The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 2nd October 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 – P Clark**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 4th September 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 4th September 2014	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Assinder	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	E Rees	To Note & Discuss	10.00
	7.2 Workforce and Staff Engagement Committee Exception Report	Enclosure 5	A Becke	To Note & Discuss	10.10
	7.3 Nurse Staffing Report	Enclosure 6	D Mcmahon	To Note & Discuss	10.20
	7.4 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 7	D Bland	To Note & Discuss	10.30
	7.5 Board Assurance Framework	Enclosure 8	J Cotterill	To Note	10.30
	7.6 Corporate Risk Register	Enclosure 9	J Cotterill	To Note	10.40
	7.7 Revalidation Report	Enclosure 10	P Harrison	To Note	10.50
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 11	D Badger	To Note & Discuss	11.00
9.	**Date of Next Board of Directors Meeting** 9.30am 2nd October, 2014, Clinical Education Centre		J Edwards		11.10

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		11.10

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 4th September, 2014 at 9:30am in the Clinical Education Centre.

Present:

John Edwards, Chairman
Ann Becke, Non Executive Director
David Badger, Non Executive Director
Paula Clark, Chief Executive
David Bland, Non Executive Director
Jonathan Fellows, Non Executive Director
Paul Assinder, Director of Finance and Information
Richard Miner, Non Executive Director
Paul Harrison, Medical Director
Jon Scott, Interim Director of Operations
Denise McMahon, Nursing Director

In Attendance:

Helen Forrester, PA
Elena Peris-Cross, Administrative Assistant
Liz Abbiss, Head of Communications and Patient Experience
Richard Cattell, Director of Support Operations
Julie Cotterill, Associate Director of Governance/Board Secretary

14/067 Note of Apologies and Welcome

14/068 Declarations of Interest

There were no declarations of interest.

14/069 Announcements

There were no announcements to be made.

14/070 Minutes of the previous Board meeting on 3rd July 2014 (Enclosure 1)

The minutes were approved by the Board as a true and correct record of the meetings discussion and signed by the Chairman.

14/070.1 Action Sheet, 3rd July 2014 (Enclosure 2)

All of the actions are either complete or are on this meeting and future meetings agendas to be discussed.

14/071 Patient Story

The Nursing Director explained that the patient in the video is regularly admitted into the hospital and has had a lot of experience with the care given by the Trust.

Board members noted that the Patient mentioned how well the clinicians providing his care had communicated with him.

The Nursing Director mentioned that this patient story was chosen as it reflects that this patient had positive comments about their call button which remains in the Trust's Quality Accounts and that the Patient was staying on C1; a Ward in which we have recently implemented staffing changes.

The Chairman noted that it was important we implement care at home packages as quickly as we possibly can to facilitate timely discharge.

The Chief Executive assured that she would pick this issue up at the collaborative leadership team meeting between the Trust and the CCG.

The Chairman thanked the Nursing Director for the Patient Story, noting that it was an interesting story and it was pleasing to see the patient was happy with the care, enjoyed the hospital food and appreciated the good communication from staff.

The Chief Executive is to pick up issues around care at home packages at the collaborative leadership team meeting between the Trust and the CCG.

14/072 Chief Executive's Overview Report (Enclosure 3)

Friends and Family: The Chief Executive informed the Board that we need to keep pushing on Friends and Family and maintain high response rates. The ED results have improved and the Trust is now reporting good Maternity scores. The Board noted that soon all departments of hospitals will be required to report on friends and family. The Director of Support Operations added that all services of the NHS such as the Ambulance Service and Primary care will also be required to report on friends and Family.

Monitor Roundtable Meeting: The Chief Executive explained that this meeting was to ensure that the CCG and the LAT were fully appraised on the financial position. We are working with the CCG around transitional funding and have agreed a high level of transparency between the organisations around finances.

The Director of Support Operations mentioned that it felt as though the GPs did not understand the financial challenges the Trust are facing.

The Director of Financial explained that this may be due to structural issues of how information is passed down to the GPs; we should remember that GPs compete with us for resources.

Richard Miner, Non Executive Director asked if the relationship between the GPs and the Trust has an effect on the balance of our elective work.

The Chief Executive explained that it could have an impact on the Trust when the local GPs form their new company and can tender bid for services. This is a pattern which is being seen across the Country.

Ann Becke, Non Executive Director explained that this was a bigger threat than she had realised to the Trust's viability.

The Medical Director explained that there is a significant scope of services the GP Company could take away from the Trust.

The Chief Executive agreed that this was a strategic danger for the organisation. We must therefore look at how we can rationalise services across the Black Country.

The Chairman informed the Board that a Board to Board is being arranged for October.

The Medical Director raised a declaration of interest that his wife was a GP in the area

David Bland asked if this was a general issue across the country.

The Chief Executive clarified that is was a national situation.

DNARs: The Chief Executive informed the Board of a Court of Appeal decision following the Tracey case on DNAR. We are currently working on rolling out required actions across the Trust.

The Medical Director told the Board that the next DNAR training session was taking place today; he added that our staff must be extremely careful and accurate around how they document conversations that have taken place around DNAR and end of life.

14/073 Patient Safety and Quality

14/073.1 Infection Prevention and Control Exception Report (Enclosure 4)

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

MRSA: There were 0 cases of MRSA to report.

C.Diff: the Trust remains within the target.

Norovirus: There are 0 cases to report.

Ebola: Board members noted that there had been a significant number of cases in Africa and the Trust has spent a lot of time working on the action plan for Ebola and have everything in place to ensure we are ready should a potential case present, including face fit training.

Whooping Cough Outbreak: There is a rise of cases in the area particularly in babies and University students; there are 3 reported child deaths.

Richard Miner, Non Executive Director asked if the Trust were within trajectory on C.Diff.

The Nursing Director confirmed that the Trust was well within the trajectory, the Trust has a target of 48 cases and we are currently up to 16.

The Chairman asked the Nursing director to clarify that all these cases were post 48hr and the Trust was not differentiating between avoidable and non-avoidable cases.

The Nursing Director confirmed that this was the case. She added that she would bring a report on avoidable and unavoidable cases to the following Board meeting.

The Nursing Director is to bring a report on avoidable and unavoidable cases to the following Board meeting.

14/073.2 Workforce and Staff Engagement Committee Exception Report (Enclosure 5).

Ann Becke presented the report given at enclosure 5 including the following issues:

- 6 Whistle blowing allegations made during 2013/2014
- Employment Tribunals: There were 11 employment tribunals, 2 of which were successfully defended, 1 of which was a negotiated settlement and the remaining 4 are ongoing. The cost of defending these tribunals is £128k
- Workforce KPIs
- LETC Group Minutes
- Taking the Committee forward

Richard Miner, Non Executive Director asked if cultural issues were a big part of strategic decisions.

Ann Becke responded that the Trust must tackle cultural issues as a priority in the recent structure change.

The Chief Executive agreed mentioning that we need to use Agenda for Change and other policies to our advantage in this process.

The Board noted the report.

14/073.3 Nurse staffing report (Enclosure 6)

The Nursing Director presented the report given as enclosure 6 which gave an update for June and July.

The Nursing Director explained that anything reported as ‘’unsafe’’ would be shown as Red in the table, fortunately the Trust has not reported any unsafe shifts and we have been regarded as having a national model. The way we do this is using Allocate and the manual piece of work is managed by Derek Eaves. The Board noted that all risks were managed effectively.

Board members also noted that the use of band 2 agency is now down to zero. There has also been a reduction in shifts outside of plan.

The Nursing Director explained that both reports will now go onto the public website. The paper to the Board on the Allocate project will be presented in the Private Agenda. All of the information in the report is auditable and Baker Tilly will risk asses the work for the Board.

The Director of Finance asked if the Trust reports actual occupancy levels as this positively impacts on nurse to bed ratios if beds are empty.

The Nursing Director explained that the figures are corrected for Unify but not for occupancy therefore the report shows the worst case scenario.

David Bland, Non Executive Director asked if there was an agreed level of staffing on each ward that the Trust should not fall below.

The Nursing Director explained that this was down to professional judgement by good risk assessment depending on occupancy and case mix.

The Chairman asked if an appendix could be added to the next report to Board showing the outline process of risk assessment.

The Nursing Director assured that this would be included in the next Matron's presentation as it falls within their role.

The Chairman agreed and asked for a headline report to also be included in the Nurse Staffing Report.

Nursing Director to ensure the outline process of staff level risk assessing is included in the Matrons presentation to Board and a headline report included in the Nurse staffing report.

14/073.4 Complaints Report (Enclosure 7):

The Director of Governance presented the report given as enclosure 7 explaining that this showed quarter 1 from the period from April to June 2014.

Board members noted that the format of the report has changed slightly as governance arrangements at divisional levels are still being agreed.

The Director of Governance informed the Board that there had been a 16% reduction of complaints during this period, all complaints were acknowledged within 3 days and 80% of complaints were answered within the 25-30 working days target. 50%of complaints were upheld and 5% of complaint investigations received a dissatisfied response.

The Director of Governance pointed out that the majority of complaints are for the clinical care. She explained that the difficulty in this report is that in some areas the numbers of complainants are so low the information may be patient identifiable. The Director of Governance explained that it was crucial that learning is captured in all areas and we can demonstrate clearly how we do this.

Board members noted the summary of the Coroner and Ombudsman issues.

Jonathan Fellows, Non Executive Director pointed out that it was worth noting the numbers of patient compliments we have received on huddle boards as there has been a massive increase.

David Badger pointed that it would be helpful to see personal liability and clinical negligence claims reported year by year.

Director of Governance to ensure that personal liability and clinical negligence claims reported year by year is included in the next complaints report.

14/073.5 Audit Committee Exception Report (Enclosure 8)

Jonathan Fellows, Non Executive Director presented the exception report given as Enclosure 8.

Board members noted the following highlights from the meeting held on the 22nd July 2014:

- Internal Audit – The Trust is on track with this and there are no areas of red to report.
- Local Counter Fraud Specialist – 1 action has been taken by the Trust.
- Mandatory Training – improvement is needed in this area as figures have dropped below the required 80%
- Deloittes review of the Trust's accounts – over one quarter of all foundation Trusts are reporting deficits for the year and almost half are declaring 1 of their targets are in breach or at risk of being in breach. There is also an increasing CIP that is non recurrent across Foundation Trusts.
- Charitable Funds – The Committee received the Charitable Funds Committee Report and approved it under delegated authority.

The Chairman asked if similar information was available about non Foundation Trusts as the information given in the table.

The Director of Finance explained that you do not tend to see this information unless there is a national picture as they are in a different community however the last information given was that 50% of all providers are forecasting a deficit position at the end of quarter 1.

Paul Assinder explained the importance of the Trust's CIP and pointed out that this was our Achilles heel.

The Chairman noted that this would be picked up under the Finance and Performance Committee.

14/073.5.1 Audit Committee Annual Report

Jonathan Fellows, Non Executive Director informed the Committee that the Annual Report response is set out in the Audit Committee exception report.

Board members noted the following points:

- Good attendance had been reported for the committee and there were no matters of concern.

- Internal auditors had reported 4 internal audits were rated red, all were followed up and reasonable progress has been made against them.

- A positive opinion given by the Head of Internal Audit on page 6 of the report.

- Internal Audit work plan- the Board noted that red rated reports are anticipated against the key strategic areas.

- Good progress has been made against Clinical Audit and Counter fraud.

- Deloittes have given a clean audit opinion for the Trust's Accounts.

- A review of the Board Committee effectiveness showed that recommendations had been made and all were being addressed.

- A tender process is in place for the Trusts internal/external auditors' service for the next five years.

- The Audit committee opinion for the year is positive.

The Chairman asked if we are confident that Baker Tilly has the resources for the internal audit plan.

Jonathan Fellows confirmed that they are on track with this and will report back to the Committee in October.

The Board noted the contents of the report and the positive opinion given by the Audit Committee.

14/073.6 Clinical Quality, Safety and Patient Experience Committee (Enclosure 09)

David Bland, Non Executive Director presented reports from June and July.

Points from the June report included:

- Quality Dashboard for Month 1 – TAL booking target had dropped below 40%, this matter has been referred to the Finance and Performance Committee.

The Chief Executive explained that this was a demand and capacity issue and an action plan is in place to address the issues.

David Badger, Non Executive Director pointed out that it was crucial the fragile position gets back on trajectory.

Points from the July report included:

- Patient Experience Group: The work that this Group are doing is beginning to have an impact on patient catering and is making good use of charitable funds to enhance patient experience in the Trust.
- National Care of the Dying Audit: This audit was done a year prior to the report. There are a number of changes and this now does not reflect the work of the team. The team is small given the number of requirements placed on it and the amount of referrals has tripled.

The Chief Executive explained that we are looking at strengthening the team and are interviewing for a consultant post. We have also met with Macmillan to try and secure some funding support.

The Chairman and the Board noted the report.

14/073.7 Quality Accounts (Enclosure 10)

The Nursing Director informed the Board that this report shows the Quality Accounts from Quarter 1.

The Trust is on track to deliver the identified targets within the report however Board members noted the disappointment that there had been two grade 4 pressure ulcers on the same ward. An action plan is in place to address this.

The Nursing Director informed the Board that infection control and nutrition and hydration are on track, and the process for mortality is much better, we performed well in the last quarter.

The Chairman asked if any common factors had been found following an RCA on the pressure ulcers. The Nursing Director explained that there had and these will be dealt this.

The Board noted the report and the positive progress, although it is disappointing to note the pressure ulcers.

The Chairman asked if we no longer have nutrition support workers on wards.

The Nursing Director clarified that we only ever had these staff on the ward A2. We took these out when we enhanced the staffing levels on that ward and have also found that Interserve should deliver some of this service contractually. All of the people that have been taken out of that role now manage dementia patients under the role of Wellbeing Workers.

14/074 Finance
14/074.1Finance and Performance Report (Enclosure 11)

David Badger, Non Executive Director explained that there had been 2 meetings since the last Board meeting. The following financial headlines in the report are as follows:

- £711k surplus in July due to elective activity.
- Deficit of £3.2m for the year to date
- Deficit forecast of £10m expected for the year 2014-15

David Badger explained that the Trusts financial position remains the biggest challenge. The financial rating with Monitor is currently good but however the liquidity is reducing at an alarming rate. There is huge importance around meeting the turnaround plan.

The Following Performance headlines are as follows:

- An encouraging report is seen against all the major targets.

- A&E 4 hour wait: Very good performance against the target for quarter 2 to date, being amongst the best in the country.
- RTT waiting times: There are a lot of pressures however the targets are being met, the Committee received assurance from the Deputy Divisional manager that this is being managed well.
- Mortality Indices: The Indices continue to improve and are better than expected for the Trust.

The Chairman noted a good performance report and encouraging signs against finance however actions against the turnaround plan are still not happening fast enough

David Bland, Non Executive Director asked when we should start to be concerned around the liquidity levels.

The Director of Finance explained that the Trust will run out of cash in the second half of next year at the current run rate.

Ann Becke, Non Executive Director asked if there was any assurance that could be given around Dementia assessment and GP discharge letters.

David Bland gave assurance around Dementia assessment and explained that everything possible that can be done around the GP letters issue is happening.

Board members noted that the Committee discussed the issue of signing contract agreements for CQUINS without being clear on the targets for achievement.

The Nursing Director pointed out that at the Nurse Director's meeting Simon Stevens notified that CQUINS will be taken out of contracts as basic quality performance should be defined in the contract.

The Interim Director of Operations noted that figures for activity trends on emergencies were starker when looked at over a long period. He explained that he would be drafting a letter to the CCG to notify them that their failure to manage demand was impacting adversely on our performance in quarter 1.

David Badger, Non Executive Director pointed out that it was important to support this initiative going forward.

The Chairman noted the report and in particular the financial challenged highlighted and the comments raised around CQUINS.

14/75 Any Other Business

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

13/076 Date of Next Meeting

The next Board meeting will be held on Thursday, 2nd October, 2014, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 4 September 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/063.3	Moving Patients Out of Hours	Update report including audit results and agreed metrics to be presented to the Board in the Autumn.	JS	2/10/14	To the November Board
14/071	Patient Story	The Chief Executive is to pick up issues around care at home packages at the Collaborative Leadership Team meeting between the Trust and the CCG.	PC	2/10/14	In Private Chief Executive's Report
14/073.1	Infection Prevention and Control Exception Report	The Nursing Director to bring a report on avoidable and unavoidable cases to the following Board meeting.	DM	2/10/14	On Agenda
14/073.3	Nurse Staffing Report	Nursing Director to ensure the outline process of staff level risk assessing is included in the Matrons presentation to Board and a headline report included in the Nurse staffing report.	DM	2/10/14	On Agenda
14/063.4	Safeguarding Quarterly Report	Board to revisit DNAR and the work being undertaken with the CCG later in the year.	PH/DM	6/11/14	
14/073.4	Complaints Report	Director of Governance to ensure that personal liability and clinical negligence claims reported year by year is included in the next complaints report.	JC	4/12/14	

Enclosure 3

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 2nd October 2014

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Test Performance
- Senior Information Risk Owner (SIRO)
- Appointment of Interim Director of Finance
- Update on Datix Refresh
- Assignment of Director for Dudley Clinical Services Board

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 – October 2014

Friends and Family Test Performance:
The roll out of FFT across the Trust means during October community, outpatients and day case surgery patients will all begin to be given the opportunity to give us feedback via FFT about their experiences. The Trust have a CQUIN for early implementation during Oct ahead of the national roll out in April 2015.We are on track to achieve this.
The latest Friend and Family Test (FFT) guidance makes some significant changes to the FFT system. In summary the key changes from April 2015 are:

- Mandatory follow up free text question, therefore no token systems
- Scoring method is changing. In future a proportion of positive responses and the proportion of negative responses will be published and 'likely' to recommend will also be counted as positive instead of being discounted.
- Strong recommendation to collect demographic data
- Children and young people will be included in the roll out
- No response rate targets

FFT Inpatient and A&E provisional Sept 14 results 01.09.14 – 21.09.14

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14
Date range	01.04.14 – 30.04.14	01.05.14 – 31.05.14	01.06.14 – 30.06.14	01.04.14 – 30.06.14	01.07.14 – 31.07.14	01.08.14 – 31.08.14	01.09.14 – 21.09.14
Number of eligible inpatients	1886	2023	1951	5860	2073	2004	1299
Number of respondents	644	519	483	1646	577	548	304
Ward FFT score	82	86	85	84	81	82	78.2
Ward footfall	34%	26%	25%	28%	28%	27%	23%
Number of eligible A&E patients	4258	*4605*	4679	13542	4843	4551	3232
Number of respondents	686	*614*	1159	2459	1712	847	373
A&E FFT Score	64	53	57	57	70	71	63.1
A&E footfall	16%	13%	25%	18%	35%	19%	12%
TRUST FFT Score (A&E/Inpatient)	73	68	66	68	73	75	69.9
TRUST footfall	22%	17%	25%	21%	33%	21%	15%

Inpatient FFT Score	82+	A&E FFT Score	68+	FFT Scores key	Top 20% of Trusts (based on March 14 scores)
	79-81		65-67		Top 30% of Trusts (based on March 14 scores)
	<79		<65		Below top 30% of Trusts (based on March 14 scores)
Response rate:					
Response rate A&E	<15%	15-20%	20%+		
Response rate Inpatients	<25%	25-30%	30-40% +	40%+ *	

FFT Maternity provisional Sept 14 results 01.09.14 - 21.09.14

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept -14 01.09.14-21.09.14
Maternity - Antenatal	Score	64	80	78	79	66	75
	Response rate	14%	18%	13%	21%	19%	16%
Maternity - Birth	Score	62	85	83	90	94	98.5
	Response rate	44%	33%	34%	30%	23%	27%
Maternity - Postnatal ward	Score	57	85	79	87	94	98.4
	Response rate	43%	31%	32%	29%	23%	27%
Maternity - Postnatal community	Score	86	90	85	85	85	74.1
	Response rate	16%	9%	15%	13%	12%	13%
Combined	Score	63	85	81	86	88	91.3
	Response rate	32%	24%	25%	24%	20%	21%

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

Antenatal	80+	76-79	<76	FFT	Top 20% of Trusts (based on March 14 scores)
Birth	89+	86-88	<86	Scores	Top 30% of Trusts (based on March 14 scores)
Postnatal ward	81+	75-81	<75	key	Below top 30% of Trusts (based on March 14 scor
Postnatal community	90+	84-89	<84		

Staff FFT

The Staff FFT has been gathered from 241 out of 245 NHS trusts providing acute, community, ambulance and mental health services in England.

A total of 163,686 responses have been gathered from staff in the first quarter of the year (April – June 2014) – which compares favourably with the 200,000 staff who took part in the last annual staff survey.

- Nationally, 76% of staff said they would recommend their organisation to friends and family in need of care or treatment, whilst 8% said they would not recommend the care delivered by their organisation.
- Nationally, 62% of staff said they would recommend their organisation to friends and family as a place to work, whilst 19% said they would not recommend their organisation as a place to work.

It is really pleasing to see The Dudley Group NHS Foundation Trust results are above the national average for both recommendation as a place to work and to receive care. With nearly a 10% difference for both care with 84% of staff recommending (putting us amongst the best in the area) and work 74% (putting us third in the area). It is based on 402 responses.

Senior Information Risk Owner (SIRO):
Julie Cotterill, Associate Director of Governance and Board Secretary is assuming the role, supported by Kevin Shine, Head of Information.

Appointment of Interim Director of Finance:
I am delighted to announce that our Interim Director of Finance and Information is Paul Taylor and he will be with us until the appointment of the permanent replacement into the role. Paul has worked in and around the West Midlands during his career and was previously the Director of Finance at West Midlands SHA. He is currently working with NHSE.

Update on Datix Refresh:
Verbal update at the Board.

Assignment of Director for Dudley Clinical Services Ltd Board:
Following the departure of Richard Cattell there is a vacancy on the Board of Dudley Clinical Services Ltd. It is proposed that this is filled by Anne Baines, Director of Strategy and Performance.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors October 2014 - PUBLIC

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

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

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

IMPLICATIONS OF PAPER:

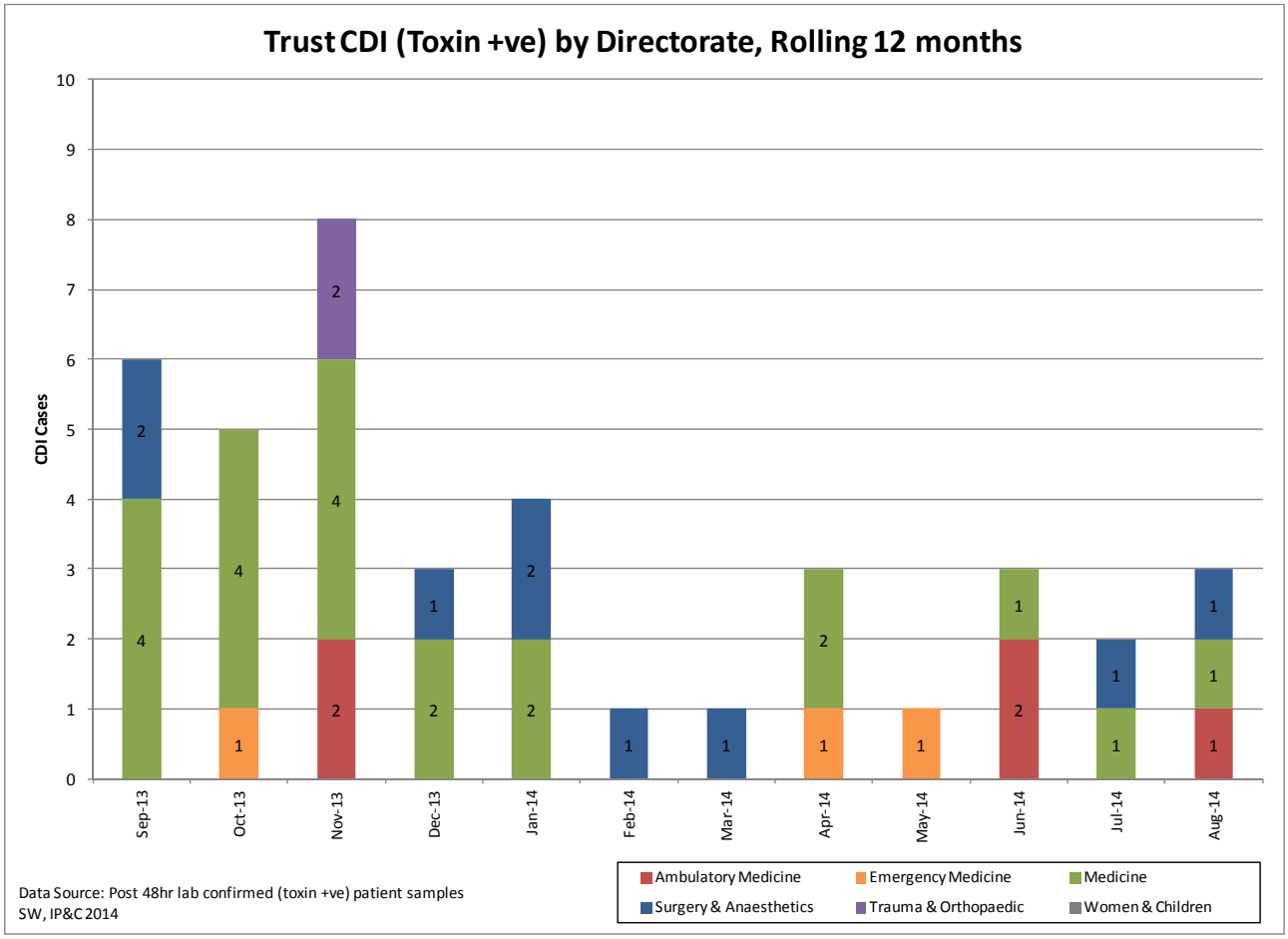
RISK	**Y**		**Risk Description:** Infection Prevention and Control	
	Risk Register: Y		**Risk Score:** IC010 – Score: 16	
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**	Outcome 8 – Cleanliness and Infection Control
	NHSLA	**N**	**Details:**	
	Monitor	**Y**	**Details:**	Compliance Framework
	Equality Assured	**/N**	**Details:**	
	Other	**N**	**Details:**	

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:
To receive report and note the content.

Clostridium Difficile – The target for 2014/15 is 48 cases, equivalent to 20.5 CDI cases per 100,000 bed days. At the time of writing (23/9/2014) we have 0 post 48 hour cases recorded in September 2014 against a trajectory for the month of 3 cases.



The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], is about to be commenced. The Trust has agreed with the CCG to use the University of Hospitals Birmingham assessment tool (modified to reflect local needs) for this purpose. The first meeting will take place on 26th September 2014. This process will be subject to audit by the CCG and an annual report describing the outcome of this process for 2014/15 will be provided by June 2015.

MRSA bacteraemia (Post 48 hrs) – There have been no post 48 hour MRSA bacteraemia cases so far this year.

Norovirus – There are no wards currently affected.

Ebola – We have trained a number of staff who will now be available to face fit test other front line staff to ensure that they can use face masks required for safe handling of suspected cases.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation, Public Health England.

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 4th September 2014

TITLE:	**Workforce and Staff Engagement Committee**		
AUTHOR:	**Dean Summlar Senior HR Business Partner**	**PRESENTER**	**Ann Becke Non Executive Director**

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

The Workforce and Staff Engagement Committee met on 11th September 2014. A shortened meeting took place due to the pending HR service review. The People Strategy session was postponed until the next meeting.

Simulation Centre
The committee received a report on the usage of the simulation centre. The report highlighted that the simulation centre is being fully utilised with all staff groups having had access to use the facilities.

Workforce KPIs

- Absence continues to achieve better than target performance with 3.44% absence in July.
- Turnover is in line with the target with no related concerns
- Mandatory Training rates drop by 0.6% to 77.2%. Urgent Care Directorate will present a recovery plan for mandatory training at the next meeting
- Appraisal performs at 71.9% against a target of 85%. The Committee received a verbal plan to increase compliance for the Nursing Division
- Pre-employment checks are compliant with the relevant policy
- 100% of professional registration checks have been completed
- There are 270.6 WTE of vacancies
- There are 85 employee relations cases with 4 active employment tribunals

National Staff Survey
The committee received a report updating on the actions established since the 2013 National Staff Survey. The lowest four performing key findings were targeted with specific actions to address these. In addition communication is being produced in line with the launch of the 2014 National Staff Survey to educate staff on questions of an ambiguous nature. The National 2014 Staff Survey goes live week commencing 22nd September.

Policies for Ratification
The Committee approved the following policies/guidelines:

- Medical Equipment and Instruction to End Users Policy
- Lone Working in Midwifery Community Guideline
- Staff Support Policy (Preceptorship and Reflective Clinical Supervision)

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

To receive the report

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

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd October 2014

TITLE:	**Monthly Nurse/Midwife Staffing Position – August 2014**		
AUTHOR:	Denise McMahon Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:

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

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

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

SUMMARY OF KEY ISSUES:

Attached is the monthly information on nurse/midwife staffing.

As previously stated, there is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. As this is a recent requirement, the format will evolve as time progresses but no changes have been made to the format since last month.

The paper indicates for the month of August 2014 when day and night shifts on all wards were (green) and were not staffed to the planned levels for both registered (amber) and unregistered staff (blue), with the day shift registered figures also taking into consideration the 1:8 nurse to patient ratio for general wards. Unsafe staffing will also be charted (red). The planned levels for each ward vary dependent on the types of patients and their medical specialities and national ratios apply to specialist areas such as intensive care, midwifery and paediatric areas.

When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined and an assessment of any impact on key quality indicators has been undertaken. The attached graph indicates the continued monthly fall in the number of overall shifts when the actual was below the planned for both registered (RN) and unregistered (UN) staff.

IMPLICATIONS OF PAPER:

RISK	**Y** **Risk Register: Y**		**Risk Score and Description:** Nurse staffing levels are sub-optimal (20) Loss of experienced midwives (15)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** 13: Staffing
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance with the Risk Assessment Framework
	Equality Assured	**Y**	**Details:** Better Health Outcomes for all Improved patients access and experience
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To discuss and review the staffing situation and actions being taken and agree to the publication of the paper.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

August 2014

One of the requirements set out in the National Quality Board Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information.

The attached chart follows the same format as the updated one last month. It indicates for the month of August 2014 when day and night shifts on all wards were and were not staffed to the planned levels for both registered and unregistered staff, with the day shift registered figures also taking into consideration the 1:8 nurse to patient ratio for general wards.

In line with the recently published NICE (2014) guideline on safe staffing:
1) An establishment (an allocated number of registered and care support workers) is calculated for each ward based on a combination of the results of the six monthly Safer Nursing Care Tool exercise and senior nurse professional judgement both based on the number and types of patients on that ward (with the Board receiving a six monthly paper on this). The establishment forms a planned number of registered and care support workers each shift.
2) Each six weeks the Lead Nurse draws up a duty rota aimed at achieving those planned numbers.
3) Each shift the nurse in charge assesses if the staff available meet the patients' nursing needs.
Following the shift, the nurse in charge completes a monthly form indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed for the patients on that day. Each month the completed form for every ward is sent to the Nursing Directorate where they are analysed and the attached chart compiled.

It can be seen from the chart (green) that the staffing available met the patients' nursing needs in the majority of cases. In a number of instances, despite attempts through the use of deployment of staff or the use of bank/agency staff, the number of planned staff for the patients on that shift were not reached.

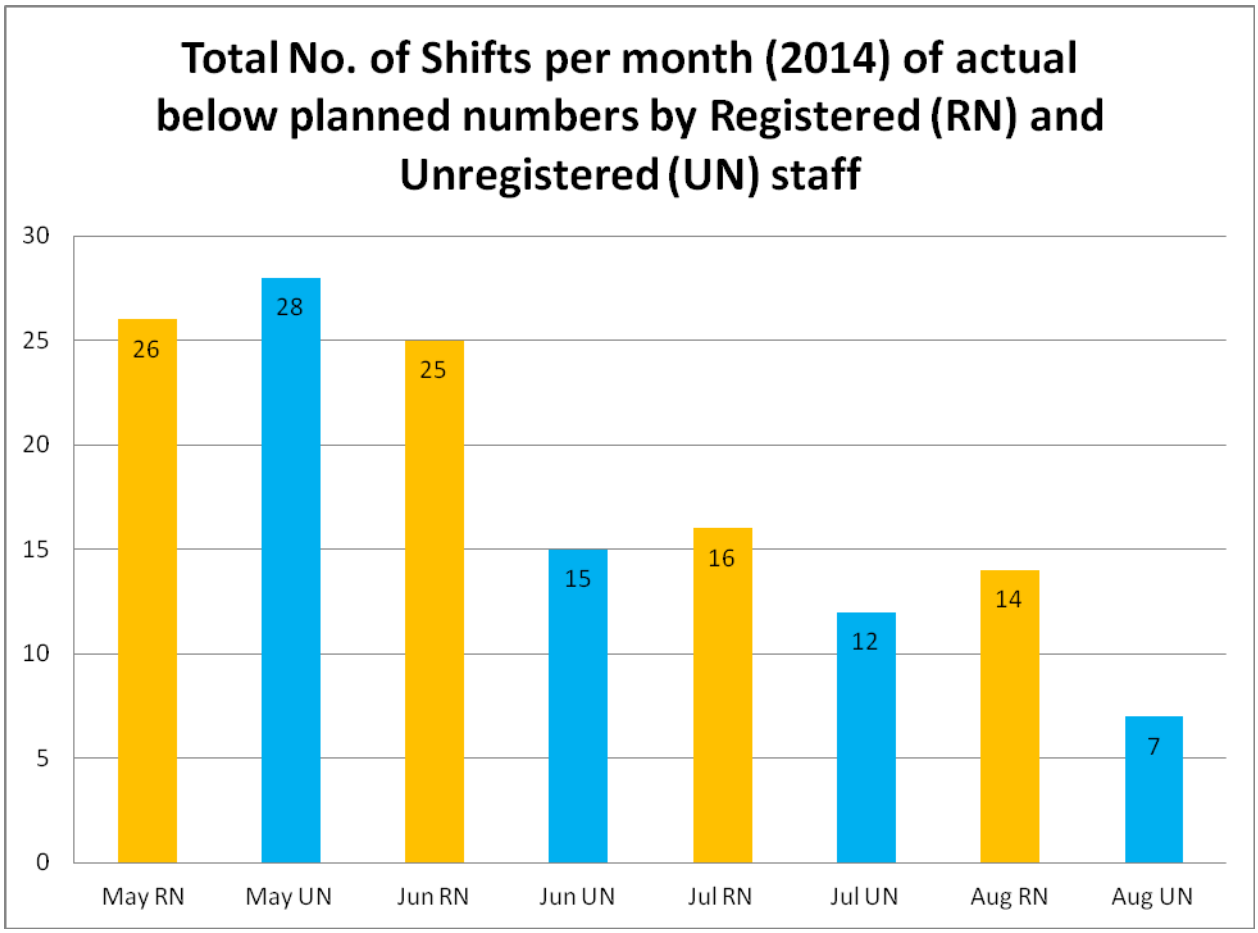
When there is an unregistered staff shortfall the shift is marked in blue and when there is a registered staff shortfall this is marked in amber. If the shift is reported as unsafe, this will be marked as red. In all instances of shortfalls, the planned and actual numbers are indicated.

When shortfalls have occurred the reasons for the gaps and the actions being taken to address these in the future are outlined below.

An attached graph indicates the monthly total number of shifts when the actual was below the planned for both registered (RN) and unregistered (UN) staff. A downward trend can be seen for both groups of staff.

An assessment of any impact on key quality indicators has been undertaken. From as far as possible as it is to ascertain, these shortfalls have not affected the results of any of the nursing care indicator measures or other quality measures such as the number of infections. In addition, there is no evidence that they have affected patient feedback in terms of the answers to the real time surveys or in the number of concerns or complaints received.

Nice (2014) Safe Staffing for nursing in adult in-patient wards in acute hospitals (London: July 2014)



MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS AUGUST 2014

WARD	No.	RN/ Unreg	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A3	1 1	RN Unreg	Sickness Vacancy	Bank staff cancelled. On both occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted.
B2H	1	RN	Sickness	Nurse went home after three hours of the 12 hour shift. Nurse holding bed bleep supported and nurse on training returned for the last six hours of the shift.
B2T	2	RN	Vacancy	Bank unable to provide qualified staff. Extra support workers on the bank employed.
B3	1	Unreg	Sickness	Less than planned. Bank requested but unable to fill but assessed as safe with patients on the ward.
B4	1	RN	Maternity Leave/Short term sickness	Ward sister had the bed manager bleep and the bleep was quiet as a weekend and so based on the ward for the whole shift
B5	3	RN	Maternity Leave and Sickness	On one occasion bank cancelled at the last minute with others bank/agency requests not filled. Lead nurse and Matron assisted.
C3B	1	RN	Vacancy/Short term sickness	Bank and agency unable to fill. Dependency of patients meant safety maintained.
C4	4	Unreg	Patients requiring 1:1 care	Lead nurse worked within ward area to maintain safety.
C5	4	RN	Vacancy	Bank and substantive staff unable to fill. Extra support workers employed. Less than planned but assessed as safe with patients on the ward.
C7	1	Unreg	Sickness	Bank unable to fill. Liaised with other areas contacted for support and Site Coordinator/Matron contacted. Staff on duty rotated around ward to maintain safety.
MHDU	1	RN	Bank nurse cancelled at short notice	Liaised with other areas contacted for support and Matron contacted. Less than planned but assessed as safe.

With regards to qualified staff vacancies, 26 local and 5 international nurses are presently on their induction.

Aug-14		SHIFT																																																											
		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
WARD	**STAFF**	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg																																																												
	Unreg																																																												
WARD A2	Reg																																																												
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	Unreg			6/5																																																										
WARD A4	Reg																																																												
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WARD B1	Reg																																																												
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WARD C7	Reg																																																												
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PCCU	Reg																																																												
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MHDU	Reg																																											4/3																		
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CRITICAL	Reg																																																												
NEONATAL	Reg																																																												
MATERNITY ****	Reg																																																												
	Unreg																																																												

Key: Unsafe staffing (red) — Registered nurse shortfall (amber) — Care Support Worker shortfall (blue)

* Critical Care has 6 ITU beds and 8 HDU beds

** Neonatal Unit has 3 ITU cots, 2 HDU cots and 18 Special care cots. Ratios reflect BAPM guidance and include a single figure for registered and non registered staff

*** Children's ward accommodates children needing direct supervision care, HDU care 2 beds, under 2 years of age care and general paediatric care. There are no designated beds for these categories, other than HDU and the beds are utilised for whatever category of patient requires care.

**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the 'Birthrate +' staffing assessment

Enclosure 7

Paper for submission to the Board on 2nd October 2014

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 14th August 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

Serious Incident Monitoring Report (July 2014) - 10 new incidents were reported (1 Safeguarding Adult, 1 Failure of Treatment, 3 Patient Falls resulting in Fracture, 2 Confidentiality Breaches, 1 Unexpected Low Apgars, 1 Emergency Hysterectomy and 1 Pre-48 hour CDiff). There were 65 open general SI's in total (18 RCA/investigations in progress, 26 awaiting assurance that all actions had been completed and 21 recommended for closure). The Committee was advised about changes to the reporting of avoidable and unavoidable pressure ulcers and the impact this would have on reporting levels. No Never Events had been reported. The Committee **noted** the current position and **supported** the recommended closure of the 21 incidents.

Quality Dashboard for Month 3 (June) 2014/2015 - The following issues were discussed:

- TAL – Appointment booking within 4 days had been raised at the Finance and Performance Committee. There had been a 36% reduction.
- Maternity: Increase in breast feeding initiation rates had increased by 2% per year
- The number of dupuytren's contracture day case procedures was higher than the acceptable range.

Policy Group Recommendations - The Committee ratified 17 Guidelines.

WMQRS Maternity Visit (13th February 2014) - The West Midlands Quality Review undertook a formative review of the Trusts Maternity Services. The Committee discussed the report and resulting action plan and agreed the timing of future updates.

Quality Account Update including Priority Targets - The following issues were highlighted:

- **Patient Experience -** There had been two hospital targets for this topic. Both targets were on track and since the last quarter the percentage of call bell answering had risen to 89%.
- **Pressure Ulcer -** Both the two hospital and two community end of year targets were on track to be achieved. Hospital quarterly figures showed that there had been no grade 4 pressure ulcers reported and there was a reduction in the grade 3 ulcers. There were no community quarterly figures to report.
- **Infection Control -** Both the MRSA and C. Difficile targets were being achieved.
- **Nutrition/Hydration -** Both targets were on track. There was a drop in the hydration target score for June but the average of the three months reached the Trust target.
- **Mortality -** there were improvements in the timings of reviews and the end of year target of 85% would be met.

The Committee **noted** the position with regard to the quality priority targets and the national clinical audit/confidential enquiry participation at the end of the quarter.

Nursing Strategy (Quarterly Update) - An action plan had been developed to embed the Nursing Strategy within the Trust in 2013/14 following the launch of the strategy in May 2013. Progress with the completion of the actions had been identified using a Red, Amber, and Green grading system for each quarter in 2013/14. At the end of March 2014 37 actions were green, 8 actions were amber, 2 actions were red and 2 actions were blue. The red actions which had not been progressed and the reasons for this were discussed.

Quality and Safety Group (15th July 2014) - The Committee received a summary of issues arising from the meeting and noted the continuing reduction in the number of patient falls. The Nursing Care indicators were also discussed and the enhanced escalation process which had been implemented to follow up areas of concern.

The Committee also received the minutes and summary of issues arising from the Trust Children's Services Group held on 10th July 2014 and the Infection Prevention and Control Forum (12th June 2014).

Complaints, PALS and Compliments Report (Quarter 1) - The Committee noted the following key facts

- A reduction in the total of complaints received in the first quarter
- 80% of complaints had been reported within 30 working days.
- 20 upheld/partially upheld complaints were received and closed during the Quarter.
- 3 complaints had been accepted for investigation by the Ombudsman.
- 14 complaints meetings had been held during the Quarter.
- 5 dissatisfied complaints had been received during the Quarter.
- 15 new claims (CNST & personal injury) had been opened in the Quarter.
- 1 Coroner's rule 28 had been received in quarter 1 and it was confirmed that the Trust had responded and actions were being progressed.

The Committee was advised that the highest percentage of complaints was within the Clinical Care (Assessment and Monitoring) and Assessment, Discharge and Transfers categories. 2 complaints were recognised as High Risk upon receipt and were being investigated. Three Internal Complaints Review meetings had been held where senior staff were invited to explain the actions taken following complaints to understand the changes in practise and learning opportunities from these.

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 14th August 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 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 2 October 2014

TITLE:	**Board Assurance Framework – as at September 2014**		
AUTHOR:	**Sharon Phillips Risk and Standards Manager**	**PRESENTER**	**Julie Cotterill Associate Director of Governance and Board Secretary**

CORPORATE OBJECTIVES: ALL

SUMMARY OF KEY ISSUES:

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

This report identifies the Trust Assurance Framework and specifically:

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

In addition to the operational risk registers (reported to Risk and Assurance Group) the Directors are currently managing 12 corporate risks. The Assurance Framework focuses on those scoring 20 – 25 only (5 risks in total). The report shows the assurance to date of the effectiveness of the management and control of these risks. Action plans are in place, or being developed to address any gaps in control or assurance identified at this time. New assurance / updates highlighted in yellow

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD:

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

THE DUDLEY GROUP NHS FOUNDATION TRUST
BOARD ASSURANCE FRAMEWORK – RISKS SCORING 20 AND 25 as at September 2014

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR072 **Director Lead: Medical Director** **Initial Risk Score 20** **Mitigated Risk Score 4** **NEW RISK**	The JAC, a medicines management system, since 2008, to generate an electronic discharge summary containing details of patients' diagnosis, and discharge medication. However a discharge summary is not always being sent to the GP or to Soarian and sometimes the messaging between systems is not processed correctly.	NHSLA - Standard 4 CQC Outcome 6	Users are trained to use both Soarian and JAC	Users trained to use Soarian & JAC before they are issued with a login	July 2014 new training programme now in place			Meet with JAC to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed ongoing

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	An admission and discharge message is sent from OASIS to JAC when the patient is either admitted or discharged	The OASIS to JAC interface is monitored by Siemens.		It is not easy to monitor the JAC system for open episodes where a patient has been discharged in OASIS	If the patient for any reason has an open episode in JAC the message will not be processed resulting in no discharge being created	Meet with Indigo4 to identify and understand the true size and complexity of the problem to produce a robust solution, that will give the Trust assurance that the problem can be addressed
						Because the system is not actively monitored the Trust is unaware when a discharge message is not sent and a GP does not receive the electronic discharge summary	The JAC to Keystone interface is not actively monitored. The Keystone system is used to send discharge summaries to GPs	Create a new set of processes to actively monitor JAC and Keystone error messages
			The Trust is able to generate the current bed state from OASIS and is then able to manually match this to the ward list in JAC in order to be able to close open episodes which would prevent an OASIS admission message being processed			This is not actively monitored, therefore discharge summaries that have failed the automated messaging are not sent to the GP and Soarian. Often the GP telephones the Trust to request a discharge letter, this is often not reported.	This requires resources from the Trust to actively match patients across both systems	Joint audit with CCG

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	In order for discharge summaries to appear in Soarian a folder in the Keystone system is searched and documents copied to Soarian.	Documents in the Keystone folder appear in Soarian		Documents belonging to Incompatible GPs are not created in the Keystone folder and they do not get sent to GPs or Soarian Aug 2014 - Delays in updating the national spine continue to cause some issues updating the files where GPs have changed	There are a number of incompatible GP practices in Keystone, therefore these do not generate a discharge summary document and as such will not appear in Soarian	Reference files across the Trust to be updated.
			Admission and discharge on OASIS does not always correspond to admission and discharge on JAC. This happens very frequently in some areas with high throughput, such as EAU or day case units	Staff should then reclose the admission so that any future admissions are generated correctly.		Staff do not close reopened admission spells on JAC until the patient is readmitted. By closing the original spell a new summary will be created and sent electronically which is now out of date	Staff are able to override the closed admission in JAC by manually opening a spell previously closed by OASIS	Display warning message on Soarian front page achieved Display warning message on doctors App achieved Create a new set of processes that only permit a select group of users to reopen correctly closed spells
			Multiple individuals complete the TTO letter, with no clear final sign-off process	A new sign-off procedure is needed for TTOs. Letters should be signed and clearly identified by the discharging doctor	Fully addressed through Sign and Stamp campaign. Pharmacy will no longer accept letters no correctly and clearly signed.			

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	Not all drugs can be included on JAC from the picklist				The drug list on JAC has not been updated for 7 years, meaning not all drugs can be picked accurately.	Display urgent message on the Hub Trust data base and drug list on the JAC to be updated with the local formulary
			TTO's are sometimes completed and sent to pharmacy when the patient is medically fit but before the patient is ready for discharge and then the TTO drugs are kept on the ward, sometimes for many days.	There needed to be a expiry date on TTOs – approx 48 hours.	Sign and Stamp Campaign has addressed this. A three way check is now in place	Nursing staff currently only check the TTOs against the TTO letter, not the patient's drug chart. This misses an opportunity to cross-check for accuracy	Patient's medication and diagnosis may change during that time, but this will not be included on the TTO.	
			There are many prescribing errors on TTOs which have to be corrected in pharmacy		Sign and Stamp Campaign has addressed this. A three way check is now in place	New mistakes can occur during the pharmacy process Doctors do not learn from their errors	When pharmacy updates a TTO, there is no process for a further sign-off by the prescribing doctor	Review TTO process to ensure it is clinically safe
			The GP list of emails on Keystone is not up to date			No assurance compatible letters are saved or GPs email list is up to date No IT solution yet available National Spine data is used, but this will remain several months in arrears	Letters are not sent electronically to GP. A copy of the letter is not stored for future reference	

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR072		NHSLA - Standard 4 CQC Outcome 6	Dudley CCG monitors receipt of discharge summaries twice yearly, to monitor contract standard target	There must be a robust audit process around discharge letters	Joint audit with CCG under development	Sept 2014 Dudley CCG have raised a contract query and want to investigate further because of the high clinical risk of missing letters Sandwell CCG have reported problems with the Trust discharge summaries – to be investigated		

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

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

Board Strategic Theme: Diversification	Strategic Goals		Key Priorities			Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG03: To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio		a) Adopting a more commercial attitude to developing services and broaden the Trust's income base to reduce reliance on NHS income alone			Section B: The Trusts Strategic position in the Local Health Economy	Outcome 6	F&P
			b) Providing excellent, appropriate and accessible services across community and acute care				Outcome 6	CQSPE
			c) Providing a re-shaped range of financially and clinically viable planned care services			Appendix 3b		F&P
			d) Developing the Trust wide clinical strategy including improved use of Trust resources, quality of care and financial efficiencies			Section C: Clinical and Quality Strategy.		CQSPE
			e) Investing in developments that support the drive for lead provider status in the Black Country			Section B: The Trusts Strategic position in the Local Health Economy	Outcome 6	F&P
Risk Ref	**Risk Description**	**Monitor / CQC / NHSLA**	**Current Controls**	**Sources of Assurance**	**Positive Assurance**	**Gaps in Assurance**	**Gaps in Control**	**Mitigating Actions**
There are currently no Corporate Risks scoring 20 – 25 in this category								

Board Strategic Theme: Clinical Partnerships	Strategic Goals	Key Priorities	Monitor Forward Plan Strategy Ref	CQC	Lead Committee
	SG04: To develop and strengthen strategic clinical partnerships to maintain and protect our key services	**a) Demonstrate a distributed leadership model with empowered clinical leaders**	**Section G: Leadership & organisational Development**	**Outcome 12, 13, 14**	**CQSPE**
		b) Promoting risk sharing with CCGs	**Appendices 3a & 3d**	**Outcome 6**	**F&P**
		c) Developing clinical links with local GPs and healthcare practitioners	**Appendix 3d**	**Outcome 6**	**CQSPE**
		d) Develop new clinical networks that provide resilience through a more distributed service model	**Appendices 3a & 3d**	**Outcome 6**	**F&P**

Risk Ref	Risk Description	Monitor / CQC / NHSLA	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR069 **Director Lead: Director Operations** **Initial Risk Score 25** **09/09/14 reduced to 20** **Mitigated Risk Score 12** **NEW RISK**	The Diagnostic standard is at risk if: • The demand rises to a level above capacity resulting in breaches to the diagnostic standard.	CQC Outcome 11 & 13	Daily monitoring	Daily information reports Performance Review meetings Finance and Performance meeting	Key Performance Target Report to F & P Committee -May 2014 The diagnostic waits target was achieved with a performance of 99%,	Key Performance Target Report to F & P Committee - Aug 2014 The diagnostic waits target was not achieved in August with a figure of 95.5%		
			Recruitment of sufficient qualified staff	Discussion at Directors group	Presentation of action plan to Finance and Performance Committee Sept 14.	Produced and agreed plan		Plan to ensure recruitment of sufficient qualified staff Capacity and Demand review to establish future demand and required capacity
			Sufficient equipment	Capacity planning		Agreed level of equipment expansion		Plan to replace or expand equipment needed based on capacity and demand review

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR071 **Director Lead: Director Operations** **Initial Risk Score 20** **Mitigated Risk Score 15** **NEW RISK**	The ED 4 hour standard is at risk if: • the level of emergency attendance or admission activity is higher than contracted activity or • there is an increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input resulting in high numbers of 4 hour breaches within ED, a below 95% performance and the implementation of fines.	CQC Outcome 6	Live capacity monitoring	Four times daily multi divisional capacity meeting. Daily information reports Performance Review meetings Finance and Performance meeting	Key Performance Target Report to F & P Committee - A&E 4 Hour Waits: Strong performance for July at 96.9%. The Committee noted that for the previous two weeks the Trust had achieved over 98% and on some days had achieved 100% performance. The Director of Operations confirmed that the Trust was 9th highest performing against the ED target in the Country the previous week. - Aug 2014 Quarter 2 continues to remain above target at 97%, with August's performance in at just above 97.1%,	Key Performance Target Report to F & P Committee - June 2014 Quarter 1 performance poor with the position as at 15th June being 91.5%.		
			Capacity meetings with CCG	Urgent Care Working Group Winter Plan	Director of Operations has written to CCG outlining the high level of demand for emergency services and requesting the CCGs plan to manage demand to contract. 2014	Delivery of UCWG plans in past No plan has been forthcoming as yet from CCG. "In summary; the Trust's ability to deliver against the contracted standards of A&E, ambulance turnaround and Referral to Treatment is impacted by the failure of the CCG to manage the emergency demand to contracted levels and provide, through contracts, sufficient ability and capacity for community bed and social care provision". Letter to CCG 8 Sept	CCG implemented plan (including Better Care Fund) to manage activity Lack of on-site Urgent Care Centre	Establish actions by CCG to reduce attendances and admissions at DGH in line with contract and BCF plans Open commissioned Urgent Care Centre

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR071		CQC Outcome 6	Daily reviews of delayed discharges	Delayed discharge reporting Delayed discharge meetings Capacity team monitoring and escalation Policies on delays including Choice	Director of Operations letter to Local Authority 15 September 2014. "As a consequence of the current capacity situation and with no assurance of a significant improvement in admission reduction or out of hospital capacity the Trust's intention is to invoke the reimbursement penalties as per guidance within the Community Care Act 2003 with effect from 1st April 2014. "	Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand	Adherence to agreement on numbers of accepted delayed discharges Activation of fining protocol	Agree Frail Elderly Unit plan to reduce LOS and create capacity Implement Winter Plan internally and gain action from partners for wider Winter Plan Agree response by partners to delayed discharge pressure and implement section 2 & 5 sanctions Activation of fines for delayed discharges as per protocol
			Length of Stay monitoring	Ward and speciality reporting Review against peers Length of Stay working group Winter plan Previous pilot of Frail Elderly Unit		Accepted and agreed plan for sustained Frail Elderly Unit		Reconfiguration of medical wards to provide additional capacity through change in flow processes and subsequent reduction in LOS. System Wide Resilience plan to manage winter demand.

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

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

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

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR061 **Director Lead: Director of Finance and Information** **Initial Risk Score 20** Mitigated Risk Score 12	The Trust must sign a "viability statement" in relation to its long term clinical and financial sustainability, as part of the 5 year strategic plan submission. At present, there is no indication that either growth, exit or redesign of our major service lines over the next 5 years, will deliver the financial efficiencies required to mitigate the projected financial deficit over that time period. This means we are currently at risk of being able to sign that viability statement and submit a robust and complete 5 year plan.	CQC Outcome 26 Monitor	1. Beyond the initial 7 specialities examined, conduct a service line options appraisal for all services, to ensure optimum service mix is recommended to the Board of Directors	1. Board workshop and private board papers on 5 year plan.	Turnround Plan presented to the Board for approval and signed off 05/06/14 5 Year Strategic Plan presented to the Board and not signed off 05/06/ 41 Outpatient focus on 5 specialties. Ownership of outpatients and length of stay targets within new Divisional structure. Launch of Black Country Alliance meetings with Walsall and Sandwell & West Birmingham	Time pressure means the depth of review, analysis and engagement for the remaining specialities won't be as deep as those done for the initial major services. Plan to complete the more in depth review as part of new Divisional arrangements during Q2 and Q3 2014/15, in advance of detailed APR scrutiny from Monitor		1. Conduct internal, exec-led mitigation planning sessions during June, to agree further, organisation-wide mitigations. These may include estate reconfigurations/alternative uses, community service rationalisation, further commercial assumptions, service marketing and elective expansion beyond current plan. Black Country Trust Finance Directors to arrange facilitated planning session(s) with respect to radical, sub-regional service configuration options and associated financial monitoring

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
COR065 **Director Lead: Director of Finance and Information** **Initial Risk Score 20** Mitigated Risk Score 12	**The current Trust plan of a £6.7m deficit is predicated on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to deliver this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years.**	CQC Outcome 26 Monitor	1.Development of rigid PMO structure to properly assess each saving opportunity, requiring completion of PID with key milestones and a QIA.	Bi-weekly meetings with managers to run through key milestones. Completion of CIP tracker showing PID and QIA. CIP update report to Directors, F&P, Board. Escalation meetings now include Director of Ops/Chief Executive; Dashboard available on Hub;		Absence of granular plans are preventing the monitoring of scheme achievement to timescales;		
			2. Development of a Turnaround programme designed to ensure that saving/efficiency opportunities are maximised without detriment to quality/patient care	Turnaround plan/reports to Directors, F&P, TME and Board.		Turnround plan presented to F&P for month 5 position shows an adverse variance of £1.093m and projected year end forecast of £9.227m is £0.991m lower than original plan.		
			3 Increased budget manager accountability to ensure rectification plans are prepared for overspending budgets	Development of controls framework. Relaunch of Budget Manager responsibility policy. Discussions held with budget managers.	Rectification plans for overspends in excess of £50k expected by end of September	Contract income to be devolved to Divisions from September to improve ownership/accountability		

Risk Ref	Risk Description	Monitor / CQC / NHSLA ref	Current Controls	Sources of Assurance	Positive Assurance	Gaps in Assurance	Gaps in Control	Mitigating Actions
Cont... COR065		CQC Outcome 26 Monitor			Discussion with CCG at CLT around re-patriation options	Many of the original schemes were income related and there is concern that they are not affordable in the current financial climate.		Work plan (via the SDIP) to agree variations to contract with CCG to recognise additional income related efficiency schemes. Determine whether to devolve income to Directorates so that income gains/losses can be properly assessed
					Chief Executive address to staff on importance of financial balance to clinical sustainability	Inability to achieve required savings due to other pressures, i.e. increased emergency activity resulting in inability to close beds		Development of increased savings plan to ensure there is a degree of flexibility to mitigate shortfalls

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors – 2nd October 2014

TITLE:	**Corporate Risk Register**		
AUTHOR:	Sharon Phillips Risk and Standards Manager	**PRESENTER:**	Julie Cotterill Associate Director of Governance and Board Secretary

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 the Directors are currently managing 12 corporate risks, of which 5 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified

6 new risks were added to the corporate risk register since the previous report (June 2014) commencing on page 4).

20 risks have been mitigated to their lowest level and have been archived or superseded (refer to page 2).

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
	Equality Assured	**Y**	Better Health outcomes Improved Patient access and Experience
	Other	**Y**	**Details:** Information requirements for the Annual Governance Statement –RR gaps in assurance and control

ACTION REQUIRED OF THE BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD:

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

To consider whether all risks should remain on the Corporate Risk Register.

CORPORATE RISK REGISTER

In addition to the operational risk registers the Directors are currently managing 12 corporate risks, of which 5 risks score 20 or above. Assurance is actively monitored and mitigating actions have been identified. The risk scores are as follows:

Risk Score	Number of Risks
20	5
16	1
15	4
12	1
8	1

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

RISK REGISTER MOVEMENT

6 new risks were added to the corporate risk register since the previous report (June 2014) (these are indicated in the table commencing page 4).

20 risks have been removed from the Corporate Risk Register (archived or moved to Directorate Risk Register) since the previous report (June 2014) and summarised below:

Director lead	Risk Summary	Date
Mr R Cattell	Cannulation of Arterio-Venous Fistula	17/09/14
Ms D McMahon	Safe Staffing – Physical resource and staffing capacity exceeded	19/06/14
Ms D McMahon	Increase in the number and grade of avoidable pressure ulcers - Trust	19/06/14
Ms D McMahon	The continuing high levels of activity exceed the available cots	19/06/14
Ms D McMahon	Patients with Learning Disabilities specific needs not being addressed as part of their care	19/06/14
Mr R Cattell	Diabetic Management	19/06/14
Mr R Cattell	Loss of all early patient discharges by the RAS team,	19/06/14
Ms D McMahon	Risk of not continuing to achieve the required Birth Rate Plus midwifery staffing levels against the activity	20/06/14
Mr P Assinder	Deteriorating liquidity position and its deteriorating cash balance, the Trust will not be able to undertake the capital developments which are central to much of our operational plan and strategic plan.	23/06/14
Mr R Cattell	Rising urgent care demand on DG NHS FT as a result of poorly planned management across health economy	25/06/14
Mr R Cattell	Failure to maintain 18-week Pathway	08/08/14
Mr J Scott	Urgent care demands exceed capacity	02/09/14
Mr J Scott	Unable to admit Emergency Patients due to externally caused delayed discharge/transfer	02/09/14
Mr J Scott	National Better Care Fund planning assumptions applied locally, do not lead to a Community Team operational response of sufficient resilience or system-wide admissions avoidance	02/09/14
Mr J Scott	Expansion of elective surgical activity to improve RTT target performance	02/09/14

Director lead	Risk Summary	Date
Dr P Harrison	The need for a medical workforce plan	09/09/14
Ms D McMahon	Delay in response from children's and /or Adults Social Services Emergency Duty Team	09/09/14
Mr R Cattell	Potential compromise of clinical care due to the non availability of clinical information	09/09/14
Mr P Assinder	Reduction in agency spend for nurses and medical staff	09/09/14
Mr R Cattell	Cancellation of elective surgical patients due to excess emergency admissions	09/09/14

PENDING NEW RISKS

There is presently 2 known pending risk to be added to the Corporate Risk Register, this is a risk that have been identified at a Committee/groups or has arisen from an incident, complaint, claim, internal external review etc for the Corporate Risk Register. The following is a summary of this:

Director lead	Risk Summary	Requested
Mr S Davis	Critical path for recovery of The Dudley Group turnround programme.	May 2014
Ms P Clark	Rationalisation of Services	Sept 2014

CORPORATE RISK REGISTER

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR061 **Director Lead: Director of Finance and Information** **Initial Risk Score 20**	The Trust must sign a "viability statement" in relation to its long term clinical and financial sustainability, as part of the 5 year strategic plan submission. At present, there is no indication that either growth, exit or redesign of our major service lines over the next 5 years, will deliver the financial efficiencies required to mitigate the projected financial deficit over that time period. This means we are currently at risk of being able to sign that viability statement and submit a robust and complete 5 year plan.	16/05/2014 **Last Review Date: Sept 2014**	6. To deliver an infrastructure that supports delivery.	1. Beyond the initial 7 specialities examined, conduct a service line options appraisal for all services, to ensure optimum service mix is recommended to the Board of Directors.	4	5	20	1. Board Workshop and Private Board papers on 5 year plan.	Time pressure means the depth of review; analysis and engagement for the remaining specialities won't be as deep as those done for the initial major services. Plan to complete the more in depth review as part of new Divisional arrangements during Q2 and Q3 2014/15, in advance of detailed APR scrutiny from Monitor.		1. Conduct internal, exec-led mitigation planning sessions during June, to agree further, organisation-wide mitigations. These may include estate reconfigurations/alternative uses, community service rationalisation, further commercial assumptions, service marketing and elective expansion beyond current plan. 1. Black Country Trust Finance Directors to arrange facilitated planning session(s) with respect to radical, sub-regional service configuration options and associated financial monitoring.	30/09/2014	4	3	12

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR069 **Director Lead: Director of Operations** **Initial Risk Score 25**	The Diagnostic standard is at risk if: the demand rises to a level above capacity, resulting in breaches to the Diagnostic standard	31/08/2014 **NEW RISK**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Daily monitoring. 2. Recruitment of sufficient qualified staff. 3. Sufficient equipment.	4	5	20	1. Daily information reports. 1. Performance Review Meetings. 1. Finance and Performance Meeting. 2. Discussion at Directors Group. 3. Capacity planning.	1. None. 2. Understanding of levels of recruitment needed. 3. Understanding of the levels of future demand and current productivity of current equipment.	1. None. 2. Produced and agreed plan. 3. Agreed level of equipment expansion.	1. Plan to ensure recruitment of sufficient qualified staff. 2. Capacity and Demand review to establish future demand and required capacity. 3. Plan to replace or expand equipment needed based on Capacity and Demand review.	30/11/2014	4	3	12
COR065 **Director Lead: Director of Finance and Information** **Initial Risk Score 20**	The current Trust plan of a £6.7m deficit is predicated on the delivery of a CIP programme of £10.2m developed in conjunction with PWC. Failure to deliver this programme of efficiency savings will result in the Trust falling further behind the desired state of financial breakeven. This in turn will result in a more significant savings requirement in future years	27/05/2014 **Last Review Date: Sept 2014**	6. To deliver an infrastructure that supports delivery.	1. Development of rigid PMO structure to properly assess each saving opportunity, requiring completion of PID with key milestones and a QIA. 2. Development of a Turnaround programme designed to ensure that saving/efficiency opportunities are maximised without detriment to quality/patient care. 3. Increased Budget Manager accountability to ensure rectification plans are prepared for overspending budgets.	4	5	20	1. Bi-weekly meetings with managers to run through key milestones. Completion of CIP tracker showing PID and QIA. CIP Update report to Directors, F&P, Board. 2. Turnaround plan/reports to Directors, F&P, TME and Board. 3. Development of controls framework. RE-launch of Budget Manager responsibility policy. Discussions held with budget managers.	4. Many of the original schemes were income related and there is concern that they are not affordable in the current financial climate. 5. Inability to achieve required savings due to other pressures, i.e. increased emergency activity resulting in inability to close beds.		4. Work plan (via the SDIP) to agree variations to contract with CCG to recognise additional income related efficiency schemes. 4. Determine whether to devolve income to Directorates so that income gains/losses can be properly assessed. 5. Development of increased savings plan to ensure there is a degree of flexibility to mitigate shortfalls.	30/09/2014	3	4	12

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR072 [FI002 (IT009) **Director Lead: Medical Director** **Initial Risk Score 20**	The JAC, a medicines management system, since 2008, to generate an electronic discharge summary containing details of patients' diagnosis and discharge medication. However, a discharge summary is not always being sent to the GP or to Soarian and sometimes the messaging between systems is not processed correctly -	12/06/2014 **Last Review Date: June 2014** **NEW CORPORATE RISK**	1. To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.	1. Users are trained to use both Soarian and JAC. 2. An admission and discharge message is sent from OASIS to JAC when the patient is either admitted or discharged. 4. The Trust is able to generate the current bed state from OASIS and is then able to manually match this to the ward list in JAC in order to be able to close open episodes which would prevent an OASIS admission message being processed. 5. In order for discharge summaries to appear in Soarian, a folder in the Keystone system is searched and documents copied to Soarian. 6. Admission and discharge on OASIS does not always correspond to admission and discharge on JAC. This happens very frequently in some areas with high throughput, such as EAU or Day Case Units. 7. Multiple individuals complete the TTO letter, with no clear final sign-off process. 8. Not all drugs can be included on JAC from the picklist.	4	5	20	1. Users must be trained to use Soarian and JAC before they are issued with a log-in. 2. The OASIS to JAC interface is monitored by Siemens. 5. Documents in the Keystone folder appear in Soarian. 6. Staff should then reclose the admission so that any future admissions are generated correctly. 7. A new sign-off procedure is needed for TTOs. Letters should be signed and clearly identified by the discharging doctor 9. There needed to be a expiry date on TTOs – approx 48 hours.	2. If the patient has an open episode in JAC, the message will not be processed resulting in no discharge being created 3. The JAC to Keystone interface is not actively monitored. The system is used to send discharge summaries to GPs 4. This requires resources from the Trust to match patients across both systems. 5. There are a number of incompatible GP practices in Keystone, therefore these do not generate a discharge summary document and as such will not appear in Soarian. 6. Staff are able to override the closed admission in JAC by manually opening a spell previously closed by OASIS 8. The drug list on JAC has not been updated for 7 years.	2. It is not easy to monitor the JAC system for open episodes where a patient has been discharged in OASIS. 3. System is not actively monitored; the Trust is unaware when a discharge message is not sent and the GP does not receive the electronic discharge summary. 4. Not actively monitored, therefore discharge summaries that have failed the automated messaging are not sent to the GP and Soarian. 5. Documents belonging to Incompatible GPs are not created in the Keystone folder and they do not get sent to GPs or Soarian	1. Meet with JAC to identify and understand the true size and complexity of the problem to produce a robust solution that will give the Trust assurance that the problem can be addressed. 2. Meet with Indigo4 to identify and understand the true size and complexity of the problem to produce a robust solution that will give the Trust assurance that the problem can be addressed. 3. Create a new set of processes to actively monitor JAC and Keystone error messages. 4. Development of Joint audit with the CCG 5. Reference files across the Trust to be updated 6. Display warning message on Soarian front page. 6. Display warning message on doctors App.	30/06/2014	4	1	4

				9. TTO's are sometimes completed and sent to Pharmacy TTO's are sometimes completed and sent to pharmacy when the patient is medically fit but before the patient is ready for discharge and then the TTO drugs are kept on the ward, sometimes for many days. 10. There are many prescribing errors on TTOs which have to be corrected in Pharmacy. 11. The GP list of emails on Keystone is not up to date. 12. Dudley CCG monitors receipt of discharge summaries twice yearly, to monitor contract standard target.					9. Patient's medication and diagnosis may change during that time, but is not included on the TTO. 10. When Pharmacy updates a TTO, no process for a further sign-off by the doctor. 11. Letters not sent electronically to GP and copy of letter not stored for future reference	6. Staff do not close reopened admission spells on JAC until the patient is readmitted. 7. Electronic solution and change in clinical practice required 9. Nursing staff currently check the TTOs against TTO letter; not patient's drug chart. 10. Mistakes can occur during pharmacy process. Doctors do not learn from errors. 11. No assurance compatible letters are saved or GPs email list is up to date. IT solution not available.	6. Create a new set of processes that only permit a select group of users to reopen correctly closed spells 8. Display urgent message on the HUB 8. Trust data base and drug list on the JAC to be updated with the local formulary 10. Review TTO process to ensure it is clinically safe				

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR071 **Director Lead: Director of Operations** **Initial Risk Score 20**	The ED 4 hour standard is at risk if: the level of emergency attendance or admission activity is higher than contracted activity or; there is an increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input, resulting in high numbers of 4 hour breaches within ED, a below 95% performance and the implementation of fines	31/08/2014 **NEW RISK**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Live capacity monitoring. 2. Capacity meetings with CCG. 3. Daily reviews of delayed discharges. 4. Length of Stay monitoring.	5	4	20	1. Four times daily multi divisional capacity meeting. 1. Daily information reports 1. Performance Review meetings 1. Finance and Performance meeting 2. Urgent Care Working Group 2. Winter Plan 3. Delayed discharge reporting 3. Delayed discharge meetings 3. Capacity team monitoring and escalation 3. Policies on delays including Choice 4. Ward and speciality reporting 4. Review against peers 4. Length of Stay working group 4. Winter plan 4. Previous pilot of Frail Elderly Unit	1. None. 2. CCG implemented plan (including Better Care Fund) to manage activity. 2. Lack of on-site Urgent Care Centre. 3. Adherence to agreement on numbers of accepted delayed discharges. 3. Activation of fining protocol. 4. None.	1. None. 2. Delivery of UCWG plans in past. 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand. 4. Accepted and agreed plan for sustained Frail Elderly Unit.	1. Agree Frail Elderly Unit plan to reduce LOS and create capacity 2. Implement Winter Plan internally and gain action from partners for wider Winter Plan 3. Agree response by partners to delayed discharge pressure and implement section 2 & 5 sanctions 4. Establish actions by CCG to reduce attendances and admissions at DGH in line with contract and BCF plans 5. Open commissioned Urgent Care Centre 6. Activation of fines for delayed discharges as per protocol	30/04/2015	5	3	15

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR059 **Director Lead: Director of Support Operations** **Initial Risk Score 16**	The Trust is working in partnership with Dudley CCG to respond to our responsibilities in the Dudley Health Economy urgent care redesign. In particular, this involves the co-commissioning of an Urgent Care Centre (UCC), integrated with our Emergency Department (ED) on the RHH site	15/05/2014 **Last Review Date: Sept 2014**	6. To deliver an infrastructure that supports delivery.	1. Urgent Care Project Group (Involves senior staff from DCCG as equal partners in planning the development and its finances). 2. Project group examining 4 different estates options and will plan that client brief for new facility can be economically met within capital envelope set aside. Variation process has begun under PFI project agreement rules. Consistent capital development fees will be applied. 3. Completion of Business Case for capital and revenue elements to be presented to July 2014 Board of Directors meeting for scrutiny.	4	4	16	1. Urgent Care Project Group Minutes. 1. DCCG Board Minutes. 1. 2-year operational plans (DCCG and DGFT). 2. DGFT investment committee notes. 2. Contract variation audit trail. 3. DGFT investment committee minutes.	2. Approval process by Summit Healthcare not within DGFT control.	3. Board of Directors may not approve business case in July, leading to potential delay in capital development and proposed start date for UCC of 1/4/15.	2. Contract negotiation with DCCG including consideration of risk share arrangement and/or local tariff on both ED attendance and AEC/SAU/EAU assessment activity, better reflecting redesigned service. 3. Presentation of business case for capital revenue to Board of Directors September 2014. 3. Agreement of capital and revenue consequences of UCC provisions on DGFT with DCCG.	31/10/2014	4	2	8

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR070 **Director Lead: Director of Operations** **Initial Risk Score 20**	The Cancer standard is at risk if: the level of emergency attendance or admission activity rises or; the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or; the theatre capacity is insufficient to meet demands, resulting in breaches to the cancer standard	31/08/2014 **NEW RISK**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Live capacity monitoring. 2. Capacity Meetings with CCG. 3. Daily reviews of delayed discharges. 4. Length of Stay monitoring. 5. Monitoring of patients on inpatient lists. 6. Theatre productivity.	5	3	15	1. Four times daily multi divisional capacity meeting. 1. Daily information reports. 1. Performance Review meetings. 1. Finance and Performance meeting. 2. Urgent Care Working Group. 2. Winter Plan. 3. Delayed discharge reporting. 3. Delayed discharge meetings. 3. Capacity team monitoring and escalation. 4. Ward and speciality reporting. 4. Review against peers. 4. Length of Stay working group. 4. Winter plan. 4. Previous pilot of Frail Elderly Unit. 5. Weekly PTL meetings. 5. Monitoring reports. 5. Performance Review meetings. 5. Finance and Performance Meeting. 5. Review of waiting list management. 6. Theatre productivity reports. 6. Theatre productivity meetings. 6. Consultant Leave policy.	1. None. 2. CCG plan to manage activity. 2. Lack of on-site Urgent Care Centre. 3. Adherence to agreement on numbers of accepted delayed discharges. 4. None. 5. None. 6. None.	1. None. 2. Delivery of UCWG plans in past. 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand. 4. Accepted and agreed plan for sustained Frail Elderly Unit. 5. None. 6. Consultant Leave planning and impact on theatre activity management.	1. Agree Frail Elderly Unit plan to reduce LOS and create capacity. 2. Implement Winter Plan internally and gain action from partners for wider Winter Plan. 3. Agree response by partners to delayed discharge pressure and implement Section 2 & 5 sanctions. 4. Establish actions by CCG to reduce attendances and admissions at DGH. 5. Open commissioned Urgent Care Centre. 6. Ensure priority of cancer patients is kept high within Capacity Meetings. 7. Agree plan for annual activity including managing consultant leave appropriately.	30/04/2015	5	2	10

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR068 **Director Lead: Director of Operations** **Initial Risk Score 20**	The RTT standard is at risk if: the level of emergency attendance or admission activity rises or; the bed capacity in the hospital reduces due to increased length of stay or reduction in ability to swiftly move patients who are medically fit but require community or social care input or; the theatre capacity and productivity is insufficient to meet demands, resulting in cancelled elective patients, breaches to the RTT standard and reduced income.	31/08/2014 **NEW RISK**	4. To develop and strengthen strategic clinical partnerships to maintain and protect our key services.	1. Live capacity monitoring 2. Capacity meetings with CCG 3. Daily reviews of delayed discharges 4. Length of Stay monitoring 5. Monitoring of patients on inpatient lists 6. Theatre productivity	5	3	15	1. Four times daily multi divisional capacity meeting. 1. Daily information reports 1. Performance Review meetings 1. Finance and Performance meeting 2. Urgent Care Working Group 2. Winter Plan 3. Delayed discharge reporting 3. Delayed discharge meetings 3. Capacity team monitoring and escalation 3. Policies on delays including Choice 4. Ward and speciality reporting 4. Review against peers 4. Length of Stay working group 4. Winter plan 4. Previous pilot of Frail Elderly Unit 5. Weekly PTL meetings 5. Monitoring reports 5. Performance Review meetings 5. Finance and Performance Meeting 5. Review of waiting list management 6. Theatre productivity reports 6. Theatre productivity meetings 6. Consultant leave policy	1. None 2. CCG plan to manage activity 2. Lack of on-site Urgent Care Centre 3. Adherence to agreement on numbers of accepted delayed discharges 4. None 5. None 6. None	1. None 2. Delivery of UCWG plans in past 3. Sign up by partners to ensure capacity outside of the Trust is sufficient to meet demand 4. Accepted and agreed plan for sustained Frail Elderly Unit 5. None 6. Consultant leave planning and impact on theatre activity management	1. Agree Frail Elderly Unit plan to reduce LOS and create capacity 2. Implement Winter Plan internally and gain action from partners for wider Winter Plan 3. Agree response by partners to delayed discharge pressure and implement section 2 & 5 sanctions 4. Establish actions by CCG to reduce attendances and admissions at DGH 5. Open commissioned Urgent Care Centre 6. Ensure priority of elective patients is kept high within Capacity meetings 7. Agree plan for annual activity including managing consultant leave appropriately	30/04/2015	5	2	10

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR063 **Director Lead: Director of Finance and Information** **Initial Risk Score 15**	The current NHS contract enables the Trust to earn additional income up to 2.5% (£6.1m) to meet specified quality targets. The Trust budget assumes that the quality targets will be achieved in full. Hence, any shortfall against any of the schemes will result in a real financial consequence to the Trust's income position which could seriously compromise financial plans	27/05/2014 **Last Review Date: September 2014**	6. To deliver an infrastructure that supports delivery.	1. Separate CQUIN Exception Report scheduled in for quarterly discussion at F&P Committee. 2. CQUIN report incorporated into monthly reporting dashboard and covered in Directorate Performance Review Meetings. 3. All CQUIN schemes have a Lead Manager and nominated Executive Lead. Progress reports reviewed monthly with the Director of Operations with Exception Reports required for red rated schemes.	3	5	15	1. Reports F&P Committee 2. Dashboards and Performance Review Meetings. 3. Progress report collected on a monthly basis from Lead Manager. Exception Reports for red rated schemes.	4. Require increased accountability for managers failing to deliver agreed milestones. 5. Some CQUIN targets/milestones not fully agreed or remain unclear.		4. Managers required to report any risk to delivery of milestones to Directors/F&P. 5. Ensure remaining targets/milestones agreed.	31/10/2014	1	5	5

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR064 **Director Lead: Director of Finance and Information** **Initial Risk Score 15**	The current NHS contract allows the CCG to invoke penalties for sub-standard performance/failure to meet key targets. The Trust budget makes no allowance for any deduction. Hence, if contract penalties are enacted, there is real financial consequence to the Trust's income position which could seriously compromise financial plans	27/05/2014 **Last Review Date: May 2014**	6. To deliver an infrastructure that supports delivery.	1. Regular monthly monitoring of Performance Reports and exposure to penalties to Directors, F&P Committee and Board. 2. Corporate and Departmental dashboards in place for monitoring. 3. Breach analysis and Directorate reporting regime in place for investigation of target failures giving rise to penalties.	3	5	15	1. Reports to Directors, F&P Committee and Board. 2. Dashboards. 3. Action plans reported to F&P with reasons for failure and action to improve. Issues debated at Directorate Performance Reviews.	4. Require focused action plan for persistent areas of failure, i.e. Ambulance Turnaround times, ED 4-hour target, RTT waits. 5. Seek to negotiate repatriation of contract penalties with CCG.		4. Develop action plans for improvement for Ambulance Turnaround times, ED 4-hour target and RTT waits and performance manage outcomes. Positive action should minimise the potential for fines to be enacted. 5. Agree with CCG mitigating reasons for not invoking fines or alternatively agree acceptable rationale for the payback of imposed contract penalties.	31/12/2014	1	5	5

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR067 **Director Lead: Director of Finance and Information** **Initial Risk Score 12**	The current Trust plans assume the receipt of £4m transitional support from Dudley CCG. Whilst this has now been approved by the CCG Board, payment is linked to compliance with certain conditions and is therefore not guaranteed. The four conditions focus on greater transparency, implementation of the Service Delivery & Implementation Plan (SDIP), improving referral practice and establishing a comprehensive elderly care pathway	22/08/2014 **NEW RISK**	6. To deliver an infrastructure that supports delivery.	1. Joint funded post across Trust/CCG and regular SDIP Steering Group Meetings.	4	3	12	1. Update of SDIP presented at monthly contract review.	2. Trust to respond to CCG letter, setting out parameters for compliance and expected payment regime. 3. System to manage delivery of the four conditions to enable quarterly progress reports to be submitted to the CCG and ensure full payment of £4m.		2. Letter drafted to CCG, setting out Trust response and expectations. 3. Lead Director to be tasked with ensuring suitable progress against four conditions to enable quarterly reports to be submitted to the CCG. Agreement of phased payments at CLT.	30/09/2014	2	2	4

Risk Ref / Initial Risk Score	Risk	Risk Start Date / Last Review 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
COR032 (OP097) **Director Lead: Director of Support Operations** **Initial Risk Score 15** **Reduced to 9 Sept 2014**	Failure to implement Business Continuity Plan during a Major Internal Incident	01/12/2011 **Last Review Date: Sept 2014**	6. To deliver an infrastructure that supports delivery.	1. Business Continuity Plan in place developed with PFI Partners. 2. 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	2	8	1. IFM Reports and business continuity. 1. RCA Reports following business continuity incidents. 2. Clinical Quality and Patient Experience Committee Reports.	2. Delivery of actions.	2. No assurance recommendation following HV incident have been implemented.	2. Provide training and undertake exercise to improve response. FM response tested December 2013 and was favourable. 2. Implement recommendations following HV incident July 2013.	30/09/2014	2	2	4

Enclosure 10

Paper for submission to the Board of Directors 2nd October 2014

TITLE:	**Revalidation Update Report**		
AUTHOR:	Teekai Beach, Directorate Manager to Medical Director	**PRESENTER**	Paul Harrison, Medical Director

CORPORATE OBJECTIVE: SG05: Staff Commitment

SUMMARY OF KEY ISSUES:

Revalidation for medical staff commenced in December 2012 and is required by all doctors to be given a licence to practice every five years. In order to be revalidated doctors require five satisfactory annual strengthened appraisals (although initial revalidation requires less). Revalidation arrangements have been in place within the Trust since December 2012. This report briefly outlines the progress made in Q1 2014/2015 and highlights any issues.

- The Trust maintains a high appraisal rate with generally positive feedback on the quality of appraisals.
- 32 doctors have been revalidated as of September 2013 with 2 deferrals.
- 122 out of 133 Core Standards of the Framework for Quality Assurance for Appraisal and Revalidation set by NHS England are achieved.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	Outcome 12: requirements relating to workers Outcome 13: Staffing Outcome 14: Supporting Workers
	NHSLA	**Yes**	**Details:** 1.9 Professional Clinical Requirements
	Monitor	**Yes**	**Details:**
	Equality Assured	**Yes**	**Details:** **Better Outcomes for All**
	Other: GMC		**Details: 'Good Medical Practice'**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			Information

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

The board is asked to note the content of this report.

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS

October 2014

Quarterly Revalidation Report

1. Introduction

This report provides an update to the Board on Medical Revalidation further to the paper presented to board on 3rd October 2013.

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Medical revalidation is a legislative requirement governing the competence of doctors outlined in the Good Medical Practice Framework for Appraisal and Revalidation (GMC March 2011). The Responsible Officer's role was set out in The Medical Profession (Responsible Officers) Regulations 2010. The background to Revalidation has been outlined in previous papers to the board.

Revalidation arrangements have been in place in the Trust since the requirement to revalidate doctors every five years commenced in December 2012.

This paper will outline the progress against plan for Medical Revalidation in the last quarter, against the issues set out in the previous report.

2. Governance Arrangements

The Trust continues to be compliant with the Framework for Quality Assurance (FQA) presented in July 2014. Compliance is Monitored against the Core Standards set out in the FQA and are reported by exception as part of the development plan in Appendix A.

The Trust is achieving 92% of the mandatory and good practice standards set by NHS England in April 2014. The table below shows progress against areas of concern reported in July 2014. A more detailed report will be provided internally to the Workforce and Engagement Committee. Key areas for improvement are the implementation of learning and development programmes for medical appraisers, case investigators and case managers. Quarterly training dates have been set for the next year to ensure that trained appraisers, case investigations and managers have sufficient professional development opportunities.

Core Standards Development Plan- Progress September 2014

	FQA Standard	Progress
1.1.4	The designated body provides the responsible officer with sufficient funds, capacity and other resources to enable the responsible officer to carry out the responsibilities of the role.	
1.1.15	The responsible officer ensures that the designated body's medical revalidation policies and procedures comply with equality and diversity legislation.	
2.2.2	The responsible officer ensures that medical appraisers are recruited and selected in accordance with national guidance (Quality Assurance of Medical Appraisers).	
2.2.6	The responsible officer ensures that medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers)	
2.2.8	The responsible officer ensures that the initial training programme is competency based and those who cannot demonstrate the competencies do not become/are not appointed as medical appraisers.	
2.2.9	The responsible officer ensures that there is an initial review of performance for appraisers covering the first three appraisals followed by an initial review.	
2.2.11	The responsible officer ensures that there is a written role description, person specification and terms of engagement for medical appraisers	
2.2.12	The responsible officer ensures that appraisers have access to regular appraiser assurance groups or networks, which will include agreement about expectations of attendance.	
3.1.18	The designated body's board (or an equivalent governance or executive group) makes provision for the cost and impact of investigating and responding to concerns about doctors' practice	
3.1.28	The responsible officer co ordinates a quality assurance look back process of cases.	
3.1.29	The responsible officer ensures that there are mechanisms are in place to define the success criteria for interventions and processes and to demonstrate that the organisation learns from experience.	
3.2.4	The responsible officer ensures that individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (ref RST guidance)	
3.2.6	The responsible officer ensures that case investigators and case managers have a regular programme of updates and skills development.	
3.2.7	The responsible officer ensures that case investigators and case managers undertake quality assurance of their roles and receive feedback on their performance.	
3.2.8	The responsible officer ensures that case investigators and case managers participate in peer networks to learn and share good practice.	

External Auditors reviewed the process for managing appraisals in September 2014 which was shared with the board in April 2014. A follow-up audit was undertaken in July 2014 to take into account the recently published guidance. The auditors were satisfied that 6 of the original recommendations had been fully implemented. Two recommendations were reopened to ensure implementation of recent changes to the Appraisal and Revalidation Policy.

3. Appraisal and Revalidation Performance Data Q1 2014/2015

A standardised quarterly return was provided to NHS England on 11th August 2014 reporting the following:

- 313 doctors had a prescribed connection to The Dudley Group NHS Foundation Trust for the period between 1st April 2014 and 30th June 2015.
- 41 doctors were due to hold an appraisal meeting within the reporting period of that number, 11 doctors did not complete their appraisal on time.
    - 2 of the 11 overdue appraisals were completed within 15 months, the maximum time allowed by the GMC to complete annual appraisal.
    - 6 of the 11 over due appraisals were due to special circumstances such as sick leave, or moving to another jurisdiction and were acceptable to the Responsible Officer.
    - 3 doctors failed to engage with the appraisal process within the 15 month period and were discussed with the GMC liaison officer.

A copy of the NHS England return is enclosed within the Appendices.

4.1 Appraisers

Following recent trust reorganisation the role of Medical Appraiser has been separated from that of the Medical Service Head role. Appraisers have been recruited from those consultants who have undergone Strengthened Medical Appraisal Training. At present the number of trained doctors who have volunteered to carry out medical appraisers means that we continue to maintain an acceptable ratio of appraisers to appraise as set out in the NHS England Medical Appraisal Policy as well as the Trust's own policy.

4.2 Revalidation Recommendations

The responsible officer made 32 recommendations for revalidation for the reporting period. All recommendations were made by the due date. 30 were positive and there were two deferrals.

Both recommendations have been deferred due to a lack of sufficient evidence contained within the medical appraisal for the Responsible Officer to make a positive recommendation.

APPENDIX 1

	Indicator	**Q1** (1 Apr to 30 Jun)	**Q2** (1 July to 30 Sep)	**Q3** (1 Oct to 31 Dec)
1	**Name of designated body** (or NHS England Area Team or Region) Note: Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	The Dudley Group NHS Foundation Trust		
2	Number of doctors with whom the designated body has a **prescribed connection**	313		
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	41		
3.1	Number of those within #3 above who **held an appraisal meeting** in the reporting period	30		
3.2	Number of those within #3 above who **did <u>not</u> hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	11		
	Data entry checker			
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	6		
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either <u>not</u> understood or accepted by the RO**	5		
	Data entry checker			
4	**Any Comments** you wish to raise (e.g. new RO, new appraisal lead etc.):	Doctors where reason is not accepted with RO(5): 3 non engagement, 2 late and completed over 15 months		

APPENDIX 2

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 30th June 2014	
Recommendations completed on time (within the GMC recommendation window)	32
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
Deferrals	2

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 2nd October 2014

TITLE	**Performance Report April – July 2014**		
AUTHOR	**Paul Assinder Director of Finance and Information**	**PRESENTER**	**David Badger Committee Chairman**
CORPORATE OBJECTIVE: SG06 Enabling Objective			
SUMMARY OF KEY ISSUES: • Deficit of £1.6m in August (£0.2m worse than plan) • Deficit of £4.9m for year to date, (£1m worse than plan) • Deficit budget for 2014-15 of £6.7m likely to be exceeded, with a forecast of £10m deficit now declared • A&E 4 Hours waiting time met in August and for Quarter 2 to date • Some RTT waiting time pressures but targets being me			

RISKS	**Risk Register**	**Risk Score Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in Q1 and risk for the year in total. Monitor has notified the Trust that it is investigating A&E performance in the Trust.** **Financial deficit above Monitor plan now forecast**
COMPLIANCE	**CQC**	**Y**	**Details:** **The Trust is awaiting a report from the Chief Inspector of Hospitals following an inspection in the Spring. This is subject to appeal.**
	NHSLA	**N**	
	Monitor	**Y**	**Details:** **The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS) at Q1. The Trust remains on monthly monitoring by Monitor.** **Monitor has notified the Trust that it is**

			investigating A&E performance in the Trust and its long term business viability.
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners**

ACTION REQUIRED OF COUNCIL

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report

The Dudley Group NHS
NHS Foundation Trust

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

Report on Finance and Performance for April to August 2014

1. Background

The Finance & Performance Committee of the Board met on 25th September 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 Board will wish to note the following matters:

2. Financial Performance for the 5 months period April to August 2014 (Appendix 1)

The Trust has had a difficult start to the year following the Board of Directors agreement to a 24 months balanced budget, with a planned deficit of £6.7m in 2014-15.The first quarter showed a trading deficit of £3.9m which was £1.3m worse than plan, although the position improved in July.

For August the Trust posted a monthly deficit of £1.6m, £0.2m worse than plan.

Thus for the 5 months period to August a cumulative deficit of £4.9m is recorded. Key variances include income at +£1.7m (+1.3%); Non Pay -£-1.6m; CIP not achieved -£1.1m.

These adverse trading trends are largely the result of the following factors:

- **Our inability to meet elective activity targets, resulting in significant loss of income from commissioners (Appendix 1)**
  For the period to date planned elective in patient activity is some 10% lower than in 2013-14.

- **Significant increases in emergency activity levels above plan (Appendix 1)**
  Of note is that despite significant investment in primary based care in the Borough, A&E attendances this year are 8% higher than 2013-14 and Emergency Admissions to the Hospital are 6% higher than last year.

- **Continued spending above budget on agency & locum front line medical & nursing staff**
  In spite of an active UK and overseas recruitment drive, the Trust has incurred additional expenditure of £3.2m on agency and locum staff during the period. The Board will also be aware that a principal component of the planned deficit in 2014-15 is a £3.1m investment in additional registered nurses, thus increasing vacant posts.

- **A slower than anticipated start to turnaround savings.**
  The Trust has set itself a very ambitious programme of savings which need to be delivered in 2014-15 (even to deliver a planned overspend of £6.7m). Whilst plans are mainly 'back ended' to deliver greater contribution later in the year, there is already significant slippage of £1.1m. The Board of Directors will need to pay particular attention to the achievement of much higher monthly savings targets in future months if budgets are to be met.

  The Committee considered a report from the Turnaround Team, on the activities of the Team. Progress on the following schemes, referred to Level 1 Escalation was considered:

  - Length of Stay
  - Out Patients
  - Managed Services
  - Coding
  - Workforce

  None were considered likely to have to be escalated further. Forecast outturn of turnaround in 2014-15 was stated as £9.8m (90% of Plan) of which £3.8m c30% had been achieved to date.

The Trust is now forecasting a deficit of £10m for 2014-15.

At 31st August 2014 the Trust had cash reserves of £21.8m (£23.5m in July) and 11.8 days liquidity (13.2 previously).

Capital spending for the period was £2m (£0.7m Medical Equipment, £0.2m IT, £0.5m PFI Lifecycle), some £0.5m below plan.

3. Working Capital Facility

The Committee agreed the 12 months renewal of a £10m banking facility with Barclays Ltd.

4. Performance Targets and Standards (Appendix 2)

The Trust's non financial performance for the period remains relatively strong. Performance against the Monitor Governance KPI set is given at Appendix 2.

The Board will wish to note the following matters:

a) A&E 4 Hour Waits

Quarter 2 has started off very strongly with July's performance measured at 96.9%, and August at 97.2%with the new quarter currently standing at 97%.

b) Never Events

The Trust had no 'never events' in August or for the period to date.

c) Referral to Treatment Waiting Times

Once again the Trust only just achieved the RTT for admitted patients due to the pressure of increased emergency admissions, performance of 90.31% against a 90% target. However, the operational Divisions are confident that all specialties apart from Urology will be back within target by September. For August the specialties that were still under target were Urology, T&O, Ophthalmology, Paediatric Surgery, Plastics and Oral Surgery.

It is worth highlighting that both the RTT non-admitted and incomplete pathways KPIs are both well within their thresholds, with performances of 98.9% and 95.9% respectively

d) Diagnostic Waits

The diagnostic waiting target of 6 weeks was missed in August (95.5% compliance v 98% target). 251 patients waited over 6 weeks of which 208 were for non obstetric ultrasound. The Committee considered rectification plans from the Division.

5. Divisional performance Review

The Committee considered the first performance presentation from the Division of Surgery. Discussion of Turnaround activities, I&E performance, activity and target performance, workforce were discussed, as well as their forward plans.

6. Cancer Peer Review Reports

The largely very positive reports of the National Cancer Peer Review Programme external peer review visits was discussed.

PA Assinder
Director of Finance & Information

THE DUDLEY GROUP NHS FOUNDATION TRUST

INCOME & EXPENDITURE SUMMARY 2014/15 as at AUGUST 2014

Current Month Plan £000	Current Month Actual £000		Annual Plan £000	Plan to Date £000	Actual to Date £000	Variance to Date £000
		Income				
23,304	23,125	NHS Clinical Revenue	289,085	120,407	120,648	240
5	2	Private Patient	57	24	24	0
662	599	Other Non Mandatory	6,475	3,090	4,049	959
51	55	Research & Development	704	346	589	243
807	934	Education & Training	9,014	3,712	3,758	47
41	49	Car Parking	489	204	241	37
15	15	Accommodation	96	58	58	0
296	316	Non Patient Services to Other Bodies	3,570	1,496	1,562	66
187	290	Miscellaneous Other	3,164	1,316	1,463	147
25,368	**25,385**	**Total Income**	**312,654**	**130,652**	**132,391**	**1,739**
		Expenditure				
(2,275)	(2,461)	Drug Costs	(26,793)	(11,389)	(12,657)	(1,268)
(2,248)	(2,232)	Clinical Supplies	(27,289)	(11,376)	(11,673)	(297)
(386)	(383)	Non-Clinical Supplies	(3,890)	(1,775)	(2,048)	(273)
0	0	Secondary Commissioning	0	0	0	0
(15,767)	(15,913)	Employee Benefits (Permanent)	(190,680)	(78,527)	(75,842)	2,685
(15)	338	Employee Benefits (Agency/Locum)	(1,299)	(561)	(3,211)	(2,649)
(76)	(89)	Research & Development	(961)	(426)	(477)	(51)
(46)	(30)	Education & Training	(617)	(241)	(200)	41
(80)	(153)	Consultancy Expense	(662)	(398)	(649)	(251)
(1,864)	(1,948)	Miscellaneous Other	(21,869)	(9,511)	(9,315)	196
(2,930)	(2,930)	PFI Unitary Payment	(39,267)	(16,361)	(16,361)	0
1,311	1,311	IFRIC12 PFI Adjustment	17,571	7,321	7,321	0
(780)	(631)	Other PFI Expenses	(7,110)	(2,967)	(2,750)	216
275	0	CIP Requirement	6,351	1,093	0	(1,093)
(24,882)	**(25,120)**	**Total Expenditure**	**(296,517)**	**(125,118)**	**(127,862)**	**(2,744)**
486	**265**	**Surplus/(Deficit) EBITDA**	**16,137**	**5,534**	**4,529**	**(1,005)**
		Other				
0	0	Profit/(Loss) on Disposal	20	20	20	0
0	0	Impairment	0	0	0	0
(750)	(749)	Depreciation	(9,137)	(3,754)	(3,794)	(40)
0	2	Donated Assets	0	0	118	118
12	10	Interest Receivable	140	58	55	(3)
(1,170)	(1,169)	Interest Payable	(13,888)	(5,826)	(5,824)	2
(1,908)	**(1,905)**	**Total Other**	**(22,865)**	**(9,502)**	**(9,426)**	**77**
(1,422)	**(1,640)**	**Net Surplus/(Deficit)**	**(6,728)**	**(3,968)**	**(4,896)**	**(928)**

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

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

Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold	Weighting	Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements							N/A
INFECTION CONTROL (SAFETY)							
HCAI - Clostridium Difficile - meeting the C Diff objective	48	1.0	7	8			**15**
CANCER WAIT TARGETS (QUALITY)							
Max waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	1.0	96.9	96.3			**96.8**
Max waiting time of 2 weeks from urgent GP referral to date first seen for symptomatic breast patients.	93%		97.3	93.5			**96.3**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	1.0	99.7	100			**99.8**
Maximum waiting time of 31 days for second of subsequent treatments – Anti Cancer Drug Treatments	98%	1.0	100	100			**100**
Maximum waiting time of 31 days for second of subsequent treatments – Surgery	94%		98.2	100			**98.9**
Maximum waiting time of 31 days for second of subsequent treatments – Radiotherapy	94%		N/A	N/A	N/A	N/A	N/A
Maximum two month (62 days) wait from referral to treatment for all cancers – Urgent GP Referral to Treatment	85%	1.0	88.1	86.8			**88.2**
Maximum two month (62 days) wait from referral to treatment for all cancers – From National Screening Service Referral	90%		100	100			**100**
							**Contains un-validated data for July*
A&E (QUALITY)							
% Patients Waiting Less than 4 hours in A&E	95%	1.0	92.1	97.0			**94.1**
REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)							
RTT – Admitted % Treated within 18 weeks	90%	1.0	90.1	90.2			N/A
RTT – Non-Admitted % Treated within 18 weeks	95%	1.0	99.2	99.1			N/A
RTT – Incomplete pathways % waiting within 18 weeks	92%	1.0	94.7	95.9			N/A

Community Services (Effectiveness)							
Referral to treatment information	50%	1.0	98.0	99.0			N/A
Referral information	50%		64.9	65.7			N/A
Treatment activity information	50%		99.5	100			N/A

Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold & Weighting	Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements						N/A
PATIENT EXPERIENCE						
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Yes/No 0.5	Yes	Yes			N/A
Risk of, or actual, failure to deliver mandatory services	Yes/No 4.0	No	No			N/A
CQC Compliance action outstanding	Yes/No 2.0	No	No			N/A
CQC enforcement notice currently in effect	Yes/No 4.0	No	No			N/A
Moderate CQC concerns regarding the safety of healthcare provision	Yes/No 1.0	No	No			N/A
Major CQC concerns regarding the safety of healthcare provision	Yes/No 2.0	No	No			N/A
Unable to maintain a minimum published CNST level 1.0 or have in place appropriate alternative arrangements	Yes/No 2.0	No	No			N/A

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.

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.

Ann Baines – Director of Strategy and Performance

Description to follow.

Photograph to follow

Julie Cotterill – Associate Director of Governance

Julie is responsible for establishing and maintaining the highest levels of corporate governance and manages the interface between the Board of Directors, Council of Governors and Members to ensure that effective relationships are established and maintained and for ensuring the Trust complies with relevant legislation and the Terms of Authorisation issued by the Regulator (Monitor). She also has operational responsibility for the management of an effective governance team supporting complaint management and incident reporting and investigation, risk management Clinical Audit and Compliance.

Photograph to follow

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