	Dr Julian Sonksen: Clinical Lead Organ Donation Dr Rajan Paw: Clinical Lead Organ Donation Miss Rebecca Timmins: Specialist Nurse Organ Donation
Lead Director:	Mr David Badger
Date of Paper:	14th March 2014
For Trust Board meeting on:	3rd April 2014

Section 1: Organ Donation Data

Below is all organ donation activity for ICU and ED combined from 1st April 2013 to 14th March 2014.



The Potential Donor Audit (PDA) is an audit of all deaths in Emergency Department's and Intensive Care Unit's where the patient was under the age of 80. The current upper age limit for organ donation is 85 years of age and therefore we would like to report to the Trust Board all donation data in the trust, at which the PDA does not capture.

Chief Executive's of Trusts will receive a separate Trust Organ Donation report of PDA activity from NHSBT 2 months after the time frame that the data reports.

Our performance is benchmarked below against the national average key milestones of the donation process.

- **Neurological Death Testing (NDT);** The trust is currently achieving a 100% NDT rate. The national average is currently 78%.
- **Referral to the Specialist Nurse- Organ Donation (SN-OD) for consideration for Donation after Brain Death (DBD) donation**; The trust is currently achieving 100% referral to the SN-OD for DBD donation. The national average is 93%.

  Approach to the family for consent for DBD donation; The trust has achieved 100% approach rate to the family for DBD Donation, the national average is 94%.

- **Obtaining consent for DBD donation;** Consent was obtained for organ donation on 3 out 4 occasions. The consent rate for DBD Donation is therefore 75%. The national average is 57%.

- **Number of Organ's donated from DBD donors;** 11 organs were donated from 3 DBD Donor at the Trust.

- **Referral to the SN-OD for consideration for Donation after Cardiac Death (DCD) donation**; The referral rate to the SN-OD for DCD donation is 95%. The national average is 58%.

- **Approach to the family for DCD donation;** There were 7 out of 8 approaches to the family for DCD donation. The approach rate in the trust is therefore 87%. The national average is 52%.

- **Consent for DCD donation;** Out of the 7 approaches to the family for DCD donation, consent was given on 1 occasion. The consent rate in the trust for DCD donation is 14%. The national average is 55%.

- **Number of Organs donated from DCD donors;** There have been 2 organs donated from 1 DCD Donor at the Trust so far this year.

- **Number of people in Dudley on the Organ Donor Register:** There are currently100,584 people in Dudley on the Organ Donor Register which is a 4.7% increase from 2013, the national average increase is 4% per year.

o Section 2 – CQC Data

The below CQC data (previous CQUINS 2011-12) demonstrates the performance of both the ED and ICU departments combined. The data shown demonstrates the Trust's performance from the 1st April 2013 to 31st March 2014

N1; No of deaths where the diagnosis of ND was suspected and patient met criteria for ND Testing and had ND tests performed	Target set 80%	Achieving 100%
N2; Number of cases where ND testing was planned and the SNOD was informed	Target set 90%	Achieving 100%
N3; Number of cases where there was a decision to WOT in a patient with a catastrophic Neuro Injury and the SNOD was informed before WOT	Target set 50%	Achieving 100%
N4; Number of cases where ND was confirmed or a decision to WOT as per N3, and an approach was made to the family for organ donation	Target set 65%	Achieving 100%
N5; Number of times that donation activity is formally considered by committee and progress with Annual Organ Donation Plan	At least quarterly	Achieving

Section 3: Issues arising from PDA audit data

Actions planned to improve organ donation data

- Optimize the potential consent rate for both DBD and DCD Donation. Actions carried out have been to implement NICE guidelines (CG135) in to local policy and deliver Consultant teaching packages on approaching families for organ donation.

- Inform the Embedded SNOD of any pending referrals early in the morning to allow planning for the SNOD to be involved in 100% of approaches to the family of the patient, for organ donation.

- Advocate that staff refer patients who meet the Minimum Notification Criteria, to the SNOD, early to ensure the on call team can arrive at the hospital in a timely manner and be involved in the approach for donation.

- There were 4 approaches to the family for DBD Donation, The SNOD was involved in 3 out of the 4 approaches. 3 families gave consent for organ donation, the SNOD was involved in all 3 of these approaches. Where the 1 family declined consent for organ donation, the SNOD was not involved in the approach.
- There were 7 approaches to the family for DCD Donation. The SNOD was involved in 1 of the approaches, the Clinicians were involved in the other 6 approaches. Consent was given on 1 occasion, this was when the Clinician approached without the SNOD present. Consent rate of 14%.

- Continue to monitor and evaluate Action plans to improve performance.

Actions planned to meet CQC target

- Continue to monitor and report to Organ Donation Committee and Trust Board.

- Datix forms to be completed on each occasion that the Trust fail to meet clinical indicators in N1,N2,N3,N4.

Section 4: Donor recognition project

A further update on this project is provided for the Trust Board. Since our last update on the 9th January 2014, our recommendation to the board for Paul Margetts to be commissioned to create the steel sculpture "The Gift of Life" was supported by the board. Paul Margetts is now working with us on this project.

During the consultative phase of this project we invited staff and governors views on the 4 shortlisted artists work, including via an exhibition on the 4th December 2013. Although Paul Margetts work was universally supported, many positive comments were received about the submission from Malcolm Sier. Staff and Governors were delighted with Malcolm's glass droplets and we have approached both artists about using these within the groundwork's surrounding the sculpture (See Appendix 3 for plans for groundwork's). A quotation for the groundwork's has been submitted by Malcolm Sier and is quoted to cost £3,400.

Critical Care have generously donated £4,000 to our project to assist with the funding for the groundwork's. Our total budget for this project is now £19,500. Summit have committed to providing some funding towards the plinth but this figure is yet to be confirmed.

We have contacted the World Health Organization regarding the similarities between "The Gift of Life" sculpture and their "Fairtransplant" logo and they have no objections regarding any potential copyright issues, they wish us luck with our project.

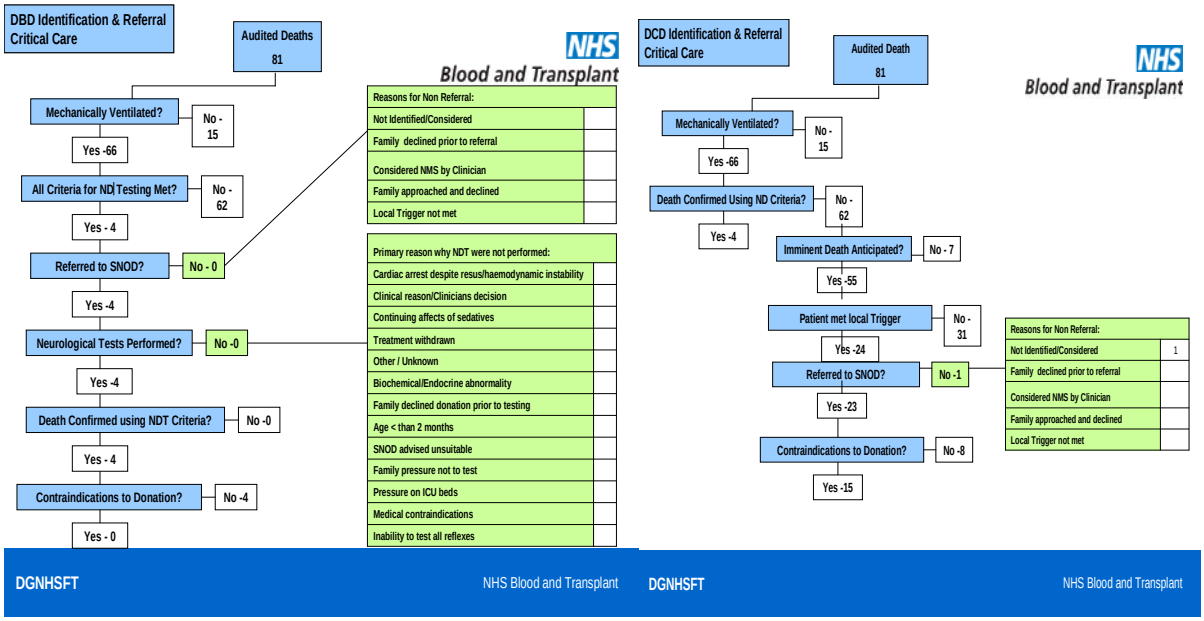
Planning permission application was submitted on 24th March 2014 and we await the outcome of this before any further commissioning of the sculpture is taken forward. Our art advisor, Steve Field has confirmed that the chosen position for the sculpture (See Appendix 4 for a plan of this) is supported and accepted by Summit. Planning permission is anticipated to take 6-8 weeks until we receive a decision regarding this.

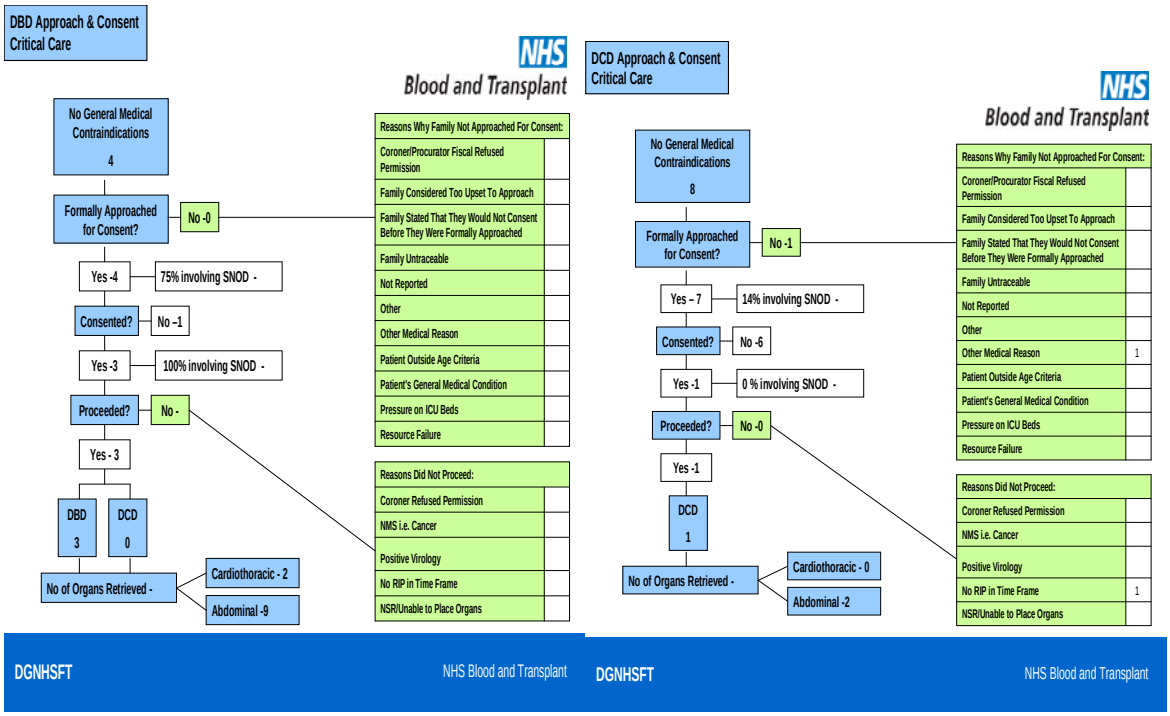
It is anticipated that the sculpture will take 8-10 weeks to be made and therefore would be ready for a grand opening by mid to end of July 2014 at the earliest. We are in the process of making enquiries for a prestige opening of the sculpture.

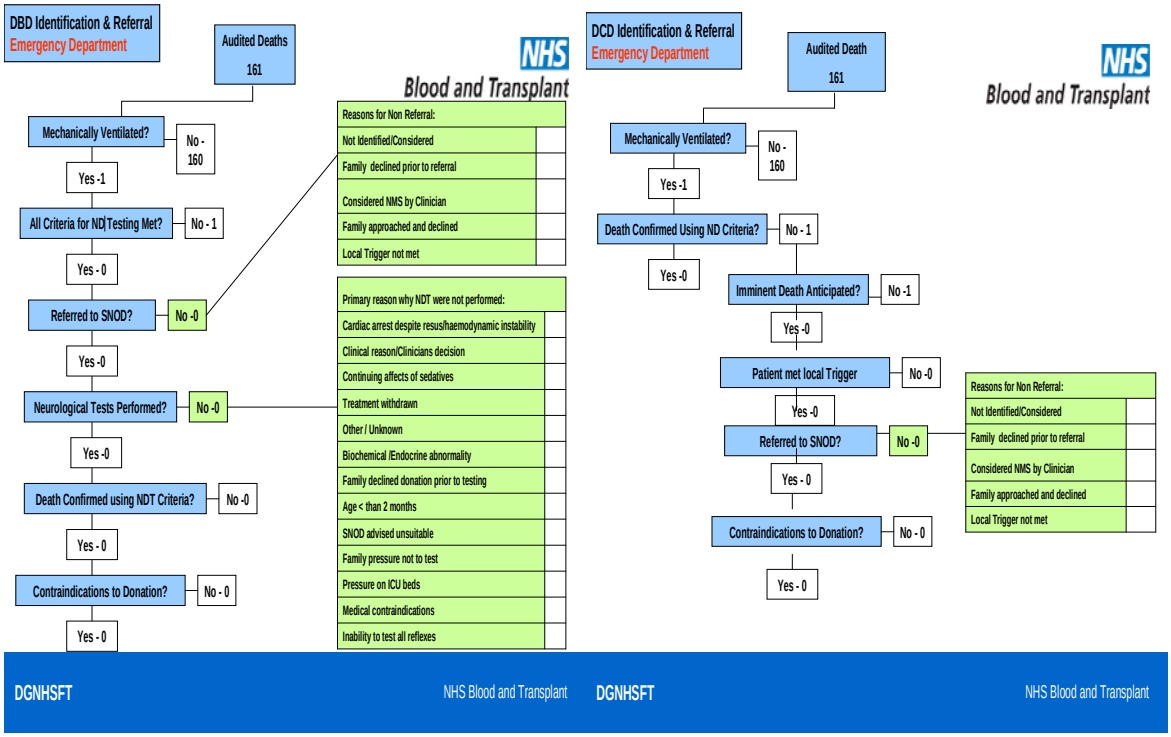
We will update the board again on this important project later on in the year.

Appendix 1: Trust Organ Donation Data 1st April 2013-14th March 2014

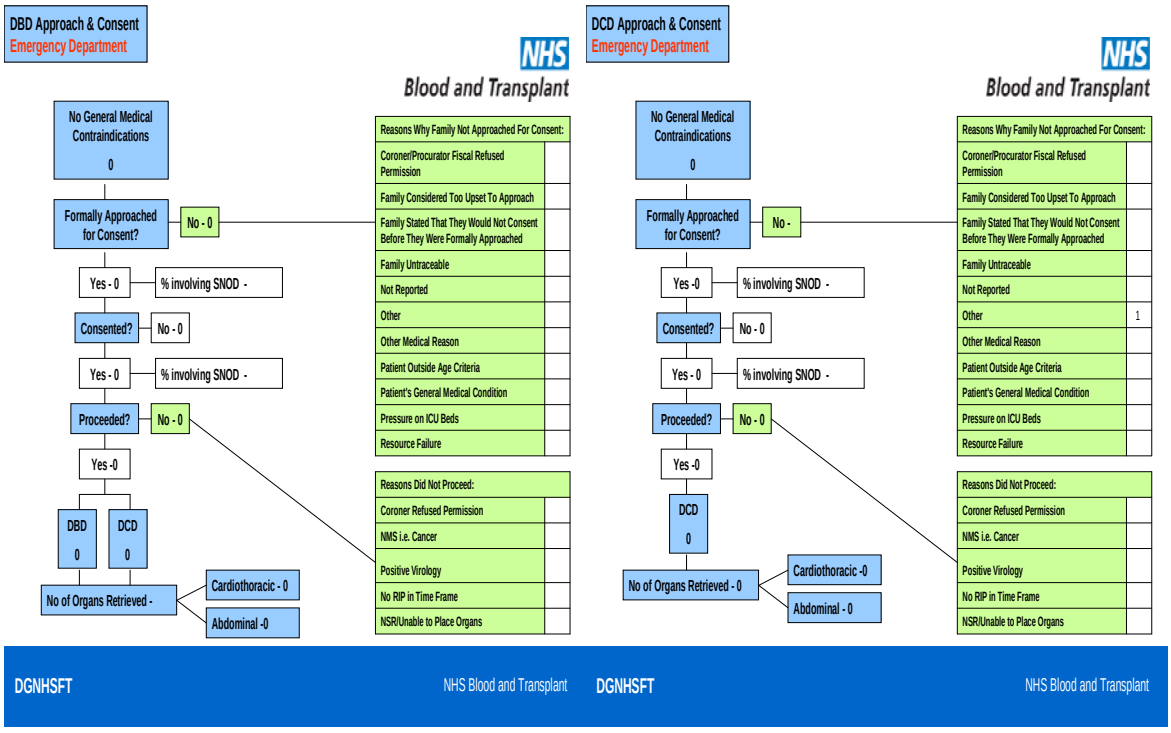
The Potential Donor Audit (PDA) is an audit of all deaths in Emergency Department's and Intensive Care Unit's where the patient was under the age of 80. The current upper age limit for organ donation is 85 years of age and therefore we would like to report to the Trust Board all donation data in the trust, at which the PDA does not capture.






DBD Identification & Referral
Emergency Department
Audited Deaths
161
Mechanically Ventilated?
No - 160
Yes -1
All Criteria for ND Testing Met?
No - 1
Yes - 0
Referred to SNOD?
No -0
Yes -0
Neurological Tests Performed?
No -0
Yes -0
Death Confirmed using NDT Criteria?
No -0
Yes - 0
Contraindications to Donation?
No - 0
Yes - 0
Reasons for Non Referral:
Not Identified/Considered
Family declined prior to referral
Considered NMS by Clinician
Family approached and declined
Local Trigger not met
Primary reason why NDT were not performed:
Cardiac arrest despite resus/haemodynamic instability
Clinical reason/Clinicians decision
Continuing affects of sedatives
Treatment withdrawn
Other / Unknown
Biochemical /Endocrine abnormality
Family declined donation prior to testing
Age < than 2 months
SNOD advised unsuitable
Family pressure not to test
Pressure on ICU beds
Medical contraindications
Inability to test all reflexes
NHS
Blood and Transplant
DGNHSFT
NHS Blood and Transplant

DCD Identification & Referral
Emergency Department
Audited Death
161
Mechanically Ventilated?
No - 160
Yes -1
Death Confirmed Using ND Criteria?
No - 1
Yes -0
Imminent Death Anticipated?
No -1
Yes -0
Patient met local Trigger
No -0
Yes -0
Referred to SNOD?
No -0
Yes - 0
Contraindications to Donation?
No - 0
Yes - 0
Reasons for Non Referral:
Not Identified/Considered
Family declined prior to referral
Considered NMS by Clinician
Family approached and declined
Local Trigger not met
NHS
Blood and Transplant
DGNHSFT
NHS Blood and Transplant


DBD Approach & Consent
Emergency Department
No General Medical Contraindications
0
Formally Approached for Consent?
No - 0
Yes - 0
% involving SNOD -
Consented?
No - 0
Yes - 0
% involving SNOD -
Proceeded?
No - 0
Yes -0
DBD
0
DCD
0
No of Organs Retrieved -
Cardiothoracic - 0
Abdominal -0
Reasons Why Family Not Approached For Consent:
Coroner/Procurator Fiscal Refused Permission
Family Considered Too Upset To Approach
Family Stated That They Would Not Consent Before They Were Formally Approached
Family Untraceable
Not Reported
Other
Other Medical Reason
Patient Outside Age Criteria
Patient's General Medical Condition
Pressure on ICU Beds
Resource Failure
Reasons Did Not Proceed:
Coroner Refused Permission
NMS i.e. Cancer
Positive Virology
No RIP in Time Frame
NSR/Unable to Place Organs
NHS
Blood and Transplant
DGNHSFT
NHS Blood and Transplant

DCD Approach & Consent
Emergency Department
No General Medical Contraindications
0
Formally Approached for Consent?
No -
Yes -0
% involving SNOD -
Consented?
No - 0
Yes - 0
% involving SNOD -
Proceeded?
No - 0
Yes -0
DCD
0
No of Organs Retrieved - 0
Cardiothoracic -0
Abdominal - 0
Reasons Why Family Not Approached For Consent:
Coroner/Procurator Fiscal Refused Permission
Family Considered Too Upset To Approach
Family Stated That They Would Not Consent Before They Were Formally Approached
Family Untraceable
Not Reported
Other
1
Other Medical Reason
Patient Outside Age Criteria
Patient's General Medical Condition
Pressure on ICU Beds
Resource Failure
Reasons Did Not Proceed:
Coroner Refused Permission
NMS i.e. Cancer
Positive Virology
No RIP in Time Frame
NSR/Unable to Place Organs
NHS
Blood and Transplant
DGNHSFT
NHS Blood and Transplant

Appendix 2: Progress with 2013-14 Annual Organ Donation Plan

Action Plan	Progress	Outstanding actions
1) To achieve 100% Neurological Death Testing rate in ED/ICU Combined when Neurological Death is suspected.	Achieving 100%	DBD Guideline is to be submitted for ratification in April 2014
2a) In over 65% of cases where the patient either had BSD confirmed or a decision was made to withdraw active treatment in patient's with a catastrophic neurological injury; The Specialist Nurse will be present with the Doctor and Nurse for the discussion with the family about donation. 2b) The specialist Nurse will also be present for at least 65% of discussions with the family about donation (non catastrophic neurological injured) with Doctor and Nurse also present as per DCD local MNC.	SNOD present for 75% of DBD SNOD present for 25% Neuro DCD SNOD present for 14% non catastrophic neurological injured DCD	No funding secured to facilitate Nursing and Medical Staff to undertake mandatory training on Organ Donation. The SNOD team to be involved in 100% approaches to the family for organ donation.
3) Referral of at least 50% of neurological injured DCD to the SN-OD and 100% of patients where ND testing is suspected.	Achieving 100% DCD Achieving 100% DBD	
4) Donor recognition project at DGNHSFT	Progress to plan as per Section 4	Planning permission outcome Making of sculpture Arrangement of member Royal Household to open sculpture
5) Annual E Learning package will be developed and implemented for DGNHSFT staff working on ICU and on organ donation	Not achieving	No funding secured, reapply funding in 2014-15
6) Increase organ donation awareness and registration on the organ donor register	Achieved 4.7 % increase of registrants from Dudley on the ODR this year between 2013-14 National average increase is 4%	

Appendix 3: Donor Recognition Project/Celebratory Sculpture: Plans for Groundwork's

Figure 1 shows The Gift of Life sculpture's plinth surround, which has glass droplets as seen in Figure 2, surrounding the plinth. Figure 3 shows the surrounding groundwork's to the sculpture.

Figure 1 Plinth Surround

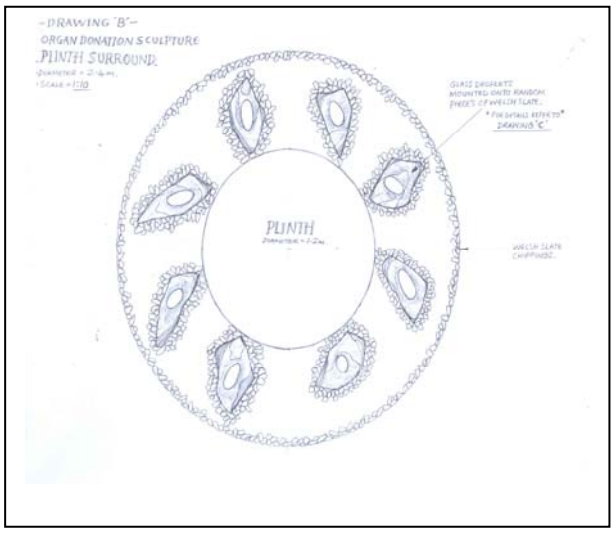


Figure 2 Glass Droplets

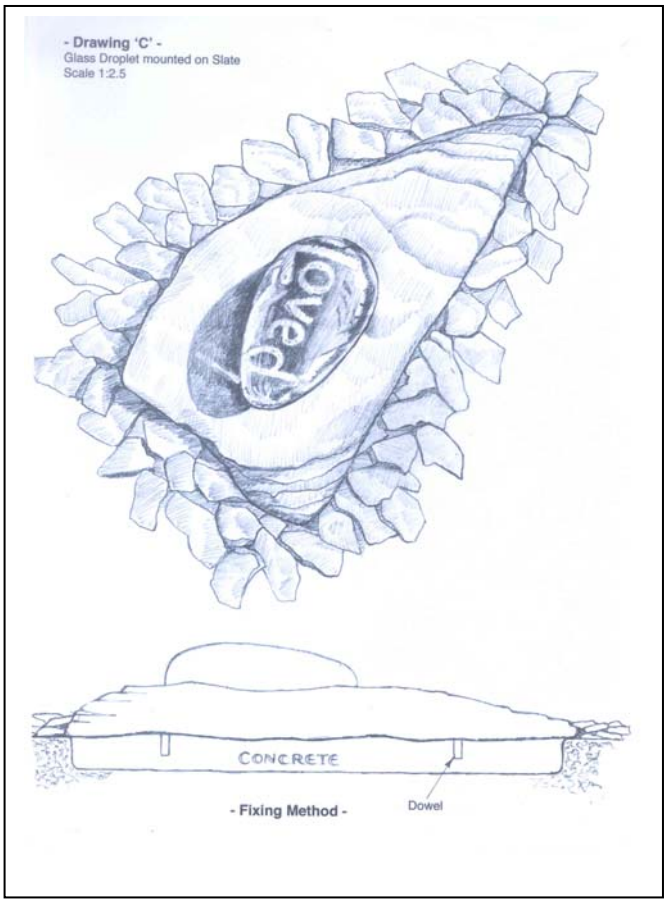


Figure 3 Surrounding Groundwork's

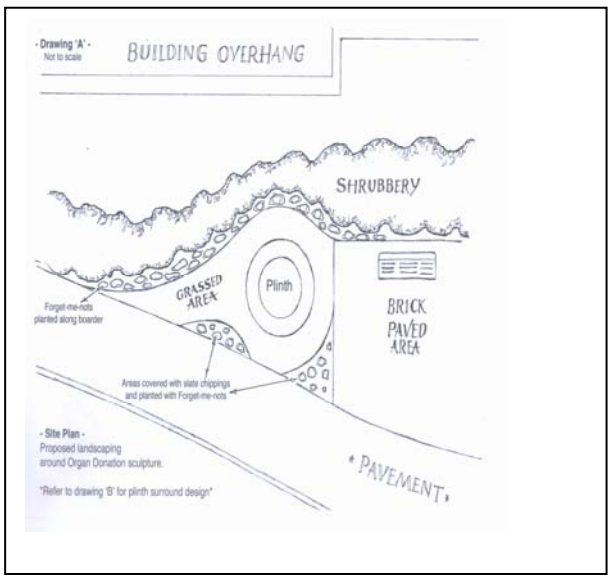
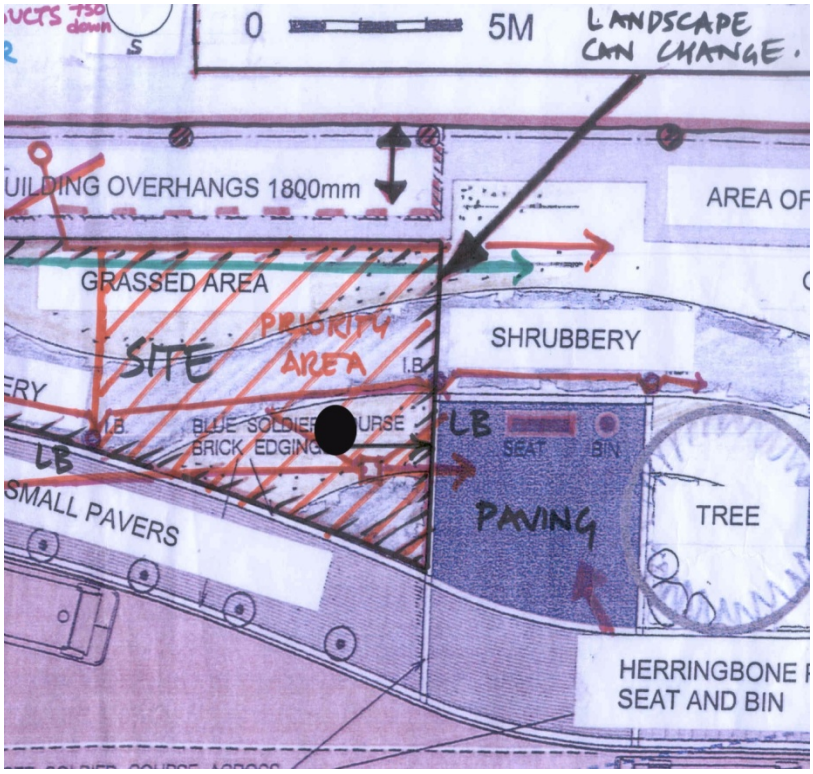


Figure 4 shows the position of the 1210 dia plinth is marked with a black circle.
Its centre is located 2700mm from the edge of the path and 2700mm from the edge of the paved area.

Figure 4 Site of Plinth and Gift of Life Sculpture



Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board on 03/04/2014

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

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR THE COMMITTEE:

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

The Dudley Group NHS
NHS Foundation Trust

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS ON 3RD APRIL 2014

RESEARCH & DEVELOPMENT REPORT

Summary

On 1st April 2014, the three West Midlands Comprehensive Local Research Networks (CLRNs) merge to become one single entity. The Trust has worked extremely hard to increase recruitment and is expected to be rewarded for increased activity in line with the Activity Based Funding model. The reality is that all Trusts will initially receive the same funding as 2013/14 in order not to de-stabilise the local research establishment. The Research & Development Directorate (RDD) will continue to bid for any additional funding that becomes available during 2014/15.

BBC CLRN NHS Acute Trusts	Recruitment target (pts) 01/10/12 – 30/09/13	Recruitment achieved 01/10/12– 30/09/13 (inc commercial)	Recruitment achieved 01/10/12 – 30/09/13 (excl commercial)	Recruitment target 01/10/13 - 30/09/14	Funding 2014/15 £
Dudley Group NHS FT	1782	2181	2149	2240	404,608
Heart of England NHS FT	3000	4049	2474	4728	1,848,716
Sandwell & West B'ham NHS FT	1651	2093	2001	2400	536,475
University Hospitals B'ham NHS FT	3230	5079	4853	5000	1,063,301
Walsall Healthcare NHS Trust	578	308	308	300	120,289

Activity (from 01/10/2012 to 30/08/2013):

National Institute for Health Research portfolio studies only:
Number of recruiting studies as of 21/03/2014: 109: 81 academic; 28 commercial
Closed studies still collecting data: 57 (A) 15 (C).
Recruiting non NIHR studies:
30 academic; 4 commercial
Publications for 2013 calendar year:
100 – this figure includes conference posters and articles

Patents for a surgical drape and a mouth mask for use by anaesthetics have been lodged. The inventor is Dr Nahla Farid, Consultant Anaesthetist. The drape is already commercialised.

Education and Training:

The Trust hosted National Institute for Health Research (NIHR) accredited Good Clinical Practice (GCP) training on 15/10/2013 and 28/02/2014. More dates are planned. An R&D Facilitator also undertakes GCP training sessions for staff requiring training to conduct observational studies. An online training package provided by NIHR is also well received by researchers. RDD continues to have a regular presence on the Health Hub in order to educate patients and carers about clinical research through the "It's ok to ask" campaign.

Research Governance Implementation:

A total of 23 studies were assessed by the Protocol Review Sub-committee between 17/09/2013 and 21/03/2014.

Reported Serious Adverse Events:

Oncology/Haematology: 16;
Cardiology: 13;
Chemical Pathology: 7;
Rheumatology: 1.

Staffing:

- Dr Jeff Neilson has been appointed Deputy Research and Development Director and will be working alongside Prof. Kitas to oversee RDD, as well as leading on cancer research activity.
- The CLRN has funded a temporary part time (25 hpw) Band 7 research nurse post until 31/03/2014. The post holder, Sue Merotra, is responsible for working clinically with disciplines new to research, including Stroke, Acute Medicine, Anaesthetics and Vascular Surgery. The post also enables RDD to offer professional nursing support to Band 6 research nurses who are not part of an established network within the Trust.
- Dermatology has appointed a FT research nurse funded by commercial income generated by Dr Ladoyanni. We look forward to welcoming Wara Mbwembwe to our team in April 2014.
- Following staff changes, two one day per week (0.2 WTE) research nurse/ midwife posts have been replaced by DGH staff, using existing CLRN funding. A Band 4 Haematology data manager (22.5 hpw) was appointed in January 2014, paid for by recruitment to a paying academic study, ROSE. A FT Band 3 Administrator commenced in post on 07/10/2013. Currently advertising for a 15 hpw Band 2 Medical Laboratory Assistant, to be based in our GCLP accredited Research Laboratory to support both commercial and non commercial research.

MHRA Inspection:

A commercial Rheumatology study underwent an MHRA inspection visit 13th - 14th February 2014 as part of the inspection of the commercial sponsor, UCB Pharma.

This Trust was the highest recruiting site for the study. The visit went very well; the inspector stated that she was satisfied that study participants were receiving a high standard of care. The full report will not be available until mid May.

Issues:

Archiving space for research data has been identified by Procurement along with clinical records. A large number of studies have now been packed up and await transport to the storage facility. It is important for RDD that this exercise is completed by May 2014 as re-accreditation for the Clinical Research Unit's Good Clinical Laboratory Practice is dependent on establishing a suitable archive facility.

The retirement of the radiographer responsible for research X-rays has necessitated training for new staff. RDD has also taken the opportunity to schedule meetings between the lead research rheumatologist and research radiographers. The issue of additional ultrasound scans for an anticoagulation study as been resolved; pressure on MRI capacity has prevented the Trust from participating in a new academic prostate cancer study.

Following the departure of Prof. David Ferry from New Cross Hospital, a considerable amount of administrative work has been undertaken to reassign his studies to other medical oncologists. Recruitment to colorectal chemotherapy studies has always been strong in this Trust; this is no longer certain.

A FT pharmacy technician has been appointed to cover maternity leave in the aseptic unit. The FT aseptic unit research pharmacist has also resigned. While R&D has funding for a 0.50 WTE post, it is unlikely that a18.75 hpw position will attract suitable applicants.

Recommendations

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

RESEARCH & DEVELOPMENT

EXCEPTION REPORT: LIST OF SERIOUS ADVERSE EVENTS, AS DEFINED BY ICH GOOD CLINICAL PRACTICE, WHICH MAY BE ATTRIBUTED TO SIDE EFFECTS OF STUDY DRUG(S) OR DEVICE

Taken from reports to Risk & Assurance Committee, 22/10/2013 AND 28/01/2014

STUDY NAME	DESCRIPTION OF EVENT	CATEGORY OF SEVERITY	DATE AND/OR OUTCOME	NOTES/ RELATIONSHIP TO STUDY MEDS?
SCOT (ID627)	Patient admitted with chest pain. Treated as acute coronary syndrome.	Patient admitted to hospital	12/09/2013 – 13/09/2013	Yes – 5FU
ST03 (ID628)	Bilateral pulmonary embolisms diagnosed during patient's pre-surgery CT scan.	Significant medical event	03/12/2012 – 31/08/2013	Possibly
ST03 (ID629)	Patient admitted with grade 4 hypokalemia. Discharge from QE date unknown. Potassium levels normalised 31/05/2013	Patient transferred to QE for tumour perforation surgery.	17/04/2013 – 31/05/2013	Possibly
ST03 (ID630)	Patient suffering from grade 3 weight loss. Patient seen on 05/08/2013, at which point weight had stabilised.	Patient in hospital 08/04/2013-17/04/2013	08/04/2013 – 05/08/2013	Possibly
MYELOMA XI and TEAMM (ID631)	Dehydration due to diarrhoea, admitted for rehydration with IV fluids. As diarrhoea settled was discharged home next day.	Patient admitted to hospital	19/09/2013 – 20/09/2013	Possibly

ENTRACTE (ID633)	Patient had been complaining of mouth ulcers on and off. Her GP had referred her to ENT specialist who sent her for a biopsy which revealed squamous cell carcinoma (tumour) on the floor of her mouth. She is booked for an MRI and chest x-ray. The tumour will be surgically removed. Awaiting date of admission and procedure.	Diagnosis of squamous cell cancer	01/10/2013 - ongoing	Possibly
MYELOMA XI (ID648)	Admitted to hospital with Neutropenic Sepsis, had bloods and blood cultures taken which grew Gram Neg Rods, had IV Antibiotics.	Patient admitted to hospital	04/01/2014 – 10/01/2014	Yes

SCOT: A study of adjuvant chemotherapy in colorectal cancer by the CACTUS and OCTO groups
PI: Prof David Ferry, Consultant Medical Oncologist

ST03: A randomised phase III trial of peri-operative chemotherapy with or without bevacizumab in operable adenocarcinoma of the stomach and gastro-oesophageal junction
PI: Prof David Ferry, Consultant Medical Oncologist

MYELOMA XI: Randomised comparison I myeloma patients of all ages of thalidomide, lenalidomide and bortezomib combinations in maintenance lenalidomide.
PI: Dr Craig Taylor, Consultant Haematologist

TEAMM: Tackling early morbidity and mortality in myeloma: assessing the benefit of antibiotic prophylaxis and its effect on healthcare associated infections.
PI: Dr Jeff Neilson, Consultant Haematologist

(Patients on MYELOMA XI study may also be enrolled on the TEAMM study; TEAMM was designed with this scenario in mind)

RESEARCH & DEVELOPMENT

CLINICAL TRIALS CURRENTLY OPEN TO RECRUITMENT BY DIRECTORATE

Total live recruiting studies across all specialities as at 25/03/2014

Ambulatory Medicine

NIHR portfolio research studies

Study title	Speciality	Principal Investigator
BADBIR	Dermatology	Dr Graeme Stewart
BSTOP	Dermatology	Michelle Taylor
Genetics of Acne	Dermatology	Dr Evmorfia Lladoyanni
Investigating Medication Adherence in Psoriasis (iMAP)	Dermatology	Dr Evmorfia Lladoyanni
Molecular genetics of adverse drug reactions	Dermatology	Dr Evmorfia Lladoyanni
BLISTER	Dermatology	Dr Verpetinske
eczema genetics	Dermatology	Dr Evmorfia Lladoyanni
TRIALNET	Diabetes	Dr Terence Pang
ADDRESS -2	Diabetes	Dr Terence Pang
DRN 725 (Chronic Disease Resource Centre Diabetes Division)	Diabetes	Dr Terence Pang
DRN 755 (Ex-EduCare: Exercise Education and Care for people with type 1 diabetes)	Diabetes	Dr Terence Pang
Positive voices	GUM/ HIV medicine	Dr Adel Shoukry
Molecular and Cellular studies on inflammation	Neurology	Dr Michael Douglas
RASCAL	Pain	Prof Jon Raphael
Bolus vs Continuous	Pain	Prof Jon Raphael
Braggs and BSRBR	Rheumatology	Prof George Kitas
National repository (BSRBR only)	Rheumatology	Dr Karen Douglas
BILAG	Rheumatology	Dr Niki Erb
Sequencing based analysis of SLE	Rheumatology	Dr Niki Erb
VLAS & MAP-HAND	Rheumatology	Dr Karen Douglas
Biological therapy and sleep in RA	Rheumatology	Dr Karen Douglas
Physical activity in cardiovascular fitness	Rheumatology	Dr Velthuijzen Van Zanten
Physical activity in CVD fitness questionnaire	Rheumatology	Dr Velthuijzen Van Zanten

CRH receptors in the vasculature and blood cells	Rheumatology	Dr Velthuijzen Van Zanten
Sympathetic nerve activity in RA	Rheumatology	Dr James Fisher
Parents with Musculoskeletal Disease: Children's Experiences and Needs	Rheumatology	Dr Elizabeth Hale
Pneumonitis in RA	Rheumatology	Dr Karen Douglas
Biologics in children with RA	Rheumatology	Dr Niki Erb
TACERA	Rheumatology	Dr Ravinder Sandhu
DCVAS	Rheumatology	Dr Rainer Klocke
BSRBR-AS	Rheumatology	Dr Karen Douglas

Commercial research studies

Study title	**Speciality**	**PI**
GESTURE	Dermatology	Dr Effie Laddoyanni
SIGNATURE	Dermatology	Dr Effie Laddoyanni
Palmoplantar pustular psoriasis	Dermatology	Dr Effie Laddoyanni
ACT-TAPER	Rheumatology	Dr Karen Douglas
ACT-OBSERVE	Rheumatology	Dr Karen Douglas
SARIL COMPARE	Rheumatology	Dr Karen Douglas
ASCORE	Rheumatology	Dr Karen Douglas
ACT MOVE	Rheumatology	Dr Karen Douglas

Non NIHR, Non commercial research

Study title	**Speciality**	**PI**
Epstein Barr Versus induced T Cell responses and pathogenesis of MS	Neurology	Dr Michael Douglas
Periodontal Study - tooth loss in patients with RA	Rheumatology	Dr Karen Douglas
The effect of psychological treatment upon the brain activity related to pain processing	Pain management	Nick Hylands-White

EEG-fMRI: towards a useful clinical tool in epilepsy	Neurology/Psychology	Dr Andy Bagshaw
A controlled study of the neural basis of chronic pain in spinal cord stimulation patients using manetoencephalography	Pain management	Lisa Bentley
Predicting the efficacy of spinal cord stimulation using psychological characteristics	Pain management	Stacey Mann
Spinal Cord Stimulation effect upon surface hyperalgesia	Pain management	Dr Rui Duarte

Emergency and Speciality Medicine

NIHR portfolio research studies

Study title	Speciality	Principal Investigator
ISARIC	Acute medicine	Dr Hassan Paraiso
ENCEPH	Acute medicine	Dr Hassan Paraiso
MENINGITIS UK	Acute medicine	Dr Hassan Paraiso
PLACE	Breast cancer	Prof Amtul Carmichael
Macmillan cancer survivors	Breast cancer	Prof Amtul Carmichael
Diligen	Cardiology	Dr Craig Barr
PBC Genetics study	Gastroenterology	Dr Neil Fisher
UK PSC	Gastroenterology	Dr Neil Fisher
CREST	Gastroenterology	Dr Sauid Ishaq
Predicting serious drug side effects in gastroenterology	Gastroenterology	Dr Sheldon Cooper
5 ASA	Gastroenterology	Dr Sheldon Cooper
PANTS	Gastroenterology	Dr Shanika De Silva
AML17	Haematology	Dr Craig Taylor
PACIFICO	Haematology	Dr Savio Fernandes
Myeloma XI	Haematology	Dr Craig Taylor
UKALL 14	Haematology	Dr Craig Taylor
NSHLG	Haematology	Dr Craig Taylor
MDSBio	Haematology	Dr Craig Taylor
LI-1	Haematology	Dr Stephen Jenkins
EXACT	Haematology	Dr Stephen Jenkins
Rialto	Haematology	Dr Stephen Jenkins
TEAMM	Haematology	Dr Jeff Neilson
PANORAMA 3	Haematology	Dr Jeff Neilson
ROSE	Haematology	Dr Stephen Jenkins

Search	Haematology	Angie Watts
RTL perioperative	Haematology	Prof David Ferry
Bortezomib Study	Haematology	Dr Jeff Neilson
ARROVEN	Haematology	Dr Stephen Jenkins
FAST FORWARD	Oncology	Dr Rozenn Allerton
Persephone	Oncology	Dr Rozenn Allerton
STO3	Oncology	Dr Mano Joseph
FOXTROT	Oncology	Dr Simon Grummett
NSCCG	Oncology	Prof David Ferry
QUARTZ	Oncology	Dr Pek Koh
STAMPEDE	Oncology	Dr Pek Koh
PATCH	Oncology	Dr Pek Koh
RADICALS	Oncology	Dr Pek Koh
FABIO	Oncology	Dr Rozenn Allerton
SELECT-D	Oncology	Dr Simon Grummett
MAMMO 50	Oncology	Prof Amtul Carmichael
LUNGCAST	Oncology	Karen Kanyi
UK Genetic Prostate cancer study	Oncology	Karen Kanyi
RTL advanced	Oncology	Dr Mano Joseph
GO-2	Oncology	Dr Mano Joseph
COMPARE	Oncology	Dr Pek Koh
TARDIS	Stroke	Dr Ashim Banerjee
A study of major configuration of stroke services	Stroke	No local PI

Commercial research studies

Study title	**Speciality**	**PI**
ASQ	Cardiology	Dr Craig Barr
GLORIA	Cardiology	Dr Craig Barr
RELAX-2	Cardiology	Dr Craig Barr
EFFORTLESS	Cardiology	Dr Craig Barr
ACCELERATE	Cardiology	Dr Craig Barr
ECHO CRT	Cardiology	Dr Craig Barr
SAFEHER	Oncology	Dr Rozenn Allerton
ACORN	Oncology	Dr Simon Grumett
Aflibercept EAP	Oncology	Dr Simon Grumett
Phase I of MK3475	Oncology	Dr Simon Grumett

Non NIHR, Non commercial research

Study title	Speciality	PI
Body Fat and Breast Cancer	Cancer - Breast	Dr James Brown
Metabolic regulation of breast cancer metastasis	Cancer - Breast	Dr James Brown
A pre test probability score for sub arachnoid haemorrhage	EAU	Dr Hassan Paraiso
Tool to determine sepsis with less invasive testing	EAU	Dr Hassan Paraiso/ Hamid Iftikhar
Immunomodulatory effects of turosine kinase inhibitors in CML	Haematology	Dr Savio Fernandes/Lewis David
WNT	Gastroenterology	Dr Shanika DeSilva
Trastuzumab Breast Ca study - Trastuzumab and Cardiac Vascular Endothelial Function	Cancer - Breast	Prof Amtul Carmichael
I-SCAN	Gastroenterology	Dr Sauid Ishaq

Surgery and Anaesthetics

NIHR portfolio research studies

Study title	Speciality	Principal Investigator
ICON3	Critical Care	Dr Jasbir Chhabra
UKAGS	Vascular	Mr Atiq Rehman
The OPEN Trial: Open Urethroplasty versus Endoscopic Urethrotomy	Surgery	Mr Paul Anderson
IMPROVE	Surgery	Mr Simon Hobbs
Physical activity rehab for cancer survivors	Surgery	Prof Amtul Carmichael

Trauma and Orthopaedics and Plastics

NIHR portfolio research studies

Study title	Speciality	Principal Investigator
Uncoupling obesity and osteoarthritis	Orthopaedic	Mr Ed Davis
Can Shoulder Arthroscopy Work (CSAW)	Orthopaedic	Mr M Sohail Butt

The role of adipose secreted cytokines in mediating pathological remodelling in the osteoarthritic joint: An exploratory study.	Orthopaedic	Mr Ed Davis

Commercial research studies

Study title	Speciality	PI
Brainlab TKA	Orthopaedics	Mr Ed Davis
Vanguard Knee System	Orthopaedics	Mr Ed Davis
MINUTEMAN	Orthopaedics	Mr Mushtaq Ahmed

Non NIHR, Non commercial research

Study title	Speciality	PI
Predicting post operative joint stability in total knee replacement	Orthopaedics	Mr Ed Davis
Factors influencing flexion extension gaps before femoral resection	Orthopaedics	Dr Soha Sajid
Does the addition of physiotherapy manual mobilisation techniques provide a greater benefit to pain and function, in comparison to exercise alone, when rehabilitating patients with a stable proximal humerus fracture?	Physiotherapy	Victoria Hawke

Women and Children

NIHR portfolio research studies

Study title	Speciality	Principal Investigator
PREP	Obstetric	Mr Hassan Morsi
PREDNOS	Paediatrics	Dr Zala Ibrahim
ICISS	Paediatrics	Dr Anil More

Diagnostics

Non NIHR, Non commercial research)

Study title	Speciality	PI
UKPID Registry	Immunology	Dr Malini Bhole
Genetic polymorphisms and low HDL	pathology	Dr Amali Abeysekera
Assessment of inflammatory markers in Cardiovascular disease. Can they be used to make an early diagnosis?	Path Lab	Kathryn Dudley
Assess the impact of anti CD20 monoclonal antibody (rituximab) treatment on B Cell subsets of rheumatology patients using the EUROclass classification	Immunology	Hiruni Dassanayake

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors 3rd April 2014

TITLE:	Corporate Risk Register		
AUTHOR:	Sharon Phillips Risk and Standards Manager	**PRESENTER:**	Paula Clark Chief Executive

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
SGO3: Diversification - To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4: Clinical Partnerships - To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude
SGO6: Enabling Objectives - To deliver an infrastructure that supports delivery

SUMMARY OF KEY ISSUES:

In addition to the operational risk registers (reported to Risk and Assurance Committee) the Directors are currently managing 19 corporate risks. Of these, 10 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified. The remaining risk scores are as follow:

Risk Score	Number of Risks
25	3
20	7
16	1
15	3
12	4
9	1

Action plans are in place, or being developed to address any gaps in control or assurance identified at this time.

IMPLICATIONS OF PAPER:

RISKS	**Risk Register Y**	**Risk Score ALL**	**Details:** Refer to paper attached
COMPLIANCE	**CQC**	**Y**	All outcomes have elements that relate to the management of risk.
	NHSLA	**Y**	**Details:** Risk management arrangements
	Monitor	**Y**	**Details:** Ability to maintain at least level 1 NHSLA
	Other	**Y**	**Details:** Information requirements for the Annual Governance Statement –RR gaps in assurance and control

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE COMMITTEE:

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

CORPORATE RISK REGISTER AS OF 28th March 2014

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR007 (OP080)	Unable to admit emergency patients due to externally caused delayed discharge/transfer	31/03/2011	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	Daily monitoring of the delayed discharges via the delayed list, ensuring its accuracy and that challenges by the ward to the patients care is being managed and escalated appropriately. Ward-based Discharge Team support and plan discharge. Use of estimated discharge at ward level. Escalation to Medical Service Head as appropriate. Lead Nurse meetings with patients and relative to identify needs for discharge. Early notification to LA via Section 2 to prepare for patients likely needs. Agreed health economy escalation plan. Provision of training on compliance with the escalation plan. Issue of letter to prepare patients and family for discharge arrangements.	5	5	25	Escalation meeting daily at 9.15am. Information available on the HUB. Section notifications. Escalation Plan. MOA (Memorandum of Agreement) Integrated Care Group Minutes and actions. Acute Medical Unit Provision of non-acute care. Capacity Team; escalate to Director of Operations as appropriate. Use of standard 'expectations' letter. Training Records. Letters to Patients. Lead Nurse contact. Early understanding of financial constraints from Local Authority and planned use of new re-ablement monies	Poor service cover from multi-agency Discharge Teams because of vacancy, sickness, leave etc resulting in further delays. Disagreement regarding the responsibilities in the DISCO database. No ubiquitous medical and support service cover across hospital. Patient or relative exercising "choice" exacerbates problem. DMBC overseeing a higher than agreed number of patients. Inconsistent bed management processes	Number of patients as per MOA is too high to prevent capacity issues.	Negotiate a reduction of agreed number of DTOC's patients as per MOA (MOA remains unagreed. Escalated to CCG/MBC/NHS leadership triumvirate for agreement for 2014/15). Evaluation of the benefit of external elements of the winter plan. .	30/04/2014	4	4	16

				Utilisation of independent company Care Home Select (CHS) to support patients/relatives in identifying suitable 24-hour care placement. Matron/Lead Nurse ensure that understanding of discharge processes is provided by all nurses/carers. Daily multi-agency teleconference at Level 2 or above. MOA - Local Authority and PCT signed off. Directorate solutions to manage delayed discharge. Training of Bed Managers and Discharge Facilitators across Directorates. Escalation of issue to Director level. Manager of the day identified for each Directorate.				to increase current capacity and response from Local Authority. Working with CCG and LA to manage delayed discharge database, improve admission prevention SW input.							

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR034	Failure to achieve the CIP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £12.45m (4% of budget). The Trust is forecasting a shortfall of just over £2m against the year-end target - (RISK LEAD: Richard Price)	08/05/2012	6. To deliver an infrastructure that supports delivery.	The Board has approved a programme of CIP savings proposals. A Programme Management Office (PMO) capability is established and has been operating effectively for some months. A CIP tracker is updated monthly. This lists all of the schemes with planned monthly savings, the status of the scheme and whether it has gone through the Quality Impact Assessment process. Detailed monthly progress reports are made to the Board's Finance & Performance Committee, Directors and TME. A programme has been scheduled for each Directorate to attend Finance & Performance Committee to update members on their progress (commencing with Women & Children in August 2013 and Specialist Medicine in September 2013 and October 2013). Emergency Medicine attended in October 2013 and November 2013, Surgery in November 2013 and Ambulatory in December 2013. Repeat attendances from both Specialty and Emergency Medicine were as a result of further details/assurance requested	5	5	25	Board and Board Committee Reports. Monthly CIP updates to F&P Committee, including attendance by Directorates to present their latest position. Reports to TME. Detailed scrutiny of Directorate and Corporate CIP Schemes at Directorate Performance Review Meetings and weekly Directors Meetings. Meetings held with each Directorate chaired by the Director of Operations. PRINCE level project management of individual schemes. Monitor approval of plan. CIP risk assessments.	The Trust has not identified sufficient deliverable savings schemes to achieve the required financial contribution of £12.45m for 2013/14. Many schemes remain to be fully developed and implemented. And many schemes will deliver benefits that are unlikely to yield cash savings in 2013/14. Many schemes are not recurrent creating pressure in future years. The efforts of managers and Trust staff is diverted on the management of day-to-day operational pressures, and in particular the Keogh review, rather than the achievement of efficiency savings.	Future years CIP schemes require further development to enable them to be brought forward. Some concern that schemes include a level of duplication between directorate specific plans and corporate-wide savings. Regulator's financial planning assumption for 2014-16 require further significant costs savings in future years.	Horizon scanning of potential new saving ideas commenced. Initial look at using an external company to pay agency medics resulting in a VAT saving. (information supplied and seeking to arrange meeting for October). Proposal now develop and needs to be considered by Director of Finance in January. Development of a process to promote successful CIP ideas that have worked well in other organisations with a challenge to apply here. Brand developed – requires rollout of ideas. Slippage on CIP schemes in 2014-15 has been largely mitigated	31/10/2014	4	5	20

				by the Committee. Directorate plans include the development of alternative schemes to counterbalance slippage. Separate sessions have been co-ordinated by the Director of Operations with each Directorate to assess the achievability of current plans, the possibility of exploiting future opportunities and planning for future years. All CIP proposals are risk-assessed for impact upon clinical standards and signed off by the Medical Director and Nursing Director. General Managers are required to attend the QIA sessions to offer additional advice/understanding on schemes. This process is now working well and the majority of the backlog has been cleared. Monitor approval of plan. CIP/Transformation team in place. Traditional and service re-design and drive towards Lean. Support on longer term CIP opportunities by the Transformation Programme. Separate monthly forecast sessions are held with the finance lead (and potentially general manager if required) to run through year end estimates in more detail. Each Director					The Trust will outturn 2013-14 at £10.2m CIP achieved, £2.2m below target.		by additional income from Commissioners. Appointment of an internal Turnaround Director and development of a strengthened CIP PMO (integrating CIP and Transformation work streams).				

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR042	Failure to deliver financial balance in 2013/14,as a result of further efficiency abatement to NHS Tariff and clinical cost pressures, the Trust is required to deliver unprecedentedly high cash releasing Cost Improvements - (RISK LEAD: Richard Price)	31/12/2012	6. To deliver an infrastructure that supports delivery.	1. CIP in place. 2. Transformation Programme Board established. 3. CIP Transformation Team in place. 4. Traditional and service redesign and drive towards LEAN. 5. Detailed monthly progress reports.	5	5	25	Monthly Progress Reports. Minutes of Transformation Project Board. Transformation & CIP PMO established and resourced. Monthly Progress reports. PWC external workforce productivity benchmarking report.	Given the transformational nature of savings sources in future years, the increased participation of clinicians in promoting clinical practice changes, is essential. This is in serious doubt given current trends in activity pressures and recent media publicity about patient safety issues. The controls have delivered effective CIP savings scheme in previous years but the size of the savings target is greater and the need is for greater transformational change to deliver significant financial benefit.	Delivering widespread clinical change will be a cultural 'hearts and minds' issue that is notoriously difficult to measure.	Directors to take personal responsibility for the delivery of individual CIP projects. Promoting successful schemes that have delivered efficiencies in other hospitals to gain clinical buy in. Development of a specialty analysis to highlight areas to focus on, commencing with 4 specialties identified by Board, T&O, Rheumatology, Pain, Renal. Slippage on CIP schemes in 2014-15 has been largely mitigated by additional income from Commissioners.	01/05/2014	2	5	10

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR056	The construction of the two year operational plan element of the IBP, which will be submitted to Monitor on 4/4/14, has identified emergent operational and quality risks which are not yet quantified or reflected on the corporate risk register. The risk is therefore that the Board of Directors are not sighted on, nor yet clear about mitigations or assurances with regard to these risks.	**25/04/2014**	Enabling: To deliver an infrastructure that supports delivery	Mitigations for these risks are articulated at summary level in the 2 year operational plan and are also being actioned by the executive	4	5	20	2 year operational plan, business cases to investment panel and Board on key developments within that plan, balanced scorecard dashboard	Detailed mitigation plans are not in place for each of the unregistered risks (i.e. Meeting NHS England 7/7 working standards in urgent care or capital investment plan)	Rejected or deferred business case(s)	Complete full risk assessments on every emerging risk within the 2 year operational plan (IBP) and reflect in corporate risk register and BAF	**30/04/1014**	**2**	**4**	**8**

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR043	The Trust will be working to a much more onerous NHS Standard Acute Contract in 2013-14 than hitherto. The DoH and NHSCB have already declared that CCGs MUST invoke financial penalties for non-compliance issues - (RISK LEAD: Richard Price)	31/12/2012	6. To deliver an infrastructure that supports delivery.	Detailed monthly monitoring of exposure to penalties by Directorates and Corporate Information Teams. Escalation procedure of risk issues to Directors. Regular performance reports to Directors/F&P Committee and Board. Corporate and departmental dashboards in place for monitoring. Breach analysis and reporting regime in place.	4	5	20	Independent audit scrutiny of data capture & reporting. Monthly discussions with Commissioners. Detailed monitoring by Commissioners and strict escalation and investigation of breaches regime in place. Directorate Performance Review Meetings. Detailed assessment of exposure for each potential penalty presented to F&P, TME & Board June. Ongoing updates provided to F&P/Board/TME of the fines applied to date and risk of future fines. Inclusion of risk within financial figures (forecast as at November assumed £750k will be incurred for penalties). Subsequent information indicates that penalties could be more in the region of £1m-£1.25m Agreed with CCG that they will waive	Continuous increases in emergency activity compromise effective risk management processes. Clinical Departments are not sufficiently sighted on such performance risks and target achievement is always subservient to safety and quality concerns. Poor or inadequate IT solutions in place to provide constant monitoring of target achievement in certain instances.	In the absence of clear targets and definitions, data capture and reporting processes may be inadequate. Absence of Ambulance data is hindering Trust validation of figures and ability to construct a mitigating argument regarding inappropriate number of ambulance arrivals within a given time period. NHS Dudley has agreed to block back fines and penalties in imposed in 2014-15.	We have negotiated with Commissioners regarding the re-deployment of any funds recovered through the imposition of fines and penalties. This includes a mitigating argument regarding the number of ambulance arrivals within an hour.	31/03/2014	2	2	4

								the ambulance turnaround penalties (greater than 30 minutes) from April to September. From October onwards they will be charged at 75% to reflect the potential inaccuracy in the recording of arrival times by the ambulance service.							

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR053 (OP052)	Failure to maintain 18-week Pathway - (RISK LEAD: Jennie Muraszewski)	31/03/2011	3. To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio.	1. Extensive training programme for medical secretaries undertaken to improve knowledge of Oasis & 18-week Access Policy. 2. Assistant GMs on behalf of GMs oversee process of validating waiting list reports. 3. Breach reports are validated weekly by RTT Support Team. 4. Extra clinics arranged by RTT Support Clerk. 5. Extra theatre lists arranged by Asst Gen Mgrs. 6. Diagnostics manage their waiting list to achieve two week diagnostic wait. 7. PTL reports of target outturns are validated prior to circulation team by RTT Support Team. 8. Directorate have developed demand and capacity models. 9. 20 extra beds available in c6 transferred from medicine.	4	5	20	18 week reports. Directorate dashboard. Reduction of medical outliers.	1. Secretaries do not follow policy. 8,9. Trauma emergencies outstrip beds available on B2 and overspill onto elective ward. A high volume of emergency surgical patients impacts on bed availability for elective patients	Lack of ring-fenced elective capacity. Consultant staff shortages in some specialties. Increased demand for specialties	To retain and monitor 18-week headroom in individual pathways so any unplanned cancellations does not cause a breach. Undertake waiting list sessions as appropriate to ensure RTT headroom is maintained. Ring-fence all of T&O and S&A beds, preventing medicine outlying at any stage.	31/05/2015	4	3	12

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR055	Cancellation of elective surgical patients due to excessive emergency admissions from medicine, trauma or surgery.	10/02/2014	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	• Matron review of elective admissions to prioritise elective admissions, if cancellations are imminent. • Surgical capacity lead involved in trust wide daily capacity planning for emergency and elective demand • Visualisation ward boards to manage patient flow. • Surgical Capacity Team 24/7. • Discharge Co-ordinators DISCO dedicated to surgery. • Escalation Policy. • Surgical patients admitted on the day of surgery, unless there is a clinical imperative to do otherwise • Training programme for medical secretaries to improve use of OASIS and knowledge of 18 week RTT pathways. • Enhanced recovery embedded in urology, general surgery. • Nurses empowered to	4	5	20	• Board Reports o18 week RTT report by specialty outcome, activity and expenditure reports for surgery Transformation Board – Length of Stay review report • Operational reports • Capacity meeting reports indicating emergency and elective demand on hospital (4 times daily) • Outlier report (daily) • Delayed discharge database (daily) • Directorate in upper quartile for KPI efficiencies e.g. LOS.	• Escalation Policy not followed • Outlier policy not followed • Emergency (medical and surgical) admissions growing Demand above plan for the vascular surgery unit Repatriation challenges with vascular patients from other health economies • Difficulty in acquiring sufficient intermediate or step down beds for medical patients means that they remain in acute beds after they are MFFD. • Matrons control of capacity not available out of hours • Failure to repatriate Walsall and Wolverhampton vascular patients	• Medicine patients continue to outlie. • Elective surgery is cancelled periodically due to capacity issues • 18 week RTT performance has dropped	Implementation of full ECIST Action Plan (from Nov 13 and Feb 14). Revised 4-hour wait recovery plan based on ECIST visits in Nov 13 and Feb 14). Plan elective surgery during weeks, months and quarters with historically lower emergency demand Complete SAU improvement project CCG commissioned Urgent Care Centre reduces non-elective demand	31/01/2015	4	4	16

				conditionally discharge patients • Hospital to home service to reduce re-admissions to urology • Increased use of day case • Medicine have purchased additional beds in the community • C6 transferred to surgery with 20 additional beds & B4-10 beds converted to inpatient care • Lean action days held in November 2013 to review functionality of SAU in order to optimise alternative pathways and avoid admissions wherever clinically safe and appropriate to do so • Ring fenced beds for vascular surgery • Reporting of incidents through DATIX • Exceptional use of WLI operating lists at times of improved capacity to recover 18wk performance					• Use of DCU for capacity • Limited availability of Ultrasound scanning in SAU. • Lack of clear pathways and senior decision makers to ensure none inpatient pathways are offered to low risk emergency surgical patients.				

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR003 (OP090)	Urgent care demand exceeds capacity	01/07/2011	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Re-designation of surgical beds to medicine has taken place. 2. CD/MSH review of elective admissions to prioritise urgent admissions, if cancellations are imminent. 4. New capacity management system partially deployed. 5. Discharge Co-ordinators to manage delayed discharges. 6. Escalation Policy and contingency capacity policy reviewed and deployed. 7. Daily capacity meetings. Using capacity hub, standardised meeting template. 8. Work with primary care and commissioners to curtail urgent care demands, provision of virtual ward. Rapid response teams and other admission avoidance schemes. 9. Admit on the day of surgery to reduce pre-op LOS. 10. IST recommendations roll-out.	5	4	20	1. Surgical LOS 2. Capacity reports / cancellation lists 3. Board reports include elements of bed capacity etc. capacity reports communicated after capacity meeting 3 Level of cancellations via reporting to CCG/LAT 4 Operation of capacity hub, output of capacity meetings 5 Delayed discharge database managed, available and communicated 6 Escalation policy up to date, 7 See 4 8 Minutes of urgent care working group 9 Surgery LOS 10 Revised ECIST action plan delivery overseen by LOS transformation steering group	1 Medical outliers in surgical beds 2 MSH/medical staff not consistently engaged in Capacity Management. 3 Bed/ Capacity Management approach/systems not aligned to predictive demand management within specialities/wards locally. 3,6 Understanding of policies by all staff. 7 Poor attendance at Capacity Meetings. 1,2,3,9 Surges in Emergency surgical activity demand. 1-10 Failure of all parties to contribute. 1-10 Failure of parties to agree. 8 DTOC remains above MOA. 8 DTOC for Sandwell patients too high.	Database only covers Dudley patients.	1. Deliver the SDIP in conjunction with the CCG to ensure 15% reduction in emergency admissions 2. Empower non-medical staff to improve MDT-led discharge (ongoing) Delivery of ECIST action plan.	30/06/2014	4	3	12

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR026	Nurse staffing levels are sub-optimal in certain areas.	01/12/2011	5. To create a high commitment culture from our staff with positive morale and a can do attitude.	1. (AKUH) Safer Care Staffing Tool has been used to determine staff levels. This will be repeated in February. 2. Ward staffing levels have been reviewed with Matrons and presented to the Board. 3. Rosters managed and monitored. Matrons and Lead Nurses and Midwives and AHP Leads identify shortfalls in staff levels and rectify. 4. Significant investment in the workforce. 5. Nurse Bank established. 6. Continue to use Bank Staff to cover vacancies and move staff to under-resourced areas. 7. Accredited training programme established for novices and new graduates. 8. Band 4 Clinical Support Worker programme developed. 9. Matrons report to Board and Nursing Care Indicators to CQPSE.	5	4	20	1. Staff Survey Results. 2/4. Datix Incident Reporting captures shifts with staffing concerns reported to CQPSE Committee and Patient Experience Group. 3. Financial investment made in high risk wards in Medical Directorate . 5. Agency Expenditure Report remains high. (Reports on agency staffing at F&P Committee). 6. Training records. 8. Nursing Care Indicators reported monthly to CQSPE . 8. Monthly Matrons presentations to the Board.	1. Optimal skill mix not fully funded. Further financial investment required (£600k). 2. Staffing levels on occasions fall below acceptable safe levels before mitigation.	2. AKUH process will be re-run in February; the Tool has been revised nationally.	Overseas recruitment - 1st trawl in February. Further trawl in June.	30/06/2014	5	2	10

				10. Staffing levels audited as part of NCIs. 11. Roster on 'pool' team daily. Two trained and two CSW on every shift to provide short term cover (reporting to EAU). 12. Overseas recruitment of Nurses from Portugal and Spain. 13. RCN best practice (1:8 general areas, 1:1/1:4 in specialty areas) posted on ward board daily and monitored.			10. Daily nurse to patient ration displayed on all wards. 11. AKHUH Dependency Tool adopted - data collected for the second time and awaiting results. 12. Programme for Registered Nurses to return to acute practice in progress. 13. Nurse to patient ration are published and displayed daily on every ward. 14. Use of in-house Bank and external Agency staff. 15. RCN best practice daily values recorded.					

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR045	Diabetic Management	04/01/2013	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Diabetes Outreach Team available for advice Mon – Fri 9am to 7pm and Saturday 9am to 5pm. Referral process in place. Sunday 9am-5pm service commenced 1/9/13. 2. Diabetes management plans formulated by DOT Team & written in pts notes. 3. Diabetes protocols and guidance available on Hub for staff to use. 4. Staff training for diabetes on induction and then 3-yearly updates, monthly updates for staff attendance now available for ward and department managers to monitor attendance compliance. 5. Link Diabetes Nurses on all wards. 6. Standardised insulin administration and testing equipment within Trust. 7. Staff responsible for prescribing, preparing and administering insulin are trained before doing so. (NPSA/2010/RRR013). 8. Datix monitoring for trends.	5	4	20	Datix Reports. Mandatory Training records. Audit reports from Pharmacy. National External Diabetes Annual Audit. Audit of patient referrals to Diabetes Outreach Team. Nurse Care Indicator Audit.	3. Staff do not follow guidelines, surgical pre-assessment do not refer patients in timely manner to enable optimisation of diabetes control pre-theatre. 4, 7. Staff do not attend Mandatory Training. 3. Guidelines for surgical management of diabetes, hyperglycaemia and self-administration of insulin are yet to be ratified. 7. While nursing staff have this as part of medicines management programme, there is no record of medical staff compliance with this control, and no evidence that this staff group have been requested to undertake this training. 6. Testing and insulin administration equipment not currently available in	Mandatory status for training in diabetes only agreed in November 2012, so poor compliance at this point Trust-wide.	2. Ensure diabetes assessment is a mandatory part of the new nursing EPR. 3. Ensure all medical staff who prescribe, prepare and administer insulin are trained. 4. Produce urgent Care Bundles for Diabetic Ketoacidosis and Hyperkalemia. 5. Produce guidelines and load on Hub for: Surgical Management of Diabetes Hyperkalemia Self-administration of Insulin 6. Increase accessibility of Diabetes Policies and Guidelines on the Hub.	31/03/2014	4	3	12

				9. Pharmacy Audit for missed doses and insulin errors. 10. Nursing Care Indicators monitor Trust compliance with diabetes screening for each patient admission, reports sent by Nursing Directorate to Diabetes Team. 11. ED and EAU undertake routine blood glucose for all new admissions as part of their biochemical test screen, effective as of 13/3/13. 12. All admissions to the Trust must have - in addition to their U&Es - a blood glucose recording.					all areas beyond wards.		8. Improve Medicines Reconciliation Service on EAU. 9. Implement electronic referral to diabetes in ED/EAU October 2013. 10. Areas without Diabetes Hypo boxes and Keto Meters to be identified and Hypo boxes to be made available. 11. Community Directorate to identify requirements in Community.				

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR035	Rising urgent care demand on ED as a result of poorly planned management across health economy	23/05/2012	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Discussion with Local Walk-in Centre (WIC) with regard to protocol for pressure period management and triage back to WIC. 2. Operational policies for the management of 'Minors' stream and ambulance patients during pressure periods. 3. Creative use of other ED areas, other that treatment cubicles, during pressure periods. 4. Management of ambulance conveyances by liaising with WMAS to influence disposition of patient on a patient by patient basis	4	4	16	1. Protocols for joint pressure period management with WIC. 1,2,3. Operational policy and procedure within ED for alternative methods of managing 'Minors' category demand. Capacity Reports, ED Performance Reports 2,3. RAT Policy (ED). 1,4. CCG Urgent Care Programme Board. 4. Including support for WMAS in terms of suitable conveyance for patients.	1,2,4. Peaks in demand for ED may still not be manageable internally. 2,3. Establishment review process (Nursing) for specialist areas in the Trust, like ED, is not yet complete. 4. Local Urgent Care forum has been restarted to enable economy wide solutions to the urgent care demand.		1,4. New Transformation Project and Urgent Care consultations underway. Led by CCG. Operation of new Urgent Care Centre (Jan 2015). 2,3. Action Plan to Sustain Delivery of 4-hr Emergency Access Target (F&P March 27th 2014).	31/01/2015	4	2	8

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR030 (MAT002 & G010)	The loss of experienced midwives from the service and replacement by newly qualified, inexperienced midwives from other hospitals has resulted in an insufficient number of midwives with the required experience for workload/activity/dependency and complexity of women requiring inpatient maternity services, resulting in increased risk of maternal and perinatal mortality/morbidity (RISK LEAD: Yvonne Jones)	01/09/2011	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Midwives have been and continue to be recruited to fill the agreed staffing establishment in line with the recommendations of Birth-rate Plus, but the vast majority have been newly qualified midwives from other hospitals who lack midwifery experience and knowledge of RHH policies and procedures. 2. Midwives on the Staff Bank are utilised to cover shortfalls in numbers of staff on duty due to absence and whilst newly appointed staff are in their induction period/on study leave to undertake mandatory training and gain experience. 3. The Escalation Policy is used for managing reduced staffing which provides clear direction and action to be followed when the staffing is compromised. 4. Managers ensure compliance with absence/ annual leave/off duty policies. 5. There is an agreement to continue the restriction of OOA bookings at the current level until the review with the CCG in July 2013. 6. There is a monthly review of MW:Birth ratio, staff appointments and vacancies with updates monthly to SHA and quarterly to Directors.	5	3	15	1. All sickness absence managed appropriately as per Trust guidelines and reviewed regularly at Lead Midwives and Managers meetings. 2. Flexible employment opportunities available to Trust staff. 3. Mandatory Training is planned to ensure that the impact of staff study leave is appropriately spaced out to avoid diminishing the workforce unnecessarily. 4. Annual Leave Policy adhered to. 5. Hospital provide accommodation available to staff who would otherwise need to commute long distances.	1. High sickness absence levels both short and long term and the delay in OH service appointments and reports which prevents timely return to work. 2. High rate of maternity leave in the Band 5-6 midwife establishment. 3. Inability to recruit experienced Midwives form other hospitals. 4. The high level resource requirement of Mandatory Training. 5. The loss of midwives who travel long distances from home who leave when they gain local employment. 6. The loss of experienced MWs to retirement, other jobs etc.	1. Delays in OH Dept reviews due to lack of capacity. 2. Child-bearing age group of midwife population. 3. Not all trainers adhere to the guidance that their training needs to the planned around all the other mandatory training or study days being delivered. 4. New staff coming into post in the Autumn months accrue annual leave but do not take it until after their induction period but then are restricted by the policy that AL is restricted around Christmas period, therefore it must be taken in the final quarter of the financial year.	Request HR/OH review service response, to ensure that staff are given timely appointments and reports available to managers to ensure staff come back to work without delay. Continue to ensure Lead Midwives/ Managers offer annual leave short notice to staff when rotas identify surplus staffing . Continue to ensure that inexperienced staff receives the support required to gain experience and achieve the competence level required to practise safely. Continue to ensure all staff receive appropriate support in their work, receive feedback, timely appraisals and opportunity to attend staff meetings and receive the notes from these meetings.	30/04/2014	5	2	9

				7. Development opportunity has been offered to Senior Midwives to gain experience as Band 7 Shift Coordinator so that there is another Band 7 available per shift to support the junior midwives on duty. 8. Unit Manager and Off Duty Coordinator to ensure best skill mix within current resource. 9. The Band 5 Midwife development pathway is in use to support newly qualified and adapted for newly appointed midwives from other hospitals. 10. An electronic diary is used for planning Mandatory Training.			6. Strong cohesive Supervisor of Midwives team available to support MWs to gain experience and support them in practise. 7. Trust provides centralised recruitment personnel.	7. Recruitment process is lengthy once appointment offer has been made.	5. Midwives with families reluctant to stay in hospital accommodation and are unwilling to commit to relocation. 6. Maternity Managers are unable to expedite recruitment process as responsibility lies with Central Recruitment team.	Support the quality and rigour of the local University Midwifery Programme develops midwives that are fit for purpose at the end of training. Continue to implement measures to ensure safe staffing levels and regularly review workforce using the 'table top' Birth Rate Plus Tool.		

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR054 (AM012)	Cannulation of Arterio-Venous Fistula	26/08/2011	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. In-house Training Programme for staff who needle fistula. This includes a competency package that is assessed initially by the Medical Service Head and then re-assessed annually by Band 6/7 Registered Nurse. 2. Patients are educated how to care for their own fistula and risks associated with fistulae. 3. Patient Information Leaflets detailing emergency actions they should take if any problems with fistulae.	5	3	15	1: Completed competency package - copies on personal files. 2: Information documented in patients notes. Datix Incident Reports to monitor trends	Inconsistency in competence attainment and assessment via MSH Failure to adopt best practice	1. Poor compliance to competency sign-off.	Implementation of the Recommendations from the Renal Network and Marsh Reports by the Renal Team.	30/06/2014	5	2	10
COR038 (NP005)	Neonatal Capacity - (RISK LEAD: Pam Smith)	01/04/2011	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	There are four beds identified within the Maternity Unit to provide Transitional Care. Robust off-duty procedures. Shift Lead Nurse monitor activity and Staffing levels/skill mix twice a day 4pm-5pm and 4am-5am and report findings to Matron ward round at 8am (Mon to Fri). Staff work flexibly to cover shortfalls. Use of Bank/Agency. Escalation Policy implemented as necessary. Monday to Friday monitoring from Shift Lead Nurse/Matron. X2 additional posts recruited above establishment to reduce reliance on	5	3	15	Compliance with off-duty rota. Sickness Absence levels. Number of Incidents when national staffing standards not met. Number of occasions unit closed due to non-compliance of off duty. Number of Compliments. Number of Complaints.	Bank/Agency do not always fulfil. Financial consequences of increased use of Bank/Agency. No monitoring in place at weekends.	Increase in incident trends.	Paediatric and Neonatal Strategy to be developed to identify workforce planning required to meet National recommendations and to be included in Directorate Business Plan.	30/04/2014	5	2	10

				Bank/Agency staff.											
Risk Ref	**Risk**	**Risk Start Date**	**Strategic Objective**	**Current Controls**	**Cons**	**Like**	**Score**	**Sources of Assurance**	**Gaps in Control**	**Gaps in Assurance**	**Mitigating Actions**	**Target End Date**	**Cons**	**Like**	**Score**
COR028	Increase in the number and grade of avoidable pressure ulcers (Trust) - (RISK LEAD: Lisa Turley)	09/03/2012	2. To provide the best possible patient experience	Framework to report and capture of pressure ulcers. Skin Bundles in every inpatient area and on Community case load. Formal 2-hourly charts and assessment records for all patients. Fluid bundles also added to process improving patient hydration. Designated person to manage the interface between the Community and the Hospital. Formal round table meetings to discuss RCA providing peer challenge. Rolling programme campaign. Report framework. Committees confirming Trust position and monitoring arrangements. All Serious Incidents reviewed. New staging process implemented. Pressure ulcer management included on induction and	3	4	12	Pressure Ulcer Documentation Audit. Reports to Risk Committee via Patient Safety Group. Nursing Care Indicators. Audit of Quality Accounts. Patient Safety Thermometer (from 14/3/2012). - Framework to Monitor progress of pressure ulcers against CQUIN targets, working towards compliance with patient skin assessments, implementation of care plans and reduction in incidence of Stage 3 and 4 pressure ulcers. On target to meet Quality Accounts Standards. On target to meet CQUIN Standards.	Difficulty in maintaining staff compliance with Pressure Ulcer Management. Only partial compliance with NICE Guidance in relation to photographing Stage 3 and 4 pressure ulcers. May need to report avoidable Stage 3 and 4 pressure ulcers which will increase the number of pressure ulcers reported into the public domain.		Develop, agree and implement a process for photographing Stage 3 and 4 pressure ulcers. Confirm the requirements related to the reporting of avoidable Stage 3 and 4 pressure ulcers to Clinical Commissioning Group and Commissioning Support Unit.	31/03/2014	3	3	9

				mandatory training.											
Risk Ref	**Risk**	**Risk Start Date**	**Strategic Objective**	**Current Controls**	**Cons**	**Like**	**Score**	**Sources of Assurance**	**Gaps in Control**	**Gaps in Assurance**	**Mitigating Actions**	**Target End Date**	**Cons**	**Like**	**Score**
COR051	Potential compromise of clinical care due to the non-availability of clinical information at time of consultation - (RISK LEAD: Louise McMahon)	09/05/2013	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Clinic are organised in advance, with Health Record preparing case notes up to 4 days in advance and having a process to identify and collect case notes not available at that time due to being tracked to another location. 2. Case note tracking system in place. 3. An internal e-mail alert if case notes required and not at last tracked location 4. For case notes not provided in time for consultation, process for provision of a temporary file which should be reconciled with case note folder at earliest opportunity. 5. Health Records have a reporting log for case notes not found at last tracked location and they monitor this on a regular basis. 6. Business continuity plans if IT system failures or planned down time so that clinical information is available. 7. Clinicians may have access to specialty shared drive and thus be able to gain access to clinical letters. 8. Process to alert clinician if clinical information may not be available for consultation	3	4	12	1. Health Records policies and procedures available through the Hub. 2. Trust and local induction. 3. Screensavers on importance of case notes tracking; case notes structure and filing.	1. Failure of logistics, to guarantee case note delivery in advance of clinic commencement. 2. Failure to know if all clinical information is available in case notes until commencement of consultation. 3. Non-compliance of case note structure resulting in inability to locate information even if filed. 4. Sub-optimal processes to retrieve and provide case notes for those appointment offered at short notice. 5. Clinics allowing 'walk-in' appointment where patient not identified on clinic list and thus notes not prepared. 6. Non-compliance of case notes tracking resulting in inability to locate and prepare case notes in time. 7. No central	1. Lack of organisational accountability and limited to no audit process of compliance with case note structure and filing process; case notes tracking. 2. No central induction, training and accountability of those staff who have responsibility for management, tracking and logistics of case notes and electronic clinical information. 3. Under reporting on Datix of non-availability of clinical information. 4. Lack of feedback on outcomes from Datix reporting and actions taken. 5. Sub-optimal performance monitoring and action with regards to poor and or non-compliance Trust or local policies and procedures.	1. To optimise preparation time for clinic preparation processes through minimising unnecessary work i.e. preparation of clinics/ appointments which are cancelled at short notice (implement via OPD Steering Group, monitor via Operational Meetings). 2. Report case note structure and filing compliance (monitor via Health Records Group). 3. To enforce case notes tracking on Oasis (report and monitor via Operational Meetings). 4. To encourage completion of Datix reporting of non-availability in order for organisation to have a better understanding of the frequency of	30/04/2014	3	2	6

				so they can make the clinical judgement if the consultation should proceed. If the decision is to not proceed with consultation, patient is informed, apology and explanation given and patient offered a rescheduled appointment. 9. Datix reporting of incidents where clinical information is unavailable; incomplete. 10. Reporting of duplicate number for same patient. Use of NHS number as unique identifier.					repository for clinical letters so availability to access clinical letters is permission controlled at speciality/clinician level. 8. Failure to report duplicate Trust ID number for same patient resulting in failure to merge number and clinical information.		occurrence and consequences of non-availability (quarterly report to Health Records Group). 5. To investigate and produce a business case for consideration of a central repository for access to clinical letters. 6. To investigate and produce a business case for consideration of an electronic patient record system.				
COR032 (OP097)	Failure to implement Business Continuity Plan during a Major Internal Incident	01/12/2011	6. To deliver an infrastructure that supports delivery.	Business Continuity Plan in place developed with PFI Partners. BCP Group including PFI Partners established to review potential incidents and agree Mitigating Actions. This work has commenced to strengthen the Estates and FM Contingency Plans.	4	3	12	CQC IFM Reports and business continuity. Risk & Assurance Committee Reports. RCA report(s) following business continuity incidents.	BCP needs review and updating in association with PFI Partners. This has now been completed and risk assessment amended accordingly.		Set up BCP Group including PFI Partners to review potential incidents and agree mitigating actions. This work has commenced to strengthen the Estates and FM Contingency Plans. Provide training and undertake exercise to improve response. Implement recommendations following HV incident July 2013.	30/04/2014	4	2	8

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR052	Loss of all early patient discharges by the RAS team, which will reduce the Trusts ability to admit emergency patients. Early patient discharges by the RAS team, have previously been calculated to be of the order of 8000 bed days or 24 extra inpatient beds in medicine on average for each day of the year.	18/06/2013	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1) Change has not occurred yet, ongoing conversations with Commissioners to try and dissuade them from these actions by presenting fully what the RAS Team do. So they have a better idea of potential risks to themselves as well as the trust and patients. 2) Ways of managing the risk, if the change actually occurs include; a) Trust to pick up the extra funding for the nursing staff that has been lost to the Community admission avoidance strategy. So that Early discharge can continue arm in arm with increased admission avoidance. b) Staff transferred from elsewhere to cover the loss of early discharge service, such as proportion of Virtual Ward staff. c) The CCG want more patients taken on by DRAS in the community. A further trial has been suggested on 50 patients and we are working towards that by February. Commissioners had been happy with this initially but the remainder of the CCG guideline development group want it immediately and a figure of 70 patients taken on	4	3	12	1) Medical and Respiratory LOS. 2) Re-admissions. 3) BTS audits of COPD, Asthma and Pneumonia. 4) Escalation level and ED breaches.	1) Unclear if CCG can be persuaded. 2) Unclear if Virtual Ward have capacity and ability to incorporate a proportion of their staff into RAS Team. 3) Unclear if Trust will find extra funding or take a gamble on non-evidence based admission avoidance strategy. 4) There is a need more evidence for early discharge and to whom the benefit lays. Commissioners perceive ED as a sole benefit to the Trust and are clearly pushing towards the Trust paying for the early discharge component and the CCG paying for admissions avoidance.	N/A – The proposal is still at pilot phase and thus no clear plan or gaps in assurance against mitigating that plan is in place at the current time. Although the risk rating has been reduced marginally since the initial risk rating was undertaken as the definition of the pilot is more refined.	Review available budget and budget setting for 2014/15, to establish funding availability. Assess VW current capacity and ability to incorporate a proportion of their staff into RAS Team. Await a clear commissioning plan from the CCG.	30/04/2014	4	2	8

				by DRAS is being pursued by commissioners. At the time of writing, admissions for asthma and COPD are below trajectory based activity figures. If the Commissioners interpret this as a success of the new system they may ask for more patients to be managed in this way as they can argue initial success.										

Risk Ref	Risk	Risk Start Date	Strategic Objective	Current Controls	Cons	Like	Score	Sources of Assurance	Gaps in Control	Gaps in Assurance	Mitigating Actions	Target End Date	Cons	Like	Score
COR044	The need for a Medical 'Workforce Plan' - a fit-for-purpose workforce is needed to meet service needs - (RISK LEAD: Dr A Whallett)	03/01/2013	6. To deliver an infrastructure that supports delivery.	1. Appointment of Trust junior and middle grade medical staff to support specialty rotas. 2. Locums to cover 'gaps' in rotas. 3. Ad hoc Trust appointed posts in individual departments. 4. We are beginning to explore the roles of non-medical staff performing the duties traditionally performed by doctors.	3	3	9	1. A business case for Junior and Middle Grade Trust doctors based upon the needs of departments working together rather than in isolation was approved and recruited to. 2. Rotations are staggered with deanery posts so that times of 'changeover' do not coincide. 3. Rotas are less hard pressed leading, so there is more flexibility if there any 'gaps' in the rota. Therefore EWTD less likely to be breached. 4. 'Spreading the load' with existing doctors reduces stress hard pressed areas. Junior doctor satisfaction is important in external QA such as deanery visits, JEST, GMC trainee's surveys etc.	1. Some of the Trust posts are still not recruited to. 2. Locums are expensive, unreliable, of lower quality and have no commitment to the organisation. 3. Ad hoc Trust appointed posts are difficult to fill, difficult to fill with quality and a considerable drain on departments to appoint in isolation with other departments in the hospital (e.g. short listing, interviewing etc). 4. The recruitment of non-medical alternatives – e.g. surgical nurse practitioners, Physician's assistants, has not been rolled out to its full potential.	Assessment of the impact of the Trust doctors has not yet been completed, as the post holders are not yet in post: 1. To analyse reduction of locum spend which we presume to reduce over time. 2. To ensure a steady stream of high quality candidates for posts, and retain them. 3. To ensure adequate appraisal and training of post holders, and revalidation if necessary. 4. This requires the assurance of available educational and clinical supervisors, clinical skills, IT and mandatory training. 5. Processes to be established for any doctors who run into difficulty.	1. Implementation of a Trust Programme for Junior and Middle Grade Trust Doctors. a) To recruit high quality, consistent junior and middle tier In-house training schemes that supplements the deanery trainees. b) Review how we can use existing funded posts, and also to offset the money currently spent on locum posts. The rotations could be viewed in isolation. 2. Develop a further rotation to offset pressures in the Anaesthetic service. This will work to the same principles. a) Review programme and extend to other departments if proven beneficial. Surgery at FY level	31/08/2014	2	2	4

								5. Posts to be under the educational stewardship of a new 'Junior Trust Doctor Tutor' post.	5. No process for overseeing education and training of locum and ad hoc post holders. 6. Little flexibility in the system if a doctor leaves a deanery rotation early (e.g. maternity leave, obtains consultant job, illness etc).		3. Develop a business case for advanced surgical nurse practitioners to take on the work traditionally performed by FY1 doctors in surgery. 4. To explore the role of Physicians assistants for other departments where posts may be threatened or where there is demand.				

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

on Thursday 6th April 2014

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

SUMMARY OF KEY ISSUES:

The Medical Directorate Management team last presented to the Board of Directors on this subject in October 2013. This report provides the requested 6 monthly update on progress being made against the Directorate's previously articulated 4 point approach to improving Dementia care within the Trust.

The Trust has achieved the 2013/14 CQUIN regarding dementia care, including the completion of a carers survey which has identified a number of areas of best practice and areas for improvement.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** OP028 – confused patient(s) becoming agitated/aggressive OP031 – confused patient leaving ward/hospital
	Risk Register: **Y**		**Risk Score:** OP028 – 12 Op031 – 15
COMPLIANCE and/or LEGAL REQUIREMENTS		**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

The Dudley Group NHS
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ACTION REQUIRED OF THE BOARD OF DIRECTORS:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

Background

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

1. Improved Identification (and diagnosis) of patients with Dementia
2. Improved care and treatment of patients with dementia
3. Improved environment of patients with dementia
4. To ensure appropriate support for carers of people with dementia.

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

1.0 Improved Identification (and diagnosis) of patients with Dementia

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

The Trust has achieved at least 90% in all areas since June 2013, securing the full CQUIN payment and screening an average of 94% of patients each month. The CQUIN will continue for 2014/15.

	Screening of all emergency admissions over 75	For patients identified at risk of Dementia - full assessment	Referred according to the Dudley Dementia Pathway
April	81.34%	100%	97.56%
May	83.04%	100%	100%
June	99.22%	100%	100%
July	99.36%	100%	100%
August	100%	100%	98.08%
September	99.6%	100%	100%
October	90.17%	100%	94.74%
November	91.49%	100%	97.5%
December	97.14%	100%	96.88%
January	99.25%	100%	100%
February	97.75%	100%	95.92%

2.0 Improved Care and Treatment for Patients with Dementia

Dementia Care Bundles
This initiative has been piloted on C3 and is currently being evaluated.

Dementia Champions
A short questionnaire has been completed by all Band 7 Nurses to identify skills and knowledge gaps. Training is due to commence in May 2014 for nominated champions.

Dementia Friends
The Trust has signed up to the Dementia Friends initiative and will be launching within the Trust during Dementia Awareness Week in May 2014.

Patients undergoing surgery
The project group identified an increasing demand for support for patients undergoing surgery. Pre-Assessment processes are being revised to identify any areas of improvement for identifying patients requiring extra support before admission.

Expectations of 1-2-1 Support
A series of expectations is being developed to provide consistency in 1-2-1 support for Dementia patients. Additionally, both the Surgical and Medical teams are in the process of producing business cases for substantive 1-2-1 support.

3.0 Improving the Environment for patients with Dementia

During winter 2013/14 a Frail Elderly Short Stay Unit has been piloted on A2 and is currently being evaluated in condition with the Acute Medical Team. Once the directorate management team have agreed if the unit should be made substantive discussions regarding the Estate will be concluded and any potential dementia ward identified.

The Trust is currently loaning a 'Rempod' for use in the A2 day room to create a suitable environment for A2 and C3 patients who have dementia. The facility will be used at set times to support activities for this particular patient group.

4.0 Ensuring appropriate support for carers of people with dementia.

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

The Trust agreed to complete a minimum of 144 surveys across the financial year and starting using a standard questionnaire to measure how well supported carers

feel from June 1st. As of 19th March a total of 139 surveys have been completed. The Trust is on target to achieve the 144 yearend target.

The largest proportion of surveys were completed by carers of patients on Elderly Care Wards;

Surgery and T&O	10%
Elderly Care	45.20%
Medical Wards	11.80%
EAU	24.40%
Clinic	8.20%

84% of responses were completed by a spouse or family member, of these respondents 68.8% were over 60.

Some key areas for consideration are;

- 93% of respondents felt that were given some information about the ward when they arrived.
- 55.6% of patients received a copy of the take the time leaflet
- 95.6% of respondents felt that staff had been available to answer their questions
- 64.4% of respondents had the opportunity to meet a dementia advisor
- 19.3% of respondents had the opportunity to meet the carers co-ordinator
- 85.9% of respondents had been referred to a dementia gateway
- 83% of respondents felt they had been involved in discussions around discharge arrangements
- 65.2% of respondents felt they had enough support to understand the diagnosis of dementia, while a further 28.1% felt they had understood the diagnosis to some extent.
- 56.3% of respondents felt they definitely had enough contacts and resources to access support once the person they cared for left hospital. A further 36.3% felt to some extent they had enough contacts and support.

Areas for consideration

- The age of carers of people with dementia
- A wider spread of ward responses for 2014/15

Strengths

- Discharge Planning
- Information about the ward
- Referral to dementia gateways

Opportunities

- Take the time initiative further embedded
- Referrals to Dementia Advisor could be increased
- Support from carers co-ordinator could be better communicated
- Contacts and resources after leaving hospital could be more consistent

5.0 Monitoring Progress

The existing project group has been strengthened to include surgical and community input. The group is meeting on a monthly basis and has developed a revised terms of reference. The group will report to the Patient Experience Group from April 1st 2014.

The Dudley Group NHS
NHS Foundation Trust

Appendix One

CQUIN Performance Summary

The national Dementia CQUIN is split into three sections;

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

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

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

	Required performance	**Current Performance**	**On target for achievement**
Find, Assess, Investigate, Refer	>90% of emergency admissions over 75 screened for dementia, assessed appropriately and referred where necessary	>90% in all 3 areas since June 2013	
Clinical Leadership	Named Clinical Lead Training Programme Approved	Mandy Aworinde named as clinical lead for dementia. Training programme agreed with CCG in April 2013	
Supporting Carers	144 carers surveys to be completed by end of March 2014	Carers surveys started June 1st 2013.	

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meetings held on 27th March 2014**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: SO6 Enabling Objective			
SUMMARY OF KEY ISSUES: **At the end of February (month 11) the Trust recorded a small surplus of £60,000, which was £658,000 better than plan. The Trust now has a cumulative deficit of £401,000 (£368,000 behind plan).** **CIP year to date savings of £9.077m have been achieved against a plan of £12.450m. The forecast CIP shortfall has deteriorated slightly to £2.184m.**			
IMPLICATIONS OF PAPER:			
RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in Q3 and Q4 to date** **Financial deficit now forecast**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **Monitor has rated Trust at 'Green' for Governance & '3' (good) for Finance at Q3. The Trust remains on quarterly monitoring by Monitor.**
	Other	**N**	**Details:** **Some exposure to performance fines by commissioners**

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

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

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the continued deterioration in the Trust's financial performance

The Dudley Group NHS
NHS Foundation Trust

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

Finance and Performance Committee Meeting held on 27th March 2014

1. Background

The Finance & Performance Committee of the Board met on 27th March 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. **PWC Report on control of bank & agency spending**

The Committee received a report from the Director of Operations on an investigation by PWC into the high level of expenditure on bank & agency nursing staff in DGFT. He identified key remedial actions as:

- Full roll out of the Allocate rostering system (scheduled for 31 March for all wards) and operation of the Centralised Rostering model.
- DoN & DoF final sign off of new ward budget establishments and any temporary staffing decisions underpinned by minimum safe levels.
- 6 weeks forward rostering policy to be strictly enforced
- No roster 'local changes' to be able to add to the net cost of nursing to a ward.
- Rigorous investigation of all 'short notice' requests and In depth investigation of high sickness/turnover wards

The Director of Operations has agreed to implement all recommendations in 'short order' and will circulate a timed plan in the next 2 weeks.

3. Report on continued failure to deliver the ED 4 hours access target

The director of Operations reported upon the continued failure to achieve the 4 hours target. Year to date performance is 93.85% and Quarter 4 to date 90.26%. Whilst there is evidence of increased acuity of patients presenting to ED (increased blue light arrivals etc) numbers of attendances and delayed transfers of care (one of the principal causes of flow problems remain consistent with 2012-13.

The Trust has reengaged the Emergency Care Intensive Support Team, which reported again in February. The Director of Operations reported upon the latest recommendations of ECIST and the internal action plan designed to deliver these recommendations. Main areas were described as:

- Improved communication of rising ED capacity issues & better use of the 'Full Capacity Protocol'
- An additional overnight middle grade doctor to cover resuscitation calls

- Consultant decision on all medical admissions from ED and AEC
- Manager presence at ward board rounds
- Professional clinical peer review and challenge
- Evaluation of Frail Elderly Unit & Ambulatory Emergency Care unit
- Run a 'Perfect Weekend' model in April
- Improved capacity planning & forecasting

The Committee will monitor progress on the achievement of this Plan.

4. 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 January is 3.77 % (3.77% previously)
The 2013-14 target is 3.50% and YTD performance is 3.64%

b. Turnover
Turnover continues to remain consistent and within target at 8.33% (8.06%previously)

c. Pre-employment Checks
Pre-employment checks managed through the Centralised Recruitment Department perform at 100%, together with 97% for Medical Workforce recruitment.
Staff bank also performed at 80% (93% previously).

d. Mandatory Training and Appraisals
The compliance rates for Mandatory Training have shown a small improvement on previous months to 77.6% (76.4% previously).
Appraisals have remained unchanged at 79%.

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

f. Vacancies
The current live vacancy rate has increased with overseas nurses to 285 WTE (293 previously).

g. Employment Tribunal Summary
The Committee noted that the Trust had 4 live ET cases.

5. Financial Performance for Month 11 – February 2014

The Trust made a modest trading surplus of £60k in February (£0.6m better than monthly plan). This was principally due to an agreement with NHS Dudley to return fines and penalties sums.

For the 11 months period in total the trust is now recording a cumulative deficit of £401,000 and is £0.4m behind plan.

It is likely that the Trust will end the financial year close to an operating break even position (the Committee have previously been appraised that the accounting treatment of provisions to support the early termination of the PFI IT contract will generate a technical 'below the line' deficit of c£2.8m).

However the Committee have expressed continuing concern about the run rate of spending in the Trust. Whilst this may be offset by one off monies in 2013-14, major cash releasing savings will have to be made if the Trust is to continue to provide the same volume and mix of services in the future.

Recent months have seen the highest headcount in the Trust's history and a totally unsustainable level of expenditure on temporary staffing at increasingly high cost premia.

The Trust's balance sheet and liquidity position remains solid. However working capital is being eroded through continued trading deficits and this is now impacting upon resources earmarked for capital replacement and developments.

6. Appointment of Turnaround Director

Mr Davies, Interim Turnaround Director, reported to the Committee that his task is to urgently address the identification and delivery of £10.2m of cash releasing cost savings in 2014-15 from a programme of £16m. He emphasised that his approach will not compromise patient care and will feature rigorous programme management arrangements.

Mr Davies is accountable to the Chief Executive and he will report to a weekly forum to be chaired by the CEO (at which attendance is mandatory for clinical and non clinical staff) and on a monthly basis to the newly established Service Improvement Committee.

7. Integrated Business Plan (2 years Operational Plan)

The Director of Strategy & Transformation presented the Draft IBP 2014-16. This has been amended following debate at the Board Workshop in March.

It was noted that this Plan will be presented to the Board on 3rd April for approval and a 5 Years full IBP will be prepared for submission in June.

The Committee expressed concern about the fragility of financial plans. The Director of Finance presented the financial 'ask' for 2014-15 as:

- Reduce a current level of overspending against agreed budgets in 2013-14 (from headcount increases and agency staff etc) of c34m per annum
- Deliver a cash releasing set of CIP cost savings in 2014-15 through turnaround of £10.2m.

- Even this will only result in a deficit budget performance of £6.4m for 2014-15.
- If this is not acceptable to Monitor then a further £6.4m will have to be cut from spending next year.

This represents a major turnaround in spending behaviours of which he sees scant evidence.

The Committee was further concerned about the early identification of CIP opportunities for 2015-16 when Monitor suggested a further 4% abatement to tariff (£10m income cut) should be planned for.

The Committee further debated the detailed assumptions made in plans for the Better Care Fund reductions and the Urgent Care Changes.

8. Financial revenue and capital budgets 2014-15

Under delegated authority, the Committee approved revenue and capital budgets for 2014-15.

The Committee approved, with reluctance, a deficit budget of £6.4m for 2014-15. The Director of Finance reported that even to deliver this position the Trust had to eliminate increased run rate spending of c£4m per annum, currently being covered by non recurrent income and achieve an ambitious budget reduction CIP exercise of £10.2m.

The Committee also noted that a deficit budget may not be acceptable to Monitor, in which case the savings target will need to be increased.

The Committee were keen to make early progress in identifying savings opportunities to meet efficiency requirements in 2015-16, since current turnaround efforts focused on next year. The Director of Strategy and Transformation was asked to develop more strategic change proposals for discussion in June.

9. 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 February was 88.8%, the 6th month in the past 11 when the target has been missed. The Trust has performed poorly throughout to Q4 and now very likely to miss this important target both for Q4 and for the year in total.

b) Diagnostic 6 week waits

The Trust had no waiting breaches in February.

c) Never Events

The Trust had no ‘never events’ in February.

d) C Difficile Infections

We have now exceeded Monitor’s de minimus target of 12 for a full year and are considerably over trajectory for year to date (42 against an annual target of 38). The Committee heard that Monitor’s focus now appeared to be on ‘unavoidable’ post 48 hour infections.

e) RTT Admitted waits

Due to pressures on emergency beds resulting in elective cancellations, the trust is now in serious danger of breaching the 90% target for 18 weeks wait for admitted patients. February performance was 90.45.

10. Monitor Risk Assessment Framework Q3 Feedback

The Committee noted Monitors rating of the Trust at Q3as:

Governance Rating	Green
New Continuity of Service (COS) rating	3 (1 *high risk – 4 lowest risk).*

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

The Committee has requested that the Board notes in particular the significant and sustained deterioration in the financial performance of the Trust.

PA Assinder
Director of Finance & Information

APPENDIX 1

THE DUDLEY GROUP NHS FOUNDATION TRUST

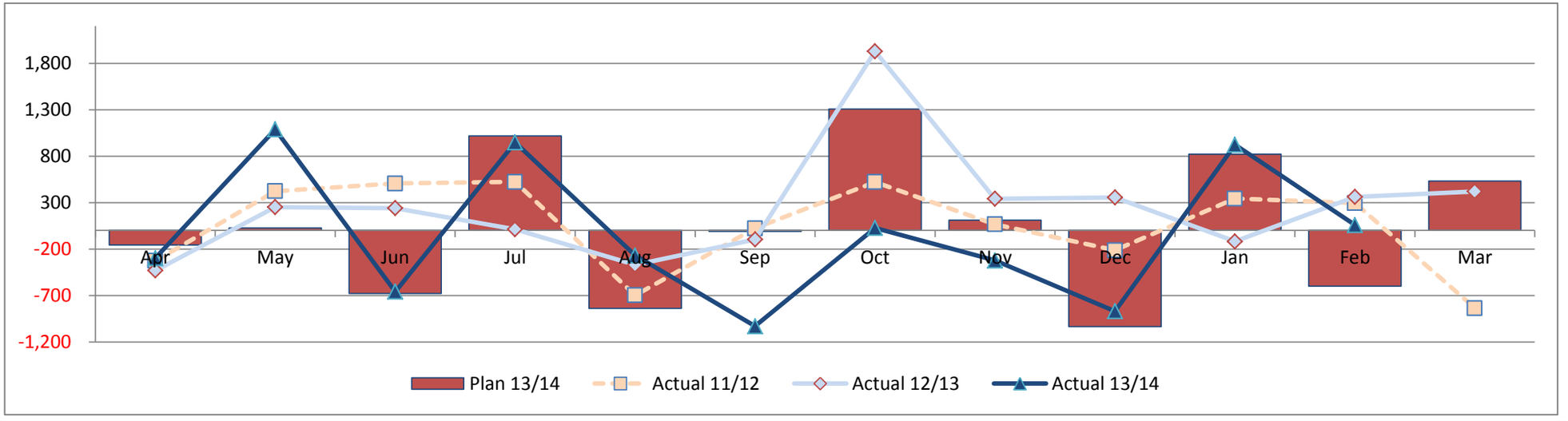
FINANCIAL SUMMARY **FEB 2014**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£24,834	£26,467	£1,633
PAY	-£15,587	-£15,866	-£279
CIP	£567	£0	-£567
NON PAY	-£8,532	-£8,682	-£149
EBITDA	**£1,282**	**£1,919**	**£638**
OTHER	-£1,880	-£1,860	£20
NET	**-£599**	**£60**	**£658**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£283,424	£287,419	£3,995
PAY	-£169,428	-£169,813	-£385
CIP	£2,864	£0	-£2,864
NON PAY	-£95,971	-£97,326	-£1,355
EBITDA	**£20,890**	**£20,281**	**-£608**
OTHER	-£20,922	-£20,682	£240
NET	**-£32**	**-£401**	**-£368**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£309,448	£312,206	£2,758
PAY	-£185,105	-£184,512	£593
CIP	£3,373	£0	-£3,373
NON PAY	-£104,369	-£105,161	-£793
EBITDA	**£23,348**	**£22,533**	**-£815**
OTHER	-£22,848	-£25,401	-£2,552
NET	**£500**	**-£2,868**	**-£3,368**

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



Key Comments

- **Surplus of £60k** in February (planned for £599k deficit so £658k better than plan). **Cumulative deficit of £401k** (£368k behind plan).
- Income performance in excess of plan for February by £1.633m (cumulatively £3.995m). Again, largely due to contract activity performance, particularly emergency spells and outpatients. Also factors in transitional support, winter pressures, repatriation of penalties/CQUIN offset by an element of risk.
- February spend reduced from high of January but both pay and non-pay are overspent in-month and cumulatively (and higher than forecast). Agency spend equated to £175k per week with unqualified nurse agency rising to new high of average £52k/week.
- Non pay pressures include dialysis, pathology consumables, other clinical supplies/tests/consumables, consultancy and legal costs.
- Year end deficit forecast now £2.868m (includes £2.809m Siemens termination/MARS/Impairment) and factors in postive contract settlement.

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

The Dudley Group NHS
NHS Foundation Trust

APPENDIX 2

Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	A&E	2% of revenue derived from the provision of the locally defined service line in the month of the under - achievement	A&E 4 hour wait	88.8%	95%	↓	●
5	Cancer		14 Day – Urgent GP Referral to Date First Seen	97.2%	93%	↓	●
5	Cancer		14 Day – Urgent GP Breast Symptom Referral	99.3%	93%	↑	●
5	Cancer		31 Day – Diagnosis to Treatment for All Cancers	100%	96%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs	100%	98%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Radiotherapy	-	-	-	-
6	Cancer		31 Day – 2nd/Subsequent Treatment – Surgery	100%	94%	→	●
6	Cancer		62 Day – Referral to Treatment after a Consultant upgrade	100%	85%	↑	●
6	Cancer		62 Day – Referral to Treatment following National Screening	100%	90%	↑	●
6	Cancer		62 Day – Urgent GP Referral to Treatment for All Cancers	87.8%	85%	↓	●
9-10	Diagnostics		Percentage of diagnostic waits less than 6 weeks	99.8%	99%	→	●
-	MSA	Retention of £250 per day the patient affected	Mixed Sex Sleeping Accommodation Breaches	0	0	→	●
7	RTT	Deduction of 0.5% for each 1% under-achievement, to a max of 5%*	Admitted % Treated within 18 Weeks	90.4%	90%	↓	●
8	RTT		Non-Admitted % Treated within 18 Weeks	99.1%	95%	↑	●
7	RTT		Incomplete % waiting less than 18 Weeks	93.8%	92%	↓	●
	RTT	£5,000 per patient	Zero tolerance RTT waits over 52 weeks	0	0	→	●
	A&E	£1,000 per breach	Trolley Waits in A&E >12 hours	0	0	→	●
-	Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payments*)	Failure to publish a Declaration of Compliance of Non-Compliance pursuant to clause 4.24. *Retention of monthly sums will continue for each month or part month until either a Declaration of Compliance or Declaration of Non-Compliance is published.*	Annual – Trust Compliant			●
-	Compliance		Publishing a Declaration of Non-Compliance pursuant to clause 4.26.				●
4	HCAI	Lesser of 1.5% of inpatient revenue or £50,000 per case above 38 threshold.	C Diff – Post 72 hours	1	3	↑	●
4	HCAI	Non-Payment of inpatient episode	Zero Tolerance for MRSA	0	0	→	●
11	Never Events - Recovery of costs of procedure and no charge to the commissioner for any corrective procedure.			0			
12-13	Monitor Summary Report (*based on Q3 2013/14)*		Governance Risk Rating				
14-15	Mortality Reports		2013/14 Qtr 1 SHMI	1.13		↓	
16	CQC Surveillance Model – Intelligent Monitoring March 2014:		Risk Rating Score & Banding	7 & 4			
	Dr Foster – Hospital Guide 2013		HSMR	100.7			

One month behind

⇩ Position Deteriorating ⇧ Position Improving ⇨ Position Unchanged

⇧ Within Target ⇧ Outside Target ⇧ Position Unconfirmed

NEVER EVENTS

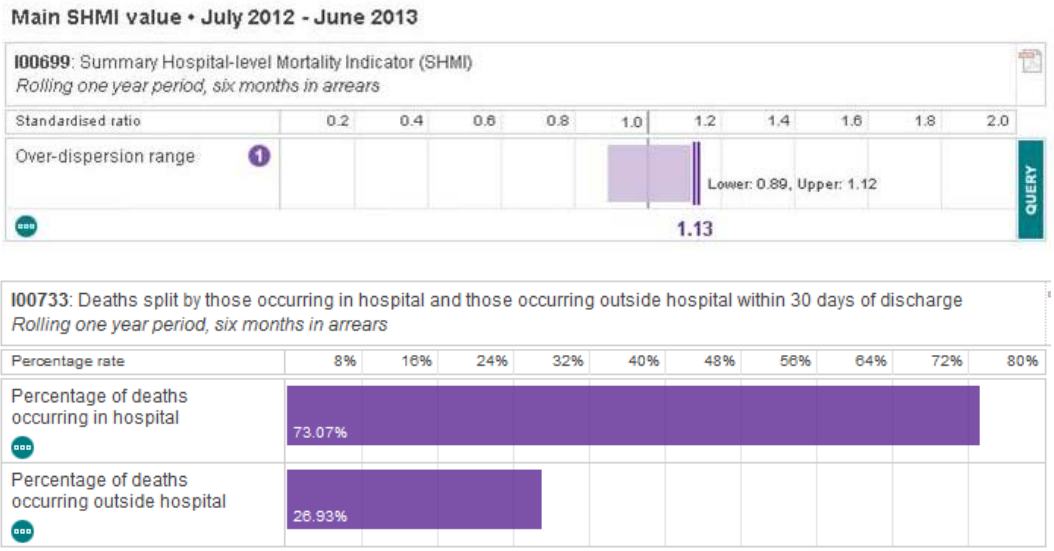
Description	Q1	Q2	Q3	Q4	YTD
Never Events : In hospital maternal death from elective caesarean section	0	0	0	0	0
Never Events : Inpatient suicide by use if no collapsible rails	0	0	0	0	0
Never Events : Intravenous administration of mis-selected concentrated potassium chloride	0	0	0	0	0
Never Events : 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



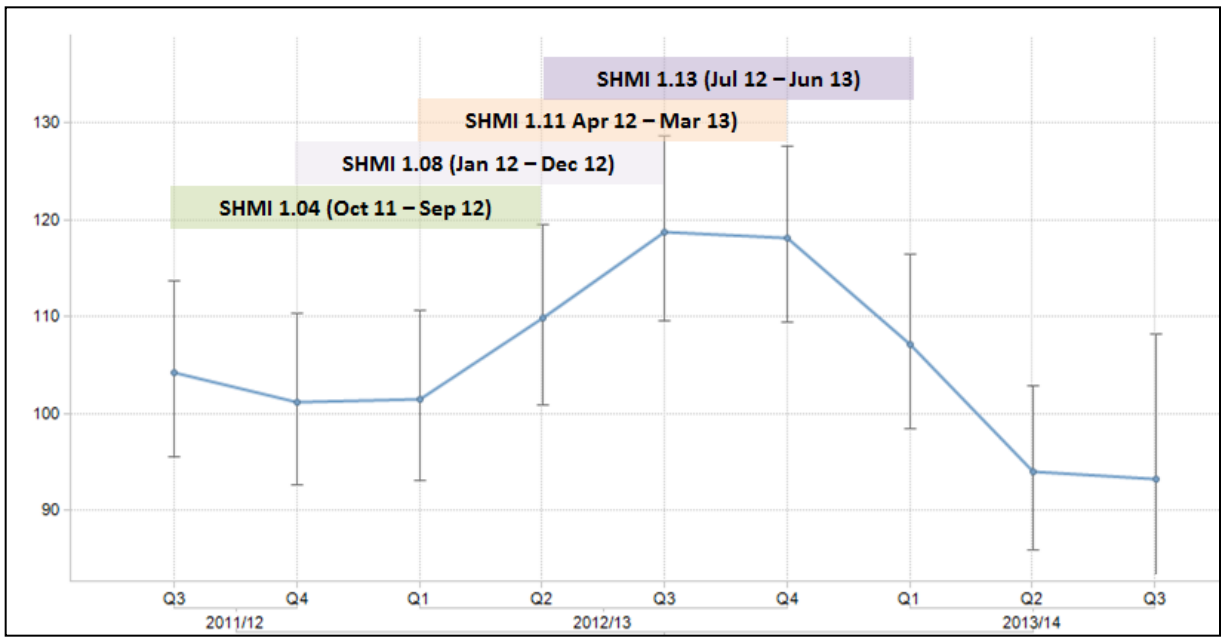
Source: NHS Choices

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

CONTRACTUAL FINES NOTIFIED as at FEB 2014

	Q1	Q2	Q3	Jan	Feb	Mar	Q4	Cumulative	
National Quality									
MRSA >0	**£0**	**£0**	**£0**				**£0**	£0	
C Diff >38	**£0**	**£0**	**£0**				**£0**	£0	
RTT wait > 52 weeks	**£5,000**	**£0**	**£0**				**£0**	£5,000	
Ambulance Handover >30 Mins	**£0**	**£0**	**£158,700**	£48,000	£38,000		**£86,000**	£244,700	
Ambulance Handover >1 hour	**£77,000**	**£44,000**	**£106,000**	£39,750	£46,500		**£86,250**	£313,250	
Trolley Waits in A&E >12 hours	**£0**	**£0**	**£0**				**£0**	£0	
Urgent operation cancelled >1	**£0**	**£0**	**£0**				**£0**	£0	
Failure to publish Formulary	**£0**	**£0**	**£0**				**£0**	£0	
Duty of Candour	**£0**	**£0**	**£0**				**£0**	£0	
Operational Standards									
RTT Admitted > 18 weeks (90%)	**£10,439**	**£12,354**	**£15,061**				**£0**	£37,854	
RTT Non Admitted > 18 weeks (95%)	**£5**	**£81**	**£0**				**£0**	£87	
RTT Incomplete > 18 weeks (92%)	**£867**	**£1,107**	**£623**				**£0**	£2,597	
Diagnostic Waits > 6 weeks (99%)	**£0**	**£5,843**	**£0**				**£0**	£5,843	
A&E Waits > 4 hours (95%)	**£50,563**	**£0**	**£49,613**				**£0**	£100,176	
Cancer outpatient >2 weeks (93%)	**£0**	**£0**	**£0**				**£0**	£0	
Breast Symptoms >2 weeks (93%)	**£0**	**£0**	**£0**				**£0**	£0	
Cancer first treat >31 days (96%)	**£0**	**£0**	**£0**				**£0**	£0	
Cancer subseq surgery >31 days (94%)	**£0**	**£0**	**£0**				**£0**	£0	
Cancer subseq drugs >31 days (98%)	**£0**	**£0**	**£0**				**£0**	£0	
Cancer subseq radio >31 days (94%)	**£0**	**£0**	**£0**				**£0**	£0	
Cancer GP to treat >62 days (85%)	**£0**	**£0**	**£0**				**£0**	£0	
Cancer screen to treat >62 days (90%)	**£0**	**£0**	**£0**				**£0**	£0	
Cancer Cons. to treat >62 days (85%)	**£0**	**£0**	**£0**				**£0**	£0	
Mixed Sex Accommodation >0	**£0**	**£0**	**£0**				**£0**	£0	
Cancelled Ops re-book >28 days	**£0**	**£0**	**£0**				**£0**	£0	
TOTAL FINES	**£143,875**	**£63,385**	**£329,996**	**£87,750**	**£84,500**	**£0**	**£172,250**	**£709,505**	

Key Comments

- The table includes invoices to December (with the exception of Ambulance Turnaround to February).
- Ambulance Turnaround fines to Feb total £558k. Estimated liability for the year equals **£635k**.
- A&E waits > 4 hours - Q1/Q3 failures equate to a fine of £100k. Expected that this will be **£150k** based on Q4 failure.
- RTT wait fines of £51k to date. Estimated total liability of **£69k** by year end.
- There remains a debate regarding the legitimacy of a fine regarding C-Diff. However, the CCG have indicated an estimated level of year end fines of **£1.154m**, incorporating a C-Diff figure of **£300k**.
- The Trust has written to the CCG, presenting a case for the repatriation of penalties on the basis of improved ED performance from April onwards. Whilst the CCG have agreed that the penalties should be returned, they remain concerned with the lack of clarity on anticipated performance improvement within our proposals so are intending to put forward alternatives.

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