The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 2nd May 2013 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion/decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – P Assinder, A Reeves**		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 April 2013	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 4th April 2013	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Enclosure 3	D Mcmahon	To Note & Discuss	9.40
6.	**Chief Executives Overview Report**	Enclosure 4	P Clark	To Discuss	10.00
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 5	D Bland	To Note	10.10
	7.2 Francis Report	Enclosure 6	D Mcmahon	To Note & Discuss	10.20
	7.3 Infection Prevention and Control Exception Report	Enclosure 7	D Mcmahon	To Note	10.30
	7.4 Nursing Strategy	Enclosure 8	D Mcmahon	To Approve	10.40
	7.5 Quality Accounts	Enclosure 9	D Mcmahon	To Approve	10.50
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 10	D Badger	To Note & Discuss	11.00
9.	**Corporate and Strategic**				
	9.1 Research and Development Report	Enclosure 11	P Harrison	To Note	11.10
	9.2 Non Executive Director Lead Responsibilities Report	Enclosure 12	J Edwards	To Approve	11.20
	9.3 Listening into Action Update Report	Enclosure 13	J Dietrich	To Note	11.30
10.	**Date of Next Board of Directors Meeting** 9.30am 6th June, 2013, Clinical Education Centre		J Edwards		11.40

11.	**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		11.40

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 4th April 2013 at 9:30am in the Clinical Education Centre.

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

In Attendance:
Helen Forrester, PA
Elena Peris-Cross, Apprentice
Tessa Norris, Associate Director for Community Services and Integrated Care
Liz Abbiss, Head of Customer Relations & Communications
Annette Reeves, Associate Director for Human Recourses.
Anaesthetic Registrars
Becky Edwards, Deputy General Manager
Rob Game, General Manager
Jeff Neilson, Clinical Director

13/001 Note of Apologies and Welcome

Apologies were received from the Medical Director and it was noted that David Perks was in attendance in his role as Assistant Medical Director.

13/002 Declarations of Interest

There were no declarations of interest.

13/003 Announcements

The Nursing Director informed the Board that there will be a new nursing strategy called 'How we Care' The new strategy will launched on the 7th May 2013, by Jane Cummings, Chief Nurse, Department of Health. The Nursing Director went on to announce Sara Davis, Ward Manager had won Nursing Ward Sister of the Year, and Sara exemplifies the spirit of the strategy.

The Chairman thanked Sara on behalf of the Board and presented her with a locally made glass vase which had been purchased with personal contributions from all Trust Board members.

Sara Davis thanked the Board and said she could not have achieved the award without her team and support from managers, she added that she was proud to work at The Dudley Group.

13/004 Chief Executive's Overview Report (Enclosure 1)

The Chief Executive presented her overview report, given as Enclosure 1. Board members noted the following items:

- **Friends and Family Report**: February was a difficult month for the organisation however in March the report showed the Trust had moved back into the green. The Trust took part in a national readiness review which showed we were in a good position to implement the new friends and family test. The programme will be commenced across the Trust including, for the first time, within A&E from April 1st.
- **Capacity Pressures:** The Trust had escalated to Level 4 on a number of occasions over the last few weeks. The pressure on the system has not eased and we saw a very busy Easter weekend along with the Launch of the 111 service having effect in March. The recent capacity issues have been seen across the country.The Trust is expected to miss the 95% A&E target for quarter 4, but is expected to achieve the target for the year as a whole. The increasing age of patients and longer length of stay are the main problems contributing to the capacity issues.
- **Keogh and Mortality Review:** More information was identified by Trust staff from trawling the NHS Choices website. The NHS Foundation Trust Network is working on our behalf to understand and help shape the review at a national level. An overall time table of the review has been received but the actual dates when they will visit the Trust are still unknown. There is an opportunity to make comments on the NHS Choices website. Ann Becke, Non Executive Director asked how the staff morale had been affected in terms of the Mortality review. The Chief Executive informed the Board that staff are ready for the review because they are proud of what we do. It is important to keep the spirits up.
- **CQC unannounced visit:** The very positive report from the CQC's unannounced visit is on the CQC website and is being made available on the Trust's website and the Hub.

13/005 Quality

13/005.1 Clinical Quality, Safety and Patient Experience Committee (Enclosure 2)

David Bland, Committee Chair, presented the Exception Report given as Enclosure 2; the Board noted the following key issues:

- **Matters arising:** The Head of Radiology attended the last meeting, his presentation was very useful.
- **Mortality Report:** The Committee spent a lot of time assessing why the indices had fallen, it was highlighted that a lot of work had been done in this area by the Medical Director and his deputy. The Board noted the positive direction of the 7 mortality indices.
- **Emergency Department National Survey Results Update:** The survey showed positive results.

David Badger, Non Executive Director suggested that the Board reflects on the information showing a consistent downwards trend.

The Chairman asked if the end of life care statistics were national.

David Bland confirmed they were national and that the Trust was fairly typical against the figures.

The Chairman asked for clarification on the acronym MUST.

The Chief Executive informed the Board that MUST stood for the malnutrition universal screening tool.

The Nursing Director added that this was an initial assessment of patient's requirements and is repeated periodically

The Board noted the report and the issues arising.

13/005.2 Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Enclosure 3)

The Nursing Director presented the report given as Enclosure 3 to note and discuss.

The Nursing Director informed the Board that five key changes had been highlighted from the report. The Boards action to date is as follows:

- Board members referred to recommendations of the report in the February Board meeting.
- Statement of acceptance issued at the same meeting
- Press comment on Mid Staffs report
- Briefing paper issued to the Council of Governors
- Key themes booklet prepared
- Schedule of recommendations
- Patients first and foremost government response to the Francis report brought to the April Board meeting

The Nursing Director informed the Board that the "Patients First and Foremost" Government response to the Francis report has a number of recommendations that the organisation needs to consider. Standards and a code of conduct have also been published for care assistants.

Richard Miner, Non Executive Director said the Government's response to the findings of the report represents a complete change of culture; it is unclear if this is a national or local cultural shift.

The Nursing Director commented that there needs to be a national change in mechanisms of how organisations work. However the Trust can do things locally within our own organisation which will make a positive change to our culture. These changes will include ensuring that our ward sisters and Matrons spend even more time on the wards looking at patients and continuing work on embedding our vision and values.

The Chief Executive reminded the Board that the culture in the Trust is our responsibility and we must continue the work started before the Francis report was published. Of the 290 recommendations in Francis 2, not many apply directly to acute providers however we are picking up the ones that do and are acting on them.

David Badger, Non Executive Director felt he was encouraged by the report as it was consistent with the Trust's values. We must ensure we have strong leadership and involve clinical staff into the leadership of the organisation.

The Chief Executive informed the Board that the Executive Team are working with the Hay Group to develop and refine our leadership strategy. The engagement from right across the Trust, including clinical colleagues is positive.

The Nursing Director mentioned the conversations in the media about untrained care support workers, and confirmed that all of the Trusts care support workers had been trained.

13/005.3 Infection Prevention and Control Exception Report (Enclosure 4)

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

C.Diff: At the end of the financial year the Nursing Director was pleased to report there had been a reduction to 55 C.Diff positive toxins cases against 113 cases last year, more than a 50% improvement. The ceiling for this year was 77 cases however for the new financial year from the 1st April the ceiling will be down to 38.

MRSA: There were no cases of MRSA to report this month bringing the figure at the end of the financial year to 1 case against the target of 2

Norovirus: There were no cases of Norovirus to report.

Ann Becke, Non Executive Director asked if the hydrogen peroxide fogging machine was having a positive effect on infection control.

The Nursing Director confirmed that it did have a positive effect; the team use it a lot and test before and after for spores and see significant improvements in the results. In addition the infection Control team are now working 7 days a week instead of 5.

The Chairman noted there were no cases of C.Diff in February and queried if we understood why and how are we dealing with Norovirus so well compared to other trusts.

The Nursing Director clarified that it is multifactoral; the team make sure they address all contributions to the spread of infections, isolate patients and areas quickly and ensure good simple procedures are followed.

The Chairman asked the Nursing Director to express the Board's thanks to the care givers for the continuing improvements. However we will need to increase the rate of improvement to meet the, very challenging, new target

The Deputy Medical Director suggested we put these good results onto the Hub for staff to see.

The Board noted the positive Report.

Express the Boards thanks to the care givers for the ongoing improvements being made in infection control

13/006 Finance

13/006.1 Finance and Performance Report (Enclosure 5)

The Director of Finance and Information presented the summary of papers received by the finance and performance committee given as Enclosure 5.

The positive green figures that were seen on Performance Reports across the Trust places The Dudley Group amongst the strongest performers in Birmingham and the Black Country.

Monitor has rated the Trust 'Good' for Governance which is the top mark and 3 out of 4 for Finance.

The Director of Finance informed the Board that the Trust was lying at 14th place out of 46th in the SHA's 'League Table' of NHS providers.

The Board noted that there was a dip in performance for the 4 hour wait target. This is a reflection of pressures that the whole of the provider network have been experiencing recently.

In Appendix 3 of the Report the Board were shown that the Trust met or exceeded the Monitor standards targets for the period. It is expected the Trust will meet the targets for the Year end.

At Appendix 4 the Board noted that the Trust's standardised hospital mortality indicator (SHMI) score of 1.04 is within the acceptable range.

The Director of Finance and Information presented the income and expenditure position of the trust shown at appendix 5. The Board noted the Following information:

- In February the Trust made a trading surplus of £361,000, the aggregated £2.4 million surplus is ahead of plan.
- NHS Dudley has given the Trust a 'one off payment' of £3 million, reflecting the ongoing pressure the Trust is facing. The additional income is likely to result in the Trust posting a forecast surplus of £3.7 million for this financial year.

The Director of Finance and information informed the Board that the Finance and Performance Sub Committee's main concern was carrying an underlying overspend of £2 million into the new financial year. The Director of Finance assured the Board that the Trust remains in a good financial position but he is concerned over the financial position for the new year with the underlying overspend.

David Badger, Chair of the Finance and Performance Committee, added, this year has been difficult financially as the Trust continued to face the pressure, in particular in Emergency Care. The positive financial position at the year end is due to the late support of NHS Dudley making available winter pressures money. He expressed his concern that the Trust is operating with a recurrent budget level that has a built in £2 million overspend.

Ann Becke, Non Executive Director asked how optimistic we were on working with our PFI partners to make savings.

The Director of Finance and Information clarified that the Committee and the Contract Efficiency Group (CEG)had been working on savings from the PFI agreement. However we had still to see actual savings being achieved from within the PFI agreement.

13/ 007 Corporate and Strategic

13/007.1 Dementia Report (Enclosure 6)

The Clinical Director, General Manager and Deputy General Manager for Specialty Medicine attended the meeting to present the Dementia Report given as enclosure 6.

The Director of Operations and Transformation reminded the Board that is was agreed a thematic review of the Dementia Services that the Trust currently offers will be undertaken.

Becky Edwards, Deputy General Manager informed the Board that the Directorate had implemented a 3 point plan to improve the Trust's Dementia Services.

- Strand 1: Improving identification and diagnosis of patients with Dementia
- Strand 2: Care and Treatment of Patients
- Strand 3: Environment

The Team found that in 6 months of running the three part screening process of Strand 1, parts B and C are performing well however part A is still not achieving the 90% target. The process is being reviewed with a view to simplifying it for staff.

Becky Edwards informed the Board that the CQUIN targets for the new operational year included a questionnaire for patient's family members to make sure we give them full support.

The Chairman asked the Team to clarify what the acronym RAID stood for.

The Team clarified RAID stood for Rapid Assessment Interface and Diagnosis.

David Bland, Non Executive Director asked what barriers were occurring at strand 1.

Becky Edwards commented that strand 1 was moving in the right direction, a graduate trainee is now in place to ensure there are not any data issues.

Rob Game, General Manager informed the Board the issue is around how the information is recorded.

Jonathan Fellows, Non Executive Director asked the Team if they had received any feedback on why the bid for a project lead to develop a capital proposal for the creation of a dementia inpatient unit was unsuccessful.

Becky Edwards clarified that this was due it being a health economy wide bid and there were issues with the geographical spread of the current inpatient Dementia Units.

The Chief Executive suggested we look at this through our estates strategy and possibly using charitable funds to fund the unit. The Chief Executive pointed out that there are issues at both ends of the care pathway in relation to care placements breaking down and behaviour of patients causing delays. We need to be sure that a dementia unit would address these issues.

The General Manager informed the Board that to address care placement issues and delays in care from happening, the single assessment process must be used effectively and access to a crisis bed out of hours must be made. A welfare nurse is now operating in ED which should help to address delays.

The Deputy Medical Director pointed out that he had seen the City and Sandwell RAID presentations and thought they were impressive, they reduce the length of stay and make savings. He went on to ask if the Dudley Group are seeing a reduction in the length of stay. The General Manager confirmed that they had seen small improvement in this area.

The Director of Operations and Transformation informed the Board that the RAID model is resource heavy.

David Badger, Non Executive Director thanked the Deputy General Manager for the good report and asked if CCG has a dementia strategy

The Director of Operations and Transformation confirmed the CCG does have a Dementia Strategy however it does not pick up elements of the patients care in a care setting other than primary care..

David Badger added that the Trust's Dementia Strategy must fit in with the strategy of other partners in the Health Economy.

The Chairman noted the issues from the report including the issues with assessments of patients, appropriate setting for care and the decline of the Trusts capital bid for £400,000.

13/007.2 Board Secretary's Report (Enclosure 7)

The Board Secretary presented his report given as Enclosure 7 including the following key issues:

- **Trust Constitution:** The Board Secretary informed the Board that the Trust Constitution had to be amended following the 2012 Health and Social Care Act, the Board were asked to approve the amendments. The Board approved these changes.
- **Licensing of NHS Foundation Trust:** The Board noted the licensing of NHS Foundation Trust runs from 1st April for 3 years. In Section 1 of the document there is a 'fit and proper 'person test that Governors must complete. In the small print of the document there is provision for Monitor to levy fees on Foundation Trusts. The Trust Secretary pointed out that notification of the fees had not been received.

Jonathan Fellows, Non executive Director queried if the Annual Declaration mechanism will be used for the Governor Fit and Proper Person Test.

The Board Secretary confirmed the Governors will undertake the fit and proper person test as part of the annual declaration.

The Chairman noted the issues of the report and the Board approved changes to the Trust Constitution.

13/008 Any Other Business

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

13/09 Date of Next Meeting

The next Board meeting will be held on Thursday, 2nd May, 2013, at 9.30am in the Clinical Education Centre.

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

Date ………………………………………………………………………………………………

PrivateBoardMinutes4thApril2013

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 4 April 2013
PRIVATE

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
13/005.3	Infection Prevention and Control Exception Report	Express the Board's thanks to the care givers for the ongoing improvements being made in infection control.	ND	2/5/13	Done

Enclosure 3

16th April 2013

Dear

I was recently an in- patient for 5 days on A1 under the care of Consultant Rheumatologist. Following my in-patient stay I felt compelled to write to you regarding my admission.

On a day to day basis I see how hospitals work from the other side. I see my side of medical and nursing care, I listen to complaints and praise from patients, but I have never experienced the NHS from the other side - the side of the patient.

I have to say I was only pleasantly surprised. The staff on A1 are probably amongst some of the best nursing staff I have encountered in my medical career. ward manager, took time personally to introduce herself to all her patients and talk through any concerns that the patients may have. She spoke to every patient on the ward daily, and was available for any questions or concerns. It felt reassuring to see that someone was co-ordinating all the activity on the ward and that I knew I could approach her if I had any queries.

I also had brilliant nurses looking after my daily nursing needs. In particular I would like to mention and They didn't treat me like a patient or like a sick person. They treated me like a human, like a person who had fears and concerns. They took time during their busy shifts to talk to me, not just about my medical problems, but to get to know me as a person. For some reason this surprised me. I was never a number or a condition to them. All the nursing staff made me feel comfortable and at ease and I can assure you I wasn't the easiest patient to look after!

I watched those nurses run around all day and night, looking extremely busy, but always felt that patient care came first. You should be truly proud of the outstanding A1 team, and how they make their patients feel.

I would also like to mention the staff in A&E. My patient journey started there. It was very difficult for me to be on the other side - to be the sick person, and not the doctor. I know this didn't make me an easy patient from the start, but again the A&E staff were excellent. Again they were extremely busy, but there was always someone on hand to help me, reassure me and provide me the assistance I needed. [redacted] and [redacted] in particular took great care of me.

My letter wouldn't be complete without mentioning the excellent medical care I received from Dr [redacted] and her medical team, [redacted] [redacted] and [redacted]. Dr [redacted] saw me very promptly in A&E with her registrar [redacted]. They showed great patience with me, understood my concerns but at the same time never let my medical care be anything less than a priority. They worked as a team to provide the best care for their patient and this care has continued even as an out patient. I really can not thank them enough, Dr [redacted] in particular, for the time they have taken to look after me.

As a surgical registrar I only see too often how patients are quick to complain about their care in hospital. I can honestly say I was pleasantly surprised by the excellent medical and nursing care I received in your hospital. I really felt your outstanding teams deserved a mention, and that you should be aware of the truly dedicated staff that you have.

Kind Regards

[redacted]

Surgeon, but patient this time!

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 2nd May 2013

<table>
<tr><td>TITLE:</td><td colspan="4">Chief Executive's Report</td></tr>
<tr><td>AUTHOR:</td><td colspan="2">Paula Clark</td><td>PRESENTER</td><td>Paula Clark</td></tr>
<tr><td colspan="5">CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5</td></tr>
<tr><td colspan="5">SUMMARY OF KEY ISSUES:
• Friends and Family Report
• Keogh Review into Mortality Indicator Outliers - update
• NHS England Business Plan
• CQC Strategy for 2013-16
• Emergency Ambulatory Care Network</td></tr>
<tr><td colspan="5">IMPLICATIONS OF PAPER:</td></tr>
<tr><td rowspan="2">RISK</td><td colspan="2">N</td><td colspan="2">Risk Description:</td></tr>
<tr><td colspan="2">Risk Register:
N</td><td colspan="2">Risk Score:</td></tr>
<tr><td rowspan="5">COMPLIANCE and/or LEGAL REQUIREMENTS</td><td>CQC</td><td>N</td><td colspan="2">Details:</td></tr>
<tr><td>NHSLA</td><td>N</td><td colspan="2">Details:</td></tr>
<tr><td>Monitor</td><td>N</td><td colspan="2">Details:</td></tr>
<tr><td>Equality Assured</td><td>N</td><td colspan="2">Details:</td></tr>
<tr><td>Other</td><td>N</td><td colspan="2">Details:</td></tr>
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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 – May 2013

Friends and Family Report:
The new Friends and Family Test commenced on the wards and in A&E at the end of March in readiness for 1st April 2013.

As at April 23rd, wards were reaching 20% of footfall but A&E is still struggling at <1%.

Anecdotally a low A&E response appears to be the case in many Trusts. The Clinical Quality, Safety and Patient Experience Committee has agreed that the Trust will look into a text survey option to try to increase response rates.

Keogh Review into Mortality Indicator Outliers:
We have been notified that the Rapid Responsive Review will take place on three days between 7th and 9th May. The team will be led by Ruth May, Director of Nursing for the region. The agenda and details of the process are as yet unknown. The data pack from Sir Bruce Keogh's office about the Trust, and which will be published on NHS Choices, will be with the Trust early in the week commencing 29th April. We will have an opportunity to comment on this prior to publication. The Key Lines of Enquiry that will be followed by the Review team will not be with us until later in the same week, although we have been promised receipt 48 hours prior to the visit itself to enable us to review them.

We are told that the Risk Summit from the first batch of reviews will take place once they are all completed but the final report will not be published until mid July.

The Board and Council of Governors will be kept informed as we get more information.

NHS England Business Plan:
NHS England has published its business plan for the next three years, with the organisation unequivocal about the challenges ahead for the service. It confirms that progress will be measured against eleven areas on a 'Scorecard', which predominantly relate to Friends and Family Test scores and the five domains contained in the Outcomes Framework, but also covers: health inequalities; NHS Constitution rights and pledges; staff survey results; and financial management. Moreover it highlights the "ambition...to enable an open, transparent, participative and inclusive NHS that delivers high quality care to every patient, every time." This goes alongside other objectives around organisational culture, patient-centred care, knowledge sharing and partnership working.

A substantial proportion of the document is devoted to consideration of NHS England's operating model, specifically its eight main activities. Key points from each are discussed below:

- **Supporting, developing and assuring the commissioning system** – In the coming year, NHS England commits to: determining clinical commissioning group (CCG) development needs; creation of a CCG 'maturity model'; developing best practice networks; creation of a collaborative commissioning programme; and offering CCG support regarding local delivery. New outcomes and access measures for mental health will be produced in 2013/14, aimed at alleviating variation and facilitating physical and mental health integration. In relation to QIPP, there will among other areas, be 'assumed liberty' for CCGs and activity, quality and cost data will be triangulated. Other areas covered here include: the NHS Commissioning Assembly; publication of a Choice & Competition Framework by July; NHS Standard Contract design; and further refinement of the quality premium. It is hoped at least 80 per cent of planned outcome improvements are delivered by CCGs in 2013/14.
- **Direct commissioning** – The £25.4bn of direct commissioning will be undertaken by the NHS England area teams. Assurances are offered that patients will "experience a seamless and integrated service" where there are overlaps in commissioning

responsibilities. The document points to "the unique opportunity to redefine the role of primary care" through areas such as contracts, transition, workforce planning and revalidation. Furthermore a primary care patient safety strategy will be developed. NHS England will focus upon ensuring "a consistent, robust and evidence-based approach" to specialised service commissioning, with area teams expected to have contracts in place no later than June. Plans for other areas such as dentistry and offender health are covered here.

- **Emergency preparedness** – NHS England will be introducing new arrangements for such incidents in 2013/14, including establishment of Local Health Resilience Partnerships (LHRPs).
- **Partnership for quality** – The document touches on the Francis and Winterbourne View reports, with a commitment that "every aspect of NHS England's work programme is now being reviewed to identify what more needs to be done." 100% of actions outlined in the Government response to Francis and the Winterbourne View concordat should be delivered upon by June 2014. Among the issues covered here are: quality surveillance groups and the national quality board; safeguarding; the concordat with the Local Government Association; partnership agreements with national bodies; and NICE Quality Standards. A Common Purpose Framework is due to be published in May to outline how NHS England "will promote, enable and encourage better integrated care and support across health and social care." Each health and wellbeing board area should have implemented its proposals around integrated care by April 2014.
- **Strategy, research and innovation** – A ten year strategy for the NHS is to be produced in the coming year, aligned with NHS Outcomes Framework domains and covering such issues as inequalities, patient rights, commissioning and primary care. It is confirmed that a framework for major service reconfiguration will be developed, setting out roles and responsibilities. Review of allocations and design of the 2014/15 tariff will also be undertaken. The main elements of Innovation, Health and Wealth need to be embedded across the commissioning system, with CCGs supported to deliver innovative approaches and a Centre of Excellence established to "spread innovation at pace and scale." NHS England will be working on a research and development strategy, which is centred on two themes: coordination of priorities across the service and research charities; and to enhance "the interface with both primary and secondary care providers to ensure research is recognised and facilitated." A Sustainable Development Strategy, produced with Public Health England, will be published in January.
- **Clinical and professional leadership** – Alongside a reiteration of the key points from Compassion in Practice, the business plan discusses a number of areas in this section, including: the publication of a report into seven day services in the autumn; the production of high level principles this spring to inform the Urgent and Emergency Care Review; ensuring both clinical networks and senates "are developing resilient and effective arrangements"; the re-launch of the Equality Diversity Council to support inequality alleviation, alongside a refresh of the Equality Diversity System; and the aims of NHS Improving Quality.
- **World class customer service** – NHS England are clear about how essential information and transparency are to improving customer service across health and care. Initiatives in this area include: outcomes data from national clinical audits to be published for each consultant performing procedures across the ten previously identified surgical specialties from this summer; the introduction of the friends and family test for acute and A&E services from April and maternity services from October; online primary care services available to all by March 2015; 100 per cent of CCGs offering personal health budgets by April 2014; and NHS England will be launching a Customer Services Platform for NHS, public health and social care services.
- **Developing commissioning support** – A strategy "to develop affordable and sustainable commissioning support services" is due to be published in June, which will feature a quality regulation framework. It is intended that by March 2016,

Commissioning Support Units will be "commercially viable and externalised" as part of the "Creation of a diverse and responsive commissioning support market."

The document also includes more detail of how the £95.623bn of funding for NHS England in 2013/14 will be distributed across the system.

CQC Strategy for 2013-16:
The CQC are making radical changes to the way they inspect and regulate services to make sure they provide people with safe, effective, compassionate and high-quality care, and to encourage them to make improvements.

They will make sure that above all else, they are always on the side of people who use care services and always put their interests first.

The changes include:

- Appointing a Chief Inspector of Hospitals, a Chief Inspector of Social Care and Support, and considering the appointment of a Chief Inspector of Primary and Integrated Care.
- Developing new fundamental standards of care.
- Making sure inspectors specialise in particular areas of care and lead teams that include clinical and other experts. Experts by experience (people with experience of care).
- Introducing national teams in NHS hospitals that have specialist expertise to carry out in-depth reviews of hospitals with significant or long-standing problems.
- Improving their understanding of how well different care services work together by listening to people's experiences of moving between different care services.
- Publishing better information for the public, including ratings of services.
- Strengthening the protection of people whose rights are restricted under the Mental Health Act.

The changes will come into effect in NHS hospitals and mental health trusts first. This is because they recognise there is an urgent need for more effective inspection and regulation of these services. They will then extend and adapt their approach to other sectors between 2014 and 2016.

Emergency Ambulatory Care Network (EACN):
Following on from the successful engagement of the Emergency Care Intensive Support Team earlier in the last financial year, the Trust has joined the EACN on their third cohort to learn from the experience of other trusts and to explore how this learning can help us improve our emergency service by increasing the number of patient pathways that can enable patients to be managed out of hospital. A team from the Emergency Department and the Emergency Admissions Unit attended for first workshop on 23rd April.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 2nd May 2013

TITLE:	**Summary of Key issues from the Clinical Quality, Safety & Patient Experience Committee held on 12th March 2013.**		
AUTHOR:	**Julie Cotterill Governance Manager**	**PRESENTER**	**David Bland (NED) CQSPE Committee Chair**

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

SUMMARY OF KEY ISSUES:

Quality Governance Framework Exception Report - this report made reference to a previous submission in November 2012 and the actions arising .Of the remaining 13 items, five further actions had been completed. The Committee approved the removal of a further 3 actions which were being monitored in other forums, leaving five actions on the report. A further report would be received in 3 months time.

Reporting Groups:

New Interventions Group - key issues from the Meeting held on 14th January 2013

- **Sub-tenon Blocks for Cataract Surgery to be performed by Physician Assistants (Anaesthesia)** –The group agreed this was appropriate and in line with National Guidelines and approved the application.
- **Renal Artery Denervation** –. Several issues required clarification prior to approval.
- **Trans Haemorrhoidal Dearterisation** –This NICE approved technique was discussed and approved subject to the provision of a patient information leaflet.
- **Resubmitted Joint Application – Clostridal Collagenase Injections for Treatment of Dupuytrens Contracture** - The application was approved, but required Drugs and Therapeutics Committee approval and a business case prior to commencement.
- **Review of Previous Applications: Endoscopic Therapy for Zenker's Diverticulum (Dr Ishaq)** – Application approved 12 months ago. Full update to be provided after 12 months.

Patient Safety Group - summary of the key issues from the meeting held on 12th February 2013

- **Falls** – Falls Prevention Action Plan was progressing. Falls bundles trialled on B2.
- **Thrombosis Group** – Concerns had been raised about the delivery of the 95% target in 2013/14 due to difficulties capturing data.
- **Hospital Transfusion Committee** –concerns raised regarding Phase 2 of the Blood Track Project (electronic bedside checking and monitoring of transfusions) which had not started. The Committee discussed the implications of the delay and the need to progress the situation or reach a final decision on the use of the equipment as soon as possible.
- **Nutrition Group:** The group discussed the possibility of re-introducing a plated meal service, the need to amend Nursing Care Indicators and the possibility of changing the protected meal time to 12.30pm (a change of ½ hour).
- **Red Incident Assurance and Learning Group** – Dr Harrison had assisted with the engagement of medical staff completing RCA's.
- **Patient Safety Leadership Walk rounds** – There were 28 walk arounds from April 2012 to February 2103. Outstanding actions were being tracked and followed up.
- **Increase in Pressure Ulcers** –Concern raised about the increase in Pressure Ulcers on Ward B2 over the last three months. Skin bundles required review.

Health Records Group - The Health Records Group report was circulated for 'Information Only'.

Infection Control Forum - summary of the key issues from the meeting held on 13th Dec 12

- No key issues or problems raised from the meeting.
- New Terms of Reference had been circulated.
- Mandatory Surveillance was on trajectory to meet the requirements for the year.
- The Trust had one episode of Norovirus in November 2012 and nothing since.
- Facilities Report Cleaning Scores were at good levels with no major concerns.
- Pharmacy Report – Antimicrobial Prescribing Training – Recent data showed that no registrars had undertaken the training. Availability of training was being explored.

Quality Dashboard Report for Month 10 - The overall performance position was very strong for the current list of Quality indicators. 3 indicators were red in January: Maternity: Increase in breast feeding, Maternity: Smoking in Pregnancy and TAL Appointment. "Stroke Patients Spending 90% of Time on a Stroke Unit" had breached in December going down to 79.25%, against the 80% target. The NHS Choices report showed an improvement, however the "Day case rate for Surgery for Dupuytren's contracture" procedure was shown as an outlier.

The Monitor Shadow Indicators highlighted a fall in the 6 week diagnostic KPI which had dropped below the 99% target. There were 133 breaches resulting in performance of 96.8%, with 126 breaches in cardiology resulting from some booking issues where patients had been wrongly categorised as planned attendances. It was anticipated that the new Monitor measures would extend the indicators to be more outcome focused. 7 new measures would be introduced in shadow form from quarter 3. The Trust had reported a Never Event in January 13.

Nursing Care Indicators - NCI's are undertaken in all areas, within the first 14 days of each month and results are published monthly. Quarterly reports are produced for each ward concentrating on the individual criteria areas of underperformance. The Quarter 4 Performance Report showed good results. The Red, Amber, Green (RAG) rating system had been reviewed and all wards were now returning their reports. Fluid balance charts were being audited weekly and monitored throughout the day. Think Glucose criteria had improved across the Trust. Bowel Assessment criteria was marked down if the initial assessment was not made following admission to the Trust. Manual Handling results had fallen this quarter; failure to implement the high risk care plan was the reason for the underperformance.

Paediatrics QA Re-visit - The Head of Medical Education attended the Committee to outline the position with regard to a previous inspection undertaken by the Midland Deanery in November 2012 and the work required prior to a further visit scheduled for 19th April 2013. The Post-Graduate Dean would be attending. The Trust was at risk of losing staff. The Deanery had identified 14 areas of concern to which the Trust had identified and progressed mitigating actions. A mock visit had also been undertaken and further actions identified. The Committee robustly discussed the concerns raised by the Head of Medical Education in respect of the junior doctors working environment and competency to undertake some procedures and focussed on the report actions, issues to be addressed and reporting and monitoring arrangements. The Committee expressed concern at the slow progress in mitigating actions and believed that appropriate triggers should be agreed for future reports. They requested Board assurance prior to the visit in April from the Clinical Director **It was agreed that this would be escalated to the Board**

Serious Incident (SI) Monitoring Report - 15 new incidents were reported – 12 general SI's and 3 pressure ulcers. There were 36 open general SI's (23 under investigation, 6 awaiting assurance that all actions identified from the RCA investigation had been completed, 1 extension granted from the CCG due to police investigation, 3 awaiting additional assurance from the Committee before closure and an additional 3 recommended for closure). Concerns highlighted from the General SI's included falls resulting in a fracture. There was one breach in the 2 day reporting from date of identification and no breaches on completion of RCAs within the agreed time scales. 1 Never Event was reported. All SIs are director led and closure is only recommended when they are satisfied with the RCA.

The Committee discussed the Serious Incident related deaths and queried how these were linked back to discussions at the regular Mortality and Morbidity Meetings. It was agreed that the

reporting arrangements and the role of Mortality and Morbidity Meeting would be discussed **with the Trust Chair.**

Friends and Family Survey Results - highlighted the following issues:

- The Net Promoter Score (NPS) was Amber for February. This would be monitored in March and reviewed.
- There was a significant rise in feedback in February with 35% of inpatients participating in the F&F test. Matrons were now using this information to challenge their staff.
- 51% of respondents gave comments on what could be improved , food slipped into second place with the most requested items for improvement reducing from 13 % in January to 7% with waiting times rising from 3 – 8%.
- Two wards were showing as red and amber on C1 and C3.
- 2013/14 National Roll Out – this had been delayed by one week in ED because of capacity issues.

Quality Strategy - The committee received the amended and updated strategy.

Pressure Ulcer Report – The Committee supported the receipt of a future quarterly Pressure Ulcers report

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 12th March 2013 and refer to the full minutes for further details.

The Clinical Quality, Safety & Patient Experience Committee was established to provide assurance to the Board on Clinical Quality and Safety standards, (including Clinical Effectiveness, Patient Safety and Patient Experience). It sets clear quality performance expectations and ensures the development and delivery of high quality care and continuous improvements through innovation and the use of levers such as CQUINS. It identifies and advises on quality improvement priorities and the organisational learning from these and monitors compliance with Health Standards ensuring the Trust fulfils its obligations with regard to the Health Act (2009) and Monitor in the production of an Annual Quality Account and Report.

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors to be held on 2nd May 2013

TITLE:	**Recommendations arising from the Francis Inquiry**		
AUTHOR:	**Julie Cotterill Governance Manager**	**PRESENTER**	**Denise Mcmahon Director of Nursing**

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

SUMMARY OF KEY ISSUES:

The final report of the Public Inquiry was published on Wednesday 6th February 2013 and made 290 recommendations. Each Chapter opens with a summary of the key themes identified and concludes with a Summary of Recommendations. The Executive Summary of the Report includes the lessons learned and related key recommendations and concludes with a Table of all Recommendations and lead organisations.

The Board received a formal briefing paper at the last meeting concluding with proposed "Next Steps". This report has been prepared in response to this and focuses on the Board review of recommendations arising from the Inquiry.

The attached table of recommendations focuses only on those areas where local action is required or is desirable and can be progressed prior to action by any related third party organisation. At this time, it omits those recommendations identified for specific external organisations/ regulatory bodies. Any local action arising from these will be incorporated into future action plans. Lead Directors have been assigned; progress is being collated and will be reported to the Board of Directors in June 2013.

This will form the basis for all future updates against the recommendations.

IMPLICATIONS OF PAPER:

RISK	Y		Risk Description:
	Risk Register:	**N**	Risk Score:
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	Many of the recommendations made in the report relate directly to these regulatory bodies and changes to their operational processes.
	NHSLA	**Y**	
	Monitor	**Y**	
	Equality Assured	**Y**	Better Health outcomes for all Improved patient access and experience
	Other	**N**	

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
√		√	

RECOMMENDATIONS FOR THE BOARD:

To receive the table of recommendations requiring local action, approve the Lead Directors to take these forward and confirm the future Board reporting requirements

1. INTRODUCTION

The Board received a Francis Inquiry briefing paper at the last meeting which concluded with proposed "next steps". This report has been prepared in response to this and focuses on the Board review of recommendations and the identification of action at a local level.

2. REPORT RECOMMENDATIONS

2.1 The final report of the Public Inquiry published on 6th February 2013 made 290 recommendations. Each Chapter opens with a summary of the key themes identified and concludes with a Summary of Recommendations.

Importantly the very first recommendation is for all commissioning, service provision and regulatory organisations in healthcare to consider the findings and recommendations and decide how to apply them in their own work. In addition, each organisation is to announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted. Thereafter at least annually reports are to be published in respect of organisations' progress against action plans.

In response to this, the Chief Executive issued a statement of acceptance of the recommendations in February 2013.

Many of the external organisations also provided initial statements confirming their acceptance of the recommendations and have since issued formal statements. The Governments response – Patients First and Foremost is available on their website.

2.2 Lessons Learned and related key recommendations

The report identified negative aspects of culture in the system which included:

- A lack of openness to criticism
- A lack of consideration for patients
- Defensiveness
- Looking inwards not outwards
- Secrecy
- Misplaced assumptions about the judgements and actions of others
- An acceptance of poor standards
- A failure to put the patient first in everything that is done.

It stressed the need for a "*relentless focus on the patients interests and the obligation to keep patients safe and protected from sub standard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care: frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations.* "

"To achieve this does not require radical reorganisation but re-emphasis of what is truly important

- *Emphasis on commitment to common values throughout the system by all within it*
- *Readily accessible fundamental standards and means of compliance*
- *No tolerance of non compliance and the rigorous policing of fundamental standards*
- *Openness, transparency and candour in all systems business*
- *Strong leadership in nursing and other professional values*
- *Strong support for leadership roles*
- *A level playing field for accountability*
- *Information accessible and useable by allowing effective comparison of performance by individuals, services and organisations.*

2.3 In the body of the report, the related recommendations to address the above areas are grouped according to themes and where possible the organisation responsible for taking them forward.

2.4 The attached table of recommendations focuses only on those areas where local action is required or is desirable and can be progressed prior to action by any related third party organisation / regulator. It omits those recommendations for specific external organisations. Any local action arising from these will be incorporated into future action plans

3. Actions to date

3.1 Where action has commenced progress is shown on the attached table.

4. Conclusion

4.1 The Trust has many existing areas of good practice and implementation of the recommendations will support and enhance the framework in place. Many of the existing initiatives in place across the Trust commenced before the report was issued and reflected the outcome of the first report. This work will build on existing initiatives.

The action plan currently focuses on those areas where local action can commence but as external organisations confirm their responses to the recommendations, it will be amended to incorporate the local actions required to deliver these.

Report to Board May 13 - Francis Inquiry Table of Recommendations requiring Local Action

Rec. No.	Theme	Recommendation	Chapter	Lead Director
	Availability for implementation of the recommendations These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.			
1	Implementing the recommendations	It is recommended that: • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;	Introduction	Board
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.			
4	Clarity of values and principles	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21	Board
	Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.			
11		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements.	20	All

Rec. No.	Theme	Recommendation	Chapter	Lead Director
		Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary.		Director of Nursing / Medical Director
12		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	2	Director of Nursing
	A common culture made real throughout the system – an integrated hierarchy of standards of service No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.			
	Responsibility for, and effectiveness of, healthcare standards			
37	Use of information about compliance by regulator from: • Quality accounts	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	11	Director of Nursing

Rec. No.	Theme	Recommendation	Chapter	Lead Director
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions			
75	Enhancement of role of Governors	The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10	Council of Governors and Chairman
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10	Council of Governors and Chairman
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10	Chairman
80		A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust's constitution.	11	Board Secretary
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11	Board
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10	Human Resources/ Board Secretary
86	Requirement of training of directors	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	10	Board/Human Resources

Rec. No.	Theme	Recommendation	Chapter	Lead Director
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings			
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing
	Enhancement of the role of supportive agencies			
97	**National Patient Safety Agency functions**	Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	17	Director of Nursing
	Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.			
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	3	Director of Nursing
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	3	Director of Nursing
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	3	Director of Nursing

Rec. No.	Theme	Recommendation	Chapter	Lead Director
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	3	Director of Nursing
113	Complaints handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	3	Director of Nursing
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	3	Director of Nursing
115	Investigations	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	3	Director of Nursing
116	Support for complainants	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	3	Director of Nursing
117		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	3	Director of Nursing
118	Learning and information from complaints	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	3	Director of Nursing

Rec. No.	Theme	Recommendation	Chapter	Lead Director
119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	3	Director of Nursing
120		Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	3	Director of Nursing
	Performance management and strategic oversight			
142	Clear lines of responsibility supported by good information flows	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	8	Director of Finance and Information
143	Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	8	Board
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.			
173	**Principles of openness, transparency and candour**	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	22	Board
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person)	22	Medical Director

Rec. No.	Theme	Recommendation	Chapter	Lead Director
		should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.		
175		Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	22	Medical Director
176	Openness with regulators	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	22	Board / Chief Executive
177	Openness in public statements	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	22	Chief Executive
179	Restrictive contractual clauses	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	22	Associate Director of Human Resources
180	Candour about incidents	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	22	All Executives
	Nursing			
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the: – Possession of the appropriate values, attitudes and behaviours; – Ability and motivation to enable them to put the welfare of others above their own interests; – Drive to maintain, develop and improve their own standards and abilities; – Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care;	23	Director of Nursing and Human Resources

Rec. No.	Theme	Recommendation	Chapter	Lead Director
		• Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: – Recognition of achievement; – Regular, comprehensive feedback on performance and concerns; – Encouraging them to report concerns and to give priority to patient well-being.		
191	Recruitment for values and commitment	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23	Associate Director of Human Resources
194		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	23	Director of Nursing
195	Nurse leadership	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	23	Director of Nursing

Rec. No.	Theme	Recommendation	Chapter	Lead Director
199	Key nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient	23	Director of Nursing
	Caring for the elderly Approaches applicable to all patients but requiring special attention for the elderly			
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25	Medical Director
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	25	Director of Nursing

Rec. No.	Theme	Recommendation	Chapter	Lead Director
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations
240	Hygiene	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	25	Director of Nursing
241	Provision of food and drink	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	25	Director of Operations
242	Medicines administration	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	25	Director of Operations
243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director
	Information			
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording	26	Director of Finance & Information

Rec. No.	Theme	Recommendation	Chapter	Lead Director
		of information on first entry • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.		
245	Board accountability	Each provider organisation should have a board level member with responsibility for information.	26	Director of Finance & Information
247	Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	26	Board secretary
248		Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	26	Director of Finance & Information
249		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	26	Board secretary
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	26	Director of Nursing
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26	Director of Nursing

<table>
<tr><th>Rec. No.</th><th>Theme</th><th>Recommendation</th><th>Chapter</th><th>Lead Director</th></tr>
<tr><td>262</td><td>Enhancing the use, analysis and dissemination of healthcare information</td><td>All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them:

• Effective real-time information on the performance of each of their services against patient safety and minimum quality standards;
• Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction.

In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges.

The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.</td><td>26</td><td>Director of Finance and Information</td></tr>
</table>

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd May 2013 - PUBLIC

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

CORPORATE OBJECTIVE: SG01 – To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation

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

IMPLICATIONS OF PAPER:

RISK	Y		**Risk Description:** Infection Prevention and Control
	Risk Register: Y		**Risk Score:** IC010 12 score M005 – 12 score
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 8 – Cleanliness and Infection Control
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance Framework
	Equality Assured	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

GLOSSARY OF INFECTIONS

MSSA

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

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

MRSA

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

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

E Coli

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

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

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

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

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

C difficile

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

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

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

SUMMARY OF WARDS AND SPECIALTIES

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

Report to: Board of Directors

Subject: Infection Prevention & Control Report

Summary:

Clostridium Difficile – Annual Target 77 (Post 48 hrs) - The Trust currently stands at 56 post 48 hr cases (not locked down) which falls within trajectory. The target of 77 cases has been achieved and this is a real improvement on 113 cases in 2011/2012. The Trust has not breached the monthly C.difficile target since November 2012. The target for 2013/2014 is 38 cases; at the time of writing the report one case has been recorded.

C.Difficile Cases Post 48 hours – Ward breakdown:

Ward	Apr '12	May '12	Jun '12	Jul '12	Aug '12	Sep '12	Oct '12	Nov '12	Dec '12	Jan '13	Feb '13	Mar '13	Totals for 12/13	As of 24th April '13
A1	0	0	0	1	0	0	0	0	0	0	0	1	2	0
A2	0	0	3	1	1	1	1	1	2	0	0	2	12	0
A4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B2	0	0	1	0	0	0	0	0	0	0	0	0	1	0
B3	0	2	0	0	0	0	0	0	1	1	0	0	4	0
B4	0	0	0	0	1	0	0	0	0	2	0	0	3	0
B5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B6	1	1	0	0	0	0	0	0	0	0	0	0	2	0
C1	1	0	1	0	0	1	0	2	1	0	0	1	7	1
C3	0	0	0	2	0	0	1	0	1	2	0	0	6	0
C4	0	0	0	0	0	0	0	1	2	0	0	1	4	0
C5	0	0	0	0	0	0	1	0	0	0	0	0	1	0
C6	1	0	0	0	0	0	1	0	0	0	0	1	3	0
C7	2	1	0	0	0	0	1	1	1	0	0	1	7	0
C8	0	0	0	0	0	0	1	0	0	1	0	0	2	0
MHDU	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CCU/PCCU	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Critical Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
EAU	0	0	0	0	0	0	1	0	0	0	0	0	1	0
SHDU	0	0	0	0	0	0	0	1	0	0	0	0	1	0
Total	**5**	**4**	**5**	**4**	**2**	**2**	**7**	**6**	**8**	**6**	**0**	**7**	**54**	**1**

See Appendix 1 & 2 – Board Report (2012/13)

MRSA – Annual Target 2 (Post 48 hrs) - There have been no cases in the last month. The Trust has recorded one case against the annual target of two which is an improvement on two cases recorded in 2011/2012.

Norovirus - There have been no confirmed cases of norovirus in the Trust.

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

Board Report 2012/13 **Appendix 1**

(N13) Clostridium difficile infection

Monthly number of C-Diff cases

Month / Year	> 48 hrs Activity	PCT Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-12	5	7	-28.6%	5	7	-28.6%	9	10
May-12	4	6	-33.3%	9	13	-30.8%	11	12
Jun-12	5	6	-16.7%	14	19	-26.3%	6	8
Jul-12	4	6	-33.3%	18	25	-28.0%	7	9
Aug-12	2	6	-66.7%	20	31	-35.5%	5	6
Sep-12	2	5	-60.0%	22	36	-38.9%	8	9
Oct-12	7	6	16.7%	29	42	-31.0%	16	16
Nov-12	6	6	0.0%	35	48	-27.1%	8	9
Dec-12	8	7	14.3%	43	55	-21.8%	14	14
Jan-13	6	7	-14.3%	49	62	-21.0%	10	11
Feb-13	-	7	-700.0%	49	69	-29.0%	4	4
Mar-13	7	8	-12.5%	56	77	-27.3%	9	10
FY 2012-13	56	77	-27.3%				107	118

The PCT target for Cdiff is 77 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.

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

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

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-12	-	1	-100.0%	0	1	-100.0%	-
May-12	-	0	0.0%	0	1	-100.0%	1
Jun-12	-	0	0.0%	0	1	-100.0%	-
Jul-12	-	0	0.0%	0	1	-100.0%	-
Aug-12	-	0	0.0%	0	1	-100.0%	-
Sep-12	-	0	0.0%	0	1	-100.0%	-
Oct-12	-	1	-100.0%	0	2	-100.0%	-
Nov-12	1	0	100.0%	1	2	-50.0%	1
Dec-12	-	0	0.0%	1	2	-50.0%	-
Jan-13	-	0	0.0%	1	2	-50.0%	1
Feb-13	-	0	0.0%	1	2	-50.0%	-
Mar-13	-	0	0.0%	1	2	-50.0%	-
FY 2012-13	1	2	-50.0%				3

As a Foundation Trust the regulator Monitor measures compliance against the contract with our commissioners Dudley PCT. The target in this contract is 2 bacteraemias.

Monthly number of MSSA cases	MSSA infections		
	Month / Year	Total	Cumulative
	Apr-12	4	4
	May-12	4	8
	Jun-12	4	12
	Jul-12	1	13
	Aug-12	2	15
	Sep-12	5	20
	Oct-12	4	24
	Nov-12	7	31
	Dec-12	5	36
	Jan-13	6	42
	Feb-13	5	47
	Mar-13	4	51
	FY 2012-13	51	

Monthly number of E coli cases	E Coli infections		
	Month / Year	Total	Cumulative
	Apr-12	15	15
	May-12	13	28
	Jun-12	17	45
	Jul-12	14	59
	Aug-12	23	82
	Sep-12	22	104
	Oct-12	30	134
	Nov-12	20	154
	Dec-12	14	168
	Jan-13	19	187
	Feb-13	19	206
	Mar-13	23	229
	FY 2012-13	229	

(N13) Clostridium difficile infections

Monthly number of C.diff cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-13	1	3	-66.7%	1	3	-66.7%	3	4
May-13		3			6			
Jun-13		3			9			
Jul-13		3			12			
Aug-13		3			15			
Sep-13		3			18			
Oct-13		4			22			
Nov-13		3			25			
Dec-13		4			29			
Jan-14		3			32			
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	1	38	-97.4%				3	4

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

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

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

(N1) MRSA infections

Monthly number of MRSA cases

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

As a Foundation Trust the regulator Monitor measures compliance against the contract with our commissioners Dudley CCG. The NHS commissioning board have established a national zero tolerance approach regarding MRSA bacteraemia for 2013/14 onwards.

Monthly number of MSSA cases	MSSA infections		
	Month / Year	**Total**	**Cumulative**
	Apr-13	3	3
	May-13		
	Jun-13		
	Jul-13		
	Aug-13		
	Sep-13		
	Oct-13		
	Nov-13		
	Dec-13		
	Jan-14		
	Feb-14		
	Mar-14		
	FY 2013-14	3	

Monthly number of E.coli cases	E.coli infections		
	Month / Year	**Total**	**Cumulative**
	Apr-13	8	8
	May-13		
	Jun-13		
	Jul-13		
	Aug-13		
	Sep-13		
	Oct-13		
	Nov-13		
	Dec-13		
	Jan-14		
	Feb-14		
	Mar-14		
	FY 2013-14	8	

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd May 2013

TITLE:	**Nursing Strategy**		
AUTHOR:	**Denise McMahon A variety of Nurses/Midwives and their support staff**	**PRESENTER:**	**Denise McMahon**

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

SUMMARY OF KEY ISSUES:

In December 2012 the Chief Nurse of NHS England published a National Nursing Strategy – 'Compassion in Practice'. Further publications in early 2013 were The Mid Staffordshire NHS Foundation Trust Public Inquiry Report and the government's response to the recommendations in that report (Patients First and Foremost: the Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry). When considering the implications for the Trust of these and other changes in the NHS, it was seen to be an opportune time for the nursing and midwifery professions at the Trust to reflect on their purpose, look to what they wish to achieve both now and in the future and to put this down in a short but clear document. As well as looking at these national reports, consideration has been made of the Trust's vision and values and the organisation's overall strategic direction. A series of workshops have been undertaken to involve as many nurses, midwives and their support staff in the construction of the attached. In addition, drafts of the document have been widely circulated for comments. The Board of Directors is asked to approve the strategy and the suggested method of monitoring the strategy that is contained in the document.

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details**: The CQC may use information in the report as part of its ongoing assessments.
	NHSLA	**N**	**Details**: N/A
	Monitor	**N**	**Details**: N/A
	Equality Assured	**Y**	**Details:** Compliant
	Other	**N**	**Details:** N/A

ACTION REQUIRED OF COMMITTEE:

Decision	**Approval**	**Discussion**	**Other**
	✓	✓	

RECOMMENDATIONS FOR THE COMMITTEE
The Board of Directors is asked to approve the strategy and the suggested method of monitoring the strategy that is contained in the document.

The Dudley Group NHS
NHS Foundation Trust

Nursing and Midwifery Strategy

DOCUMENT TITLE:	Nursing and Midwifery Strategy 'The Way We Care'
Originator/Author & Specialty:	Nursing Director
Director Lead:	Nursing Director
Target Audience:	All staff, patients, public and interested regulatory organisations
Version:	0.1
Date of Final Ratification:	2 May 2013
Name of Ratifying Committee:	Trust Board
Review Date:	Feb 2016
Expiry Date:	May 2016
Registration Requirements Outcome Number(s) (CQC)	Standard 16: Assessing and monitoring the quality of service provison
Relevant Documents /Legislation/Standards	The Code: Standards of Conduct, performance and ethics for nurses and midwives. NMC: 2008 Compassion in Practice. DoH/NHS England: 2012 Patients First and Foremost. DoH: 2013 Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England. Skills for Health: 2013
Linked Procedural documents	Trust Forward Plan and Strategic Objectives 2012 Trust Quality Strategy 2013 Trust Clinical Strategy 2013
The electronic version of this document is the definitive version	

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	Contributors:	Designation: Cross section of Nursing, Midwifery and Care Giving staff Executive Team
	Consulted:	Designation: Cross section of Nursing, Midwifery and Care Giving staff Executive Team
	EQUALITY SCREENING	Y Date: 4 March 2013
	EQUALITY IMPACT ASSESSMENT	Full assessment not required

CHANGE HISTORY

Version	Date	Reason
0.1	2013	This is a new document

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

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THE DUDLEY GROUP NHS FOUNDATION TRUST

NURSING AND MIDWIFERY STRATEGY
('THE WAY WE CARE')

(the terms nursing/midwifery used throughout this document include support workers)

1. INTRODUCTION

This strategy is an important part of our overall Trust strategic objectives and links with the Trust Forward Plan, its Vision and Values and other strategies including the Clinical, Quality and Patient Experieince strategies. The primary purpose of the Trust is to deliver high quality care to our patients and service users, and this strategy describes how we intend to develop our nursing, midwifery and support services.

This strategy sets out what we want to achieve and what patients can expect both now and over the next 3 years. Taking into consideration both professional and national standards, it outlines the nursing and midwifery contribution to what patients can expect from the Trust. It also describes a number of underpining aims and actions that will take place from 2013-16.

This strategy will be used by the Trust Board and senior nurses/midwives in their annual plans. These plans will incrementally move us towards the delivery of our vision and will be the method by which we are able to determine organisational, team and individual priorities, develop implementation plans and track progress.

2. STATEMENT OF INTENT/PURPOSE

At a time when there have been some recent national high profile failures in the quality of care, it is opportune to set a compelling vision for the future for our nursing/midwifery services and provide a clear framework for delivering of the Trust's overall vision, priorities in care identified by staff and priorities that meet the public's expectations.

3. SCOPE

The strategy relates to the whole Trust. It uses the Chief Nursing Officer's strategy (Compassion in Practice. NHS Commissioning Board/DoH December 2012), the Mid Staffordshire NHS Foundation Trust Public Inquiry Report (2013) and the Government's intial response (2013) to that report together with the outcomes of a series of workshops at the Trust, attended by four hundred nursing/midwifery/care support staff. With regards to the national influences mentioned above, if further directives or recommendations occur these will be considered and built into this strategy and associated action plan, as appropriate.

4. DEFINITIONS

None

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5. DUTIES (RESPONSIBILITIES)

All nursing, midwifery and care support staff are involved in the deliver of this strategy with the Nursing Director, her team and Matrons taking leading roles.

The overall delivery of the strategy is a personal objective for the Nursing Director and this will be monitored by the Chief Executive. As discussed in Section 6.8. below the detailed action plan that accompanies the strategy will list names of the nursing and midwifery staff responsible for specific actions.

As this is a key strategy for the Trust it will be overseen by the Clinical Quality, Safety and Patient Experience Committee of the Board which will monitor progress and report to the Trust Board of Directors and the Council of Governors.

6. STRATEGY

6.1 OVERVIEW OF SERVICES

The Trust is an integrated service provider offering both acute and adult community services to the local population in Dudley and the surrounding area. There are 1602 nurses and midwives and 662 nursing/midwifery care support staff employed by the Trust.

6.2 OUR VISION AND VALUES

This strategy reflects the Trust's agreed vision and values:

"Our vision is of a highly regarded healthcare provider for the Black Country and West Midlands, offering a range of closely integrated acute and community based services, driven by the philosophy that people matter"

This vision distils into a strong memorable strapline for the staff and patients of *"where people matter"* and drives the pursuit of our three core values of *Care, Respect and Responsibility* each and every day.

It provides the nursing/midwifery contribution to acheiving the Trust's overall strategic goals of:

- To provide the best possible patient experience
- To develop and strengthen strategic clinical partnerships to maintain and
- protect our key services
- To deliver an infrastructure that supports delivery
- To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation

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- To create a high commitment culture from our staff with positive morale and a “can do” attitude

- To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio

6.3 THE SIX Cs

With a consideration of the three core values of the Trust (see above), this nursing strategy has adopted and adapted the ‘Six Cs’ of the national nursing and midwifery strategy. The overall framework of nursing and midwifery at the Trust is seen to be:

Care is our core business, it defines what we do and who we are.
Our role includes helping people to stay healthy, recover from illness and caring and comforting people at the end of their lives. The care we provide includes clinical expertise, compassion and humanity and we are proud to deliver this to a high standard.

Compassion: It is our ability to be compassionate that defines us as decent human beings. To be compassionate requires us to show kindness, respect and dignity for the people we care for. Our ability to do this is how we are judged by the people who receive our care.

Competence: People have a right to expect competent care from us. We have a responsibility to ensure we have the expertise and clinical knowledge to deliver high standards of care.

Communication is central to a successful caring relationship. Listening is as important as what we say and do. We have a responsibility to ensure that our patients’ views and wishes are heard, respected and responded to.

Courage enables us to do the right thing for the people we care for. We are in a privileged position acting to protect the people we care for. We must take responsibility and speak out and challenge when we have concerns or when we witness inappropriate or poor practice.

Commitment: A commitment to the role we have in providing care for people is an essential part of being able to deliver good care. Commitment enables us to provide good consistent care and enables us to strive to make improvements.

These are the building blocks on which actions and monitoring will take place.

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6.4 KEY ACTIONS WE INTEND TO TAKE TO DELIVER OUR STRATEGY

To deliver our vision we have developed key actions based on each of the six Cs:

6.4.1 Care:

- **Nursing Care Indicators (NCIs)**: Continue to develop the NCI system and take action when results fall below agreed standards and ensure the associated measured outcomes of care (tissue viability, nutrition, hydration) form part of the Trust's overall quality priorites as published in the Trust's Quality Report.
- **Dementia:** Enhance the care and management of patients with dementia.
- **Care closer to home:** Continue to prioritise care closer to home for patients so reducing the need for hospital attendance and admission.

6.4.2 Compassion:

- **Learning Disabilities:** Further improve the way we care and manage the individual needs of patients with Learning Disabilities
- **Recruitment:** Develop and implement a recruitment process that ensures employmment is only offered to staff who demonstrate expected values, attitiudes and behaviours
- **End of Life:** Strenghten our services for patients nearing their end of life

6.4.3 Competence:

- **Appraisal/Developing staff:** Ensure that the system for staff having time with managers, assess performance and agree development plans is further strengthened and improved.
- **Leadership:** Build on the success of our present leadership development programmes
- **Skills:** Continue to monitor and improve the skills of staff using agreed competency measures so that all staff can continue to deliver high standards of care.

6.4.4 Communication:

- **Patient Experience:** Further develop our systems of gaining our patients views of the care they receive and taking action when it falls below an expected standard or when improvements are suggested.
- **Carer Support:** Enhance the support and education of carers so that they feel fully involved in the care of their relatives and friends.
- **Access to the Directors:** Continue and develop the systems of the nursing/midwifery voice reaching the Board of Directors.

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6.4.5 Courage:

- **Raising Concerns:** Encourage staff to raise any concerns over care issues
- **Supervision:** Further develop the system of clinical supervision so that staff have a further mechanism of support to encourage the raising of any care concerns.
- **Whistleblowing:** Encourage staff to use the whistleblowing process if and when other avenues of raising concerns are unproductive

6.4.6 Commitment:

- **Codes of Conduct:** Develop systems of ensuring that registered staff are fully aware of and follow their code of conduct. Implement the new code for healthcare support workers and ensure staff are aware of the contents and abide by them.
- **Safeguarding**: Ensure that the concept of Safeguarding of both children and adults continues to be embedded throughout the organisation
- **Customer Care:** Develop further good customer care skills across all groups so that patients are confident in and trust nurse/midwives they encounter during their stay/visit to the hospital

6.5 AGREED INDICATORS TO ASSESS OUR ACHEIVEMENT OF THE ABOVE ACTIONS

6.5.1 Care:

- **Nursing Care Indicators (NCIs)**:

Hospital:
Reduce avoidable grade 4 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50 per cent in 2013/14.
Reduce avoidable grade 3 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.

Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90% of patients will have the weekly risk assessment completed and this will rise to at least 93% by the end of the year (March 2014).

Increase the number of patients having a food recording chart and a fluid balance chart in place if the MUST score is 1 or above. Through the year on average at least 90% of patients will have the charts in place and this will rise to at least 93% by the end of the year (March 2014).

Community:
Reduce avoidable grade 3 and 4 acquired pressure ulcers that occur on the district nurse caseload so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.

Ensure that throughout the year the number of community nursing patients who have a risk assessment of their nutritional status is 90% or above.

Ensure that by the end of the year (March 2014) at least 90% of community nursing patients with a MUST score of more than 1 have a nutritional care plan.

- **Dementia:**

Undertake the FAIR (Find, Assess, Investigate and Refer) process on at least 90% of appropriate patients

Agree a training programme for staff with the commissioners and complete that programme by the end of the year (March 2014)

Undertake a monthly audit of carers for people with dementia to test whether they feel supported and report the results to the Trust Board. .

- **Care closer to home:**

Increase the types of patient conditions and number of patients who are treated by the OPAT service (Out of Hospital Parenteral Antibiotic Team).

Expand the use of telehealth with the virtual ward team to maintain more patients cared for at home rather than having to attend or be admitted to hospital

6.5.2 Compassion:

- **Learning Disabilities:**

Appoint a learning disabilities liaison nurse.

Develop and implement a training programme to raise awareness and further improve the management of patients with learning disabilities who need acute or core community care care

- **Recruitment:**

Review the recruitment process and develop and implement a system for assessing values, attitides and behaviours.

- **End of Life:**

Sign up to Phase 2 of theTransforming End of Life Care in Acute Hospital programme.

Ensure there is an End of Life champion on every ward and in the community.

Ensure that 80% of all staff are trained in End of Life issues by the end of the year (March 2014).

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6.5.3 Competence:

- **Appraisal/Developing staff:**

Ensure that at least 89% of nursing/midwifery staff have an annual appraisal

Develop the appraisal process further so it contains an assessment and monitoring of behaviour that reflects the values of the Trust

- **Leadership:**

Ensure that there are at least two Band 5, two Band 6 and one Band 7 leadership programmes each year and all places are filled and all attendees acheive competency.

- **Skills:** .

Ensure that all care support workers are trained and acheive a acceptable level of competence.

Ensure that all staff on the novice programmes acheive 100% of their competencies.

Commence an Edexcel accredited assistant practitioner development programme (Band 4) to enhance the skill mix and provide support to qualified nurses/midwives

Ensure that all graduate nurses receive competency based training and are deeemed competent prior to being given substantive contracts

Ensure that all staff develop and enhance their clinical skill/competence through expected attendance at appropriate in-house and higher education training programmes.

6.5.4 Communication:

- **Patient Experience:**

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

By the end of the year, at least 80% of patients will report that their call bells are always answered in a reasonable time.

Community:

Increase the number of patients who use their Health and Social Care Passport to monitor their care from 49.4% to 80% by the end of the year (March 2014).

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Increase the number of patients who would know how to raise a concern about their care and treatment if they so wished from 86.8% to 90% by the end of the year (March 2014)

- **Carer Support:**

Develop the role of the appointed 'carer co-ordinator' and agree an action plan of developments

Ensure that the Trust carer co-ordinator and the Emergency Department welfare nurse work closely to produce an agreed set of outcomes

- **Access to the Directors:**

Ensure that a Matron attends each Board of Directors meeting and each Matron has a system of reporting any concerns raised by staff.

Commence discussing patient complaints and lessons learned that have occurred in an area during the Directors Patient Safety walkrounds

Ensure that there is a voice for community nurses at the Board of Directors by the attendance at each meeting of the Director of Community Services and Integrated Care and organising a senior community nurse to join the rota of attendance of hospital Matrons.

6.5.5 Courage:

- **Raising Concerns:**

Develop a Staff Forum on The Hub (intranet) where staff can raise concerns about care and suggested improvements to care

- **Supervision:**

Ensure that all new graduates receive clinical supervision and all other staff have access to clinical supervision if they request it.

Re-launch the concept of clinical supervision throughout the organisation so all staff are aware of its availability

- **Whistleblowing:**

Publicise the mechanisms for raising concerns using managers, The Hub (Staff Forum) and the Whistleblowing Policy

Monitor the use of the Whistleblowing Policy, ensure that lessons are learned through the Matrons meetings and report cases to the Board of Directors

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6.5.6 Commitment:

- **Codes of Conduct:**

Ensure that the Nursing and Midwifery Council (NMC) Code is covered and discussed in all appraisal meetings

Produce a quarterly report, which includes lessons learned, to the Board of Directors on all referrals to the professional bodies

Integrate the new Healthcare Support Workers Code of Conduct into all care support workers programmes

Ensure that the new Healthcare Support Workers Code of Conduct Code is covered and discussed in all appraisal meetings

- **Safeguarding:**

Ensure that at least 85% of nursing and midwifery staff attend Safeguarding training

Ensure that Safeguarding is covered and discussed in all appraisal meetings

- **Customer Care**

Add a question on confidence and trust in nurses to the local surveys undertaken and agree a target for positive answers following an intial pilot

Ensure that customer care training is covered in all Novice and Graduate nurse programmes

Develop a specific programme of customer care training that utilises patients/carers and their experience.

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6.6 RESOURCES

Delivering our strategy and achieving excellence will require investment. However it is recognised that investment can only be made in circumstances in which there is a strong business case or in which savings elsewhere in the business can be made to offset the additional spend. We will continue to improve our already excellent facilities and ensure we recruit and maintain the necessary highly competent staff to ensure many years of long term, acute and complex care both in the hospital and community. This investment will ensure that we keep pace with improving standards of modern healthcare.

6.7 SUPPORTING STRATEGIES

- Quality Strategy
- Clinical Strategy
- Patient Experience
- IT Strategy
- Estates Strategy
- Trust Annual Plan

6.8 IMPLEMENTING OUR NURSING AND MIDWIFERY STRATEGY

Communication of the strategy

We will ensure that our staff and our external stakeholders are clear about our strategy and what it means for patients and services.

Achieving delivery

A more detailed action plan will be drawn up based on the targets above. This will include timescales and the names of person(s) responsible for the actions. Through performance reviews we will ensure delivery of the actions are monitored with qualrterly reports through the CSQPE Committee and annually at Board.

7. TRAINING/SUPPORT

A variety of clinical and support training and education is in place to deliver this strategy. This will be reviewed as the strategy progresses.

8. PROCESS FOR MONITORING COMPLIANCE

See checklist below

9. EQUALITY IMPACT ASSESSMENT

Dudley NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been assessed appropriately.

10. REFERENCES

The Code: Standards of Conduct, performance and ethics for nurses and midwives. NMC: 2008

Compassion in Practice. DoH/NHS England: 2012

Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England. Skills for Health: 2013

The Mid Staffordshire NHS Foundation Trust Public Inquiry Report (2013) London: The Stationery Office

Patients First and Foremost: the Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) London: DoH

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COMPLIANCE MONITORING CHECKLIST

MONITORING THE EFFECTIVENESS OF THIS POLICY- As a minimum the following will be monitored to ensure compliance:

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Examples of key aspects to include are given below:						
Indicators outlined in Section 6.5	Nursing Director	Framework of Indicators	Quarterly Annually	At CSQPE At Board of Directors	Identify actions required and delegate indivduals to take forward	Annual Report Reports to Monitor
Quality Targets	Nursing/Medcial Directors Executive Directors	Quality Account	Quarterly	At CSQPE	Identify actions required and delegate indivduals to take forward	Communicatins Department to publicise Quality Account /Report published

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Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd May 2013

TITLE:	**Quality Report/Account**		
AUTHOR:	**Denise McMahon/Derek Eaves**	**PRESENTER:**	**Denise McMahon**

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

SUMMARY OF KEY ISSUES:

The Board will recollect that the timetable for the production of the Quality Report/Account has always been tight and this year dates have been brought forward even further. Last year the final draft had to be with the external auditors on the 27th April 2012 while this year the timetable stipulated the 22nd April. It can be appreciated to have the full end of year data (31st March) for all of the diverse measures together with our own informed comment and the comments of stakeholders is difficult. The latest draft is attached for the Board to note. The remaining timetable is the auditors returning to the Trust on the 4th May with their formal comments after which the Trust needs to draw up a response and action plan (where relevant) by the 10th May. The QA is to be finally approved at the Audit Committee dated 15th May, when it is presented by the external auditors. This means that the draft is primarily for information rather than comment although minor issues may be able to be changed. At the time of writing (24th April) comments from NHS Dudley, the local Healthwatch and Governors are still awaited. The format of the report will follow last year except a number of changes (such as having one column of text and insertion of patient quotes and stories) will be made which are based on comments from a recent Governors workshop.

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details**: The CQC may use information in the report as part of its ongoing assessments.
	NHSLA	**N**	**Details**: N/A
	Monitor	**Y**	**Details**: Final report to be with Monitor on 30th May
	Equality Assured	**Y**	**Details:** Compliant
	Other	**Y/N**	**Details:** DoH: The report complies with the requirements as laid down by the DoH

ACTION REQUIRED OF COMMITTEE:

Decision	**Approval**	**Discussion**	**Other**
	✓	✓	

RECOMMENDATIONS FOR THE COMMITTEE

To note the draft Quality Report/Account, agree any minor amendments and note their responsibilities as noted on page 64

The Dudley Group NHS
NHS Foundation Trust

Quality Report 2012/13

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PART 1: CHIEF EXECUTIVE'S STATEMENT

I am again delighted to introduce the annual Quality Report and Account, the purpose of which is to give a detailed picture of the quality of care provided by our hospitals and adult community services. This report covers April 2012 to the end of March 2013.

The very core of our work is to provide high quality care for all of our patients.

By this we mean we aim to provide:

- **A good patient experience**
- **Safe care and treatment**
- **A good and effective standard of care**

In this report we have used these three elements to describe the quality of care given at the Trust over the year. We have given an overall picture of what the organisation is achieving and where it still needs to improve.

With regards to the report's format, in Part 2 of this document we have outlined our priority quality measures and charted their progress throughout the year. A summary of current and previous priorities can be seen in the table on page 6; more information on each priority can be found on the page numbers listed in the table. This further information includes progress made to date, as well as our new targets for 2013/14. This part of the report also includes sections required by law on such topics as clinical audit, research and development and data quality.

In Part 3 we have included other key quality initiatives and measures and specific examples of good practice on all of the three elements of quality listed above which hopefully give a rounded view of what is occurring across the whole of the Trust. Although some parts of the report are divided into hospital and community sections, we have deliberately not included a separate distinct section on the community services as we take the patient perspective that services should be seamless and integrated and many of our services cross the hospital and community boundary.

The report hopefully indicates that we are constantly monitoring the quality of our care in a variety of ways in order both to assure patients and ourselves of where we are doing well and to learn where we need to change practice and improve our services. We believe the wide range of measures and checks detailed in this report indicate that the overall quality of care delivered at The Dudley Group is good and in line with that of other similar Trusts both locally and nationally. This view is based not only our internal monitoring but, as the report shows, many outside organisations review the Trust. I am particularly pleased to report that the main hospital inspectorate, the Care Quality Commission, has visited the Trust on a number of occasions, both announced and unannounced, during the year and, after talking to staff and patients and checking a variety of documentation, always found the Trust compliant with its standards.

Our quality objectives

The Trust's strategic objectives for quality, as set out in the 'Annual Forward Plan dated May 2012' are:

- To exceed all internal quality targets by 2014 and to be recognised as the highest quality service provider in the region by patient groups, staff and other key stakeholders.
- To provide excellent service and care making patients feel involved, valued and informed.

Our quality priorities

You will see in the following pages that we have performed very well with our 2012/13 priorities. In fact, we have achieved or exceeded them all except one. The successful priorities relate to positive patient experience feedback of our hospital, reducing in-patient MRSA and Clostridium difficile infections, improved recording of fluid intake and output of patients, improved assessing of patients' nutritional status and a large reduction in numbers of both hospital and community acquired pressure ulcers. I am particularly pleased by our 50 per cent reduction in grade 3 and 4 pressure sores in the hospital as we also managed to reduce the numbers by half in the previous year. In saying that, we are not complacent, and recognise we need to be working towards further reductions next year. With regards to the patient experience target in the community that was only partially achieved, we realise that we need to improve the implementation of and patients' understanding of the single assessment process. With regards to 2013/14, we have retained all of the topics from 2012/13 due to their importance, although we have amended the specific targets dependant on the detailed outcomes in 2012/13.

Measuring Quality

Although, the report includes a range of objective indicators of quality, we have also included a number of specific examples of quality initiatives at the Trust. We couldn't include them all but hopefully the examples give a flavour of the quality of care, awards, innovation and initiatives that trust staff have achieved and implemented in the year.

I am especially pleased to report that the Trust is receiving positive feedback from our patients in the new Family and Friends Test (Section 3.2.2). Our nurses continue to improve the quality of care they provide as measured by our detailed monthly Nursing Care Indicator assessments (Section 3.3.4). I am particularly glad to report that one of our nurses has won the prestigious national Ward Sister of the year award and the skills of our newly appointed Head of Medical Education has been recognised (Section 3.4.2).The Trust's patients are also experiencing less than the national average of all four harm events, falls with harm, pressure ulcers, catheter related infections and venous thromboembolisms, as measured by the new NHS Safety Thermometer (Section 3.3.5)

I hope you will find useful the information on the quality priorities we have chosen to focus on, the ways in which we assure ourselves of quality of care and a selection of the targets, both national and local, we use to form a picture of quality across the Trust.

We would appreciate any feedback you would like to give us on both the format and content of the account but also the priorities we have chosen. You can either phone the communications team on 01384 244404 or email communications@dgh.nhs.uk

I can confirm that, to the best of my knowledge, the information contained in this document is accurate.

Signed:

Paula Clark, Chief Executive　　　　Date:

PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE TRUST BOARD

2.1 Quality Improvement Priorities

2.1.1 Quality priorities summary

The table below gives a summary of the history of our quality priorities and also those we will be working towards in 2013/14.

Priority	2009/10	2010/11	2011/12	2012/13	2013/14	Comments	More info
PATIENT EXPERIENCE Increase in the number of patients who report positively on their experience on a number of measures	√ Achieved	We improved on one measure but had a slight decreased in another	Hospital: Partially Achieved Community: √ Achieved	Priority 1 Hospital: √ Achieved Community: Partially Achieved	Priority 1		8-11
PRESSURE ULCERS Improve systems of reporting and reduce the occurrence of avoidable pressure ulcers	N/A	N/A	Hospital: √ Achieved Community: Partially Achieved	Priority 2 Hospital: √ Achieved Community: √ Achieved	Priority 2		12-15
INFECTION CONTROL Reduce our MRSA rate in line with national and local priorities Reduce our Clostridium Difficile rate in line with (or better than) local and national priorities	√ Achieved	√ Achieved	√ Achieved Not Achieved	Priority 3 √ Achieved	Priority 3		15-17
NUTRITION Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission	N/A	N/A	N/A	Priority 4 √ Achieved	Priority 4		18-22
HYDRATION Increase the number of patients who have their fluid balance charts	N/A	N/A	N/A	Priority 5 √ Achieved	Priority 5		18-22
HIP OPERATIONS Increase the number of patients who undergo surgery for hip fracture within 36 hours from admission (where clinically appropriate to do so)	N/A	√ Achieved	√ Achieved	N/A	N/A	*As the target was achieved for two consecutive years this priority has now been replaced for 2012/13*	N/A
CARDIAC ARRESTS Reduce the numbers of cardiac arrests	√ Achieved	√ Achieved	N/A	N/A	N/A	*With a decrease from 32 per month in 2008 to 13 per month by 2011 this issue no longer remained a challenge*	N/A

2.1.2 Choosing our priorities for 2013/14

The Quality Account Priorities for 2012-13 covered the following five topics:

Patient Experience | **Infection Control** | **Pressure Ulcers**

Nutrition | **Hydration**

These topics were agree by the Trust Board on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Indicators (see Section 3.3.4)) and a national perspective (e.g. reports from national bodies e.g. Age Concern, CQC findings etc). These topics were endorsed by a Listening in Action event on the Quality Account, hosted by the Chief Executive and Director of Nursing, at which fifty five people attended comprising of 24 staff (three of which are governors), 5 other governors (4 public, 1 appointed), 21 Foundation Trust members and 5 others from the following organisations Dudley LINK, Dudley PCT, Dudley MBC, Dudley Stroke Association and Dudley Action for Disabled People and Carers (ADC).

Two of the above topics (Nutrition/Hydration) were new in 2012/13 with the others rolling over from previous years (Patient Experience/Infection Control have been continual priorities since the commencement of Quality Accounts in 2009/10 and Pressure Ulcers were introduced in 2011/12)

In November 2012, the Trust Board agreed that the existing topics should be retained for 2013/14. This is because Nutrition and Hydration remain important and were new in 2012-13 and so improvement trends over time need to be seen before they are removed as a priority. The other three topics remain important issues both from a local and national perspective. Patient experience is at the core of why the Trust exists, the reduction and maintenance of low infection rates are a key commissioner and patient requirement and there is a national campaign of zero tolerance to pressure ulcers.

As stated above, the five priority topics originated from an event attended by staff, governors, Foundation Trust Members and representatives from local organisations. The retention of the topics was further discussed and agreed at both a Governors workshop in November 2012 and the Full Governors Meeting in December 2012 and input from members was canvassed through the Trust members newsletter 'Your Trust' and from the general public via the Trust website.

> "The care, professionalism and willingness to answer questions was excellent"

2.1.3 Our Priorities Priority 1 for 2012/13

PATIENT EXPERIENCE	
Hospital	**Community**
(a) Increase the number of patients who receive enough assistance to eat their meals from 81 per cent to 85 per cent.	(a) Increase the number of patients who use their Single Assessment Process folder to monitor their care from 75.3 per cent to 80 per cent.
(b) Increase the number of patients who receive enough information about ward routines from 57 per cent to 65 per cent.	(b) Increase the number of patients who would know how to raise a concern about their care and treatment if they wished to do so from 80.8 per cent to 85 per cent.

How we measure and record this priority

Hospital

This priority has been measured using our real-time survey system. A random sample of inpatients are asked to share their experiences by participating in the survey about their stay before they leave hospital. Responses to the surveys are input directly into a hand-held computer and downloaded straight into our database to provide timely feedback.

During 2012/13 the Trust has continued to develop its real-time survey system resulting in 3063 patients participating, more than double the response rate from the previous year (1286).

All surveys are anonymous and results are shared with individual wards enabling them to take action on patient comments.

Community

The community priority has been measured using an annual survey. A paper questionnaire was distributed to community patients who were also provided with a freepost envelope to ensure an anonymous response; 1183 responses to the survey were received, with question (a) answered by 326 respondents and (b) answered by 1140 – the different in respondents is because not all patients have a Single Assessment Process folder, which is a useful document that acts as a communication tool for staff from all services who contribute to the care and management of people with long-term conditions.

Developments that occurred in 2012/13

Monthly Essence of Care meetings continue to reinforce the need to identify patients who require assistance at mealtimes by utilising the behind the bed boards, red tray system and electronic handover. This has been complemented by a poster campaign to raise awareness of the 15-minute (check says 30 in nutrition section) meal bell alert, compliance of which is monitored via mealtime audit. The mealtime audits check usage of the behind the bed boards which share important information around nutritional needs.

Nutrition Support Workers remain in post on ward A2 since May 2011. During 2012/13 a staffing review discussed adopting the Nutrition Support Worker role more widely, however it was decided to appoint Clinical Support Workers, who could assist patients with additional tasks in addition to assisting with nutritional needs.

During 2012/13 we also introduced bespoke welcome leaflets to each ward. The 'Welcome to the Ward' leaflet contains important information such as: visiting times, mealtime routines, uniforms who's who and ward contact numbers both for relatives and in case of health concerns once patients go home.

The leaflets are printed on A5 card to sit on the bedside cabinet where visitors can also read the important information contained within.

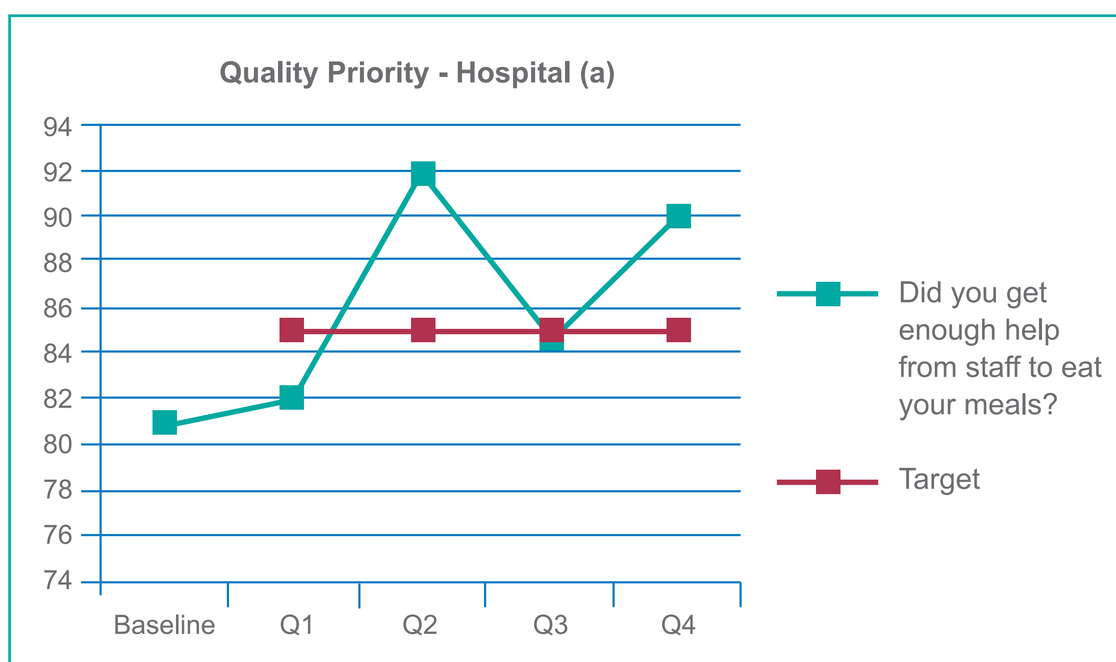
In the community we have been working with Dudley Council to develop an improved Single Assessment Process folder and this has taken longer to complete than we expected. The document is now almost complete so will be launched in 2013/14.

We have also ensured that PALS leaflets are available for patients, refreshed posters in clinic areas advising patients how to complain if they wish to and given PALS advice as part of assessments.

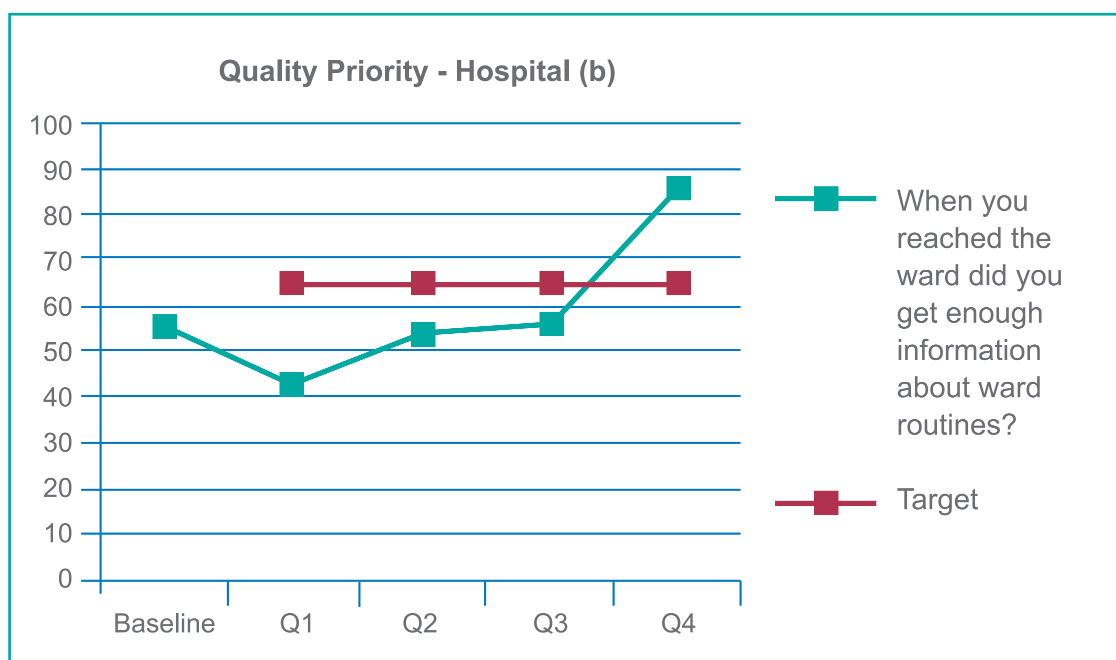
Current status

Hospital

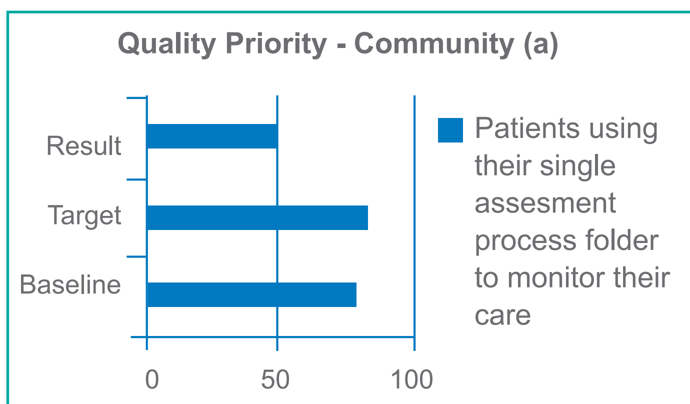
(a) The Trust exceeded its target in quarter two and quarter four achieving 92 and 90 per cent respectively against a target of 85 per cent. However some fluctuation in the score was apparent during the year and, therefore, this priority will be carried forward to 2013/14 to aim for a consistent service.

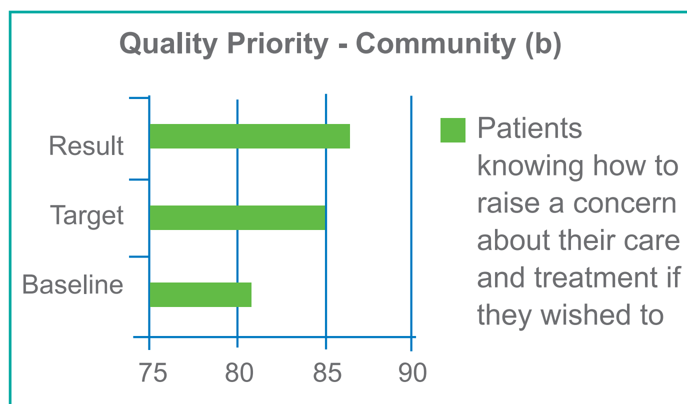


(b) The introduction of the new 'welcome to the ward' leaflets in January 2013 has seen this priority being achieved in quarter four with the score rising to 87.2 against a target of 65. We will continue to monitor that leaflets are given out but will remove this as a priority as the actions taken have been successful.



Community





The patient experience quality priority for community has been partially achieved for 2012/13. We are pleased that the number of patients reporting that they would know how to raise a concern about their care and treatment if they wished to do so has risen from 80.8 per cent to 86.8 per cent against a target of 85 per cent. However, the number of patients using their single assessment process folder to monitor their care has dropped from 75.3 per cent in 2011/12 to 49.4 per cent. While this is disappointing we recognise that finalising the new single assessment process folder and educating patients and families/carers on its use will help us to improve next year.

New Priority 1 for 2013/14

PATIENT EXPERIENCE	
Hospital	**Community**
a) Maintain an average score of 85 or above throughout the year for the patients who report receiving enough assistance to eat their meals. b) By the end of the year, at least 80% of patients will report that their call bells are always answered in a reasonable time.	a) Increase the number of patients who use their Single Assessment Process folder/Health and Social Care Passport to monitor their care from 49.4 per cent to 80 per cent by the end of the year. b) Increase the number of patients who would know how to raise a concern about their care and treatment if they so wished from 86.8 per cent to 90 per cent by the end of the year.

Rationale for Inclusion

We have retained (and in most cases strengthened) three out of the four patient experience targets from 2012/13. The reason we have carried these forward is because we felt that there was still progress to be made.

The hospital (a) target had seen fluctuation during the year and we are looking for a more consistent approach to this important aspect of patient care. Hospital (b) is a new target for 2013/14 aimed at ensuring timely response to call bells as this is something that patient feedback tells us we could do better at.

The community (a) target saw a large decrease in score in 2012/13 so is carried forward with the same target into 2013/14. The newly developed Single Assessment Process folder is being renamed the Health and Social Care Passport; this new name is reflected in the priority above. Community (b) was achieved and is carried forward with a stretched target to ensure that we have processes in place so that patients know how to raise a concern if they wish to.

> I have had good treatment, I couldn't ask for better.
> They tell me everything they are doing

Developments planned for 2013/14

- Include the hospital patient experience quality priority in the newly developed Quality Outcome Measures Dashboard, which is a list of key quality indicators, to give lead nurses and matrons timely feedback
- Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells, thereby allowing sufficient time for patients & nursing staff to adequately prepare for mealtimes.
- Recruitment of additional nutritional support workers within Stroke & Elderly Care Dept.
- Increase the number of volunteers trained to provide mealtime assistance
- Include details in our patient information around the welcoming of family members to assist their relatives at mealtime if they wish to do so
- Launch of the new Health and Social Care Passport.
- This document is for information sharing between the patient, carers and health and social care professionals.
- The document will be simpler to follow and will encourage patient and carers to use to monitor their care.
- Produce a information leaflet for existing Single Assessment Process folder holders to explain to them how to use the document to monitor their care.
- Extend the annual survey to try to discover the reason for patients choosing not to use the documents to monitor their care.
- Pilot an improved system of call bell answering on the surgical wards, monitor its impact and roll out to other areas dependant on its success
- Design and trial new posters giving patients clear information on the call bell system.

Board sponsor: Denise McMahon, Director of Nursing

Operational lead: Mandy Green, Deputy Head of Communications and Patient Experience

Priority 2 for 2012/13

PRESSURE ULCERS	
Hospital	**Community**
Reduce avoidable stage three and four hospital acquired pressure ulcers, against activity, so that the number for 2011/12 has been reduced by 50 per cent in 2012/13.	Reduce avoidable stage three and four acquired pressure ulcers that occur on the district nurse caseload through the year, so that the number for the final quarter of 2011/12 has been reduced by 10 per cent at the second quarter of 2012/13 (Jul- Sep) and by 20 per cent at the final quarter of 2012/13 (Jan-Mar).

How we measure and record this priority

Pressure ulcers, also called pressure sores and bed sores, are graded one to four with four being the most serious. When a patient is identified as having a pressure ulcer the details are entered into the computer incident reporting system and is reviewed by the Tissue Viability team prior to reporting externally.
If pressure damage is noted within 72 hours of admission this is not considered to have developed in hospital. This time frame is agreed regionally by the Strategic Health Authority. It is recognised that pressure damage can occur but not be visible immediately.

> "One thing I really like is the way they respect your privacy.
> They are always closing the curtains when they come to talk to you"

Developments that occurred in 2012/13

A new campaign was launched to follow on from the "We love your skin" campaign. The '50 day dash' was an Olympic theme campaign with the aim to reach 50 days free from pressure ulcers that gave wards a visual representation of their progress. Awards were presented to those wards that were successful. The race, however, continues and some wards have now reached 150 days free.

There is now a more robust reporting system for the hospital and community to ensure all pressure ulcers are reported through Datix and verified by a Tissue Viability Nurse, although further work continues to ensure that nurses correctly differentiate pressure ulcers from moisture lesions.

In order to ensure the same standard of pressure ulcer prevention across the Trust a joint pathway has been developed between the hospital and community.

The pressure ulcer prevention and management documents have been launched in the community in November 2012. This document includes a skin bundle which is a document completed on a regular basis by nursing staff including all the important components of care to prevent pressure ulcers. SKIN is an acronym which stands for *Surface, Keep Moving, Incontinence* and *Nutrition*. Progress is now underway to audit the correct completion of the documentation and skin bundle.

Skin bundle training has taken place for all the Trust's community nurse and specialist teams. In addition, we have organised this training for both carers in residential homes and home carers. It has been recognised that this needs to continue as a rolling programme of education for all carers.

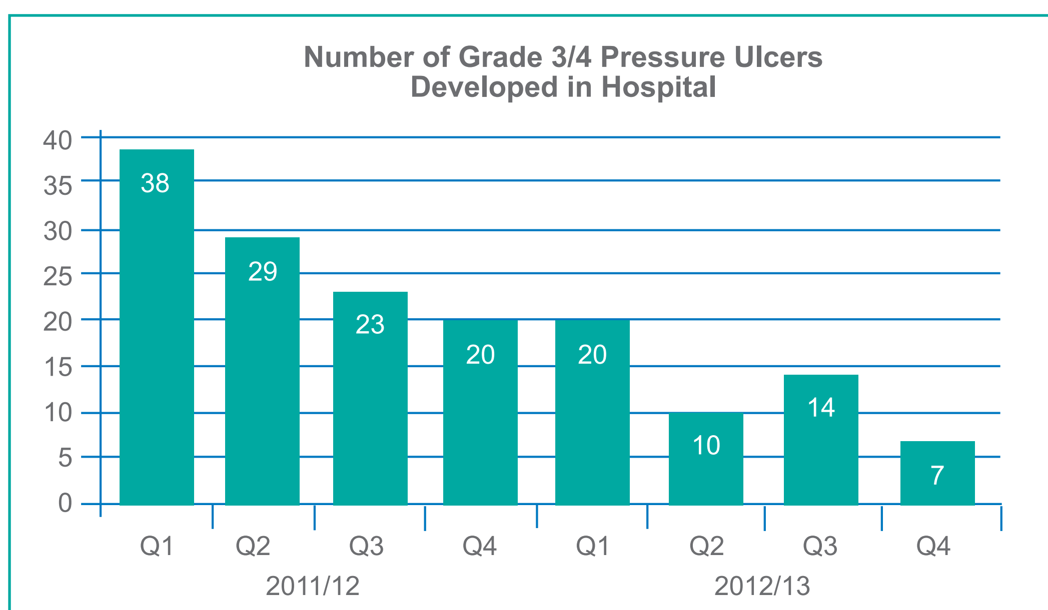
Meetings have taken place with managers of private care agencies as there was some initial resistance to complete this documentation but initial reservations have now been addressed and plans are in place to initiate their training sessions.

All stage 3 and 4 pressure ulcer incidents continue to be discussed and monitored in the pressure ulcer group meetings on a weekly basis, ensuring that lessons are learned to reduce reoccurrence.

Current Status

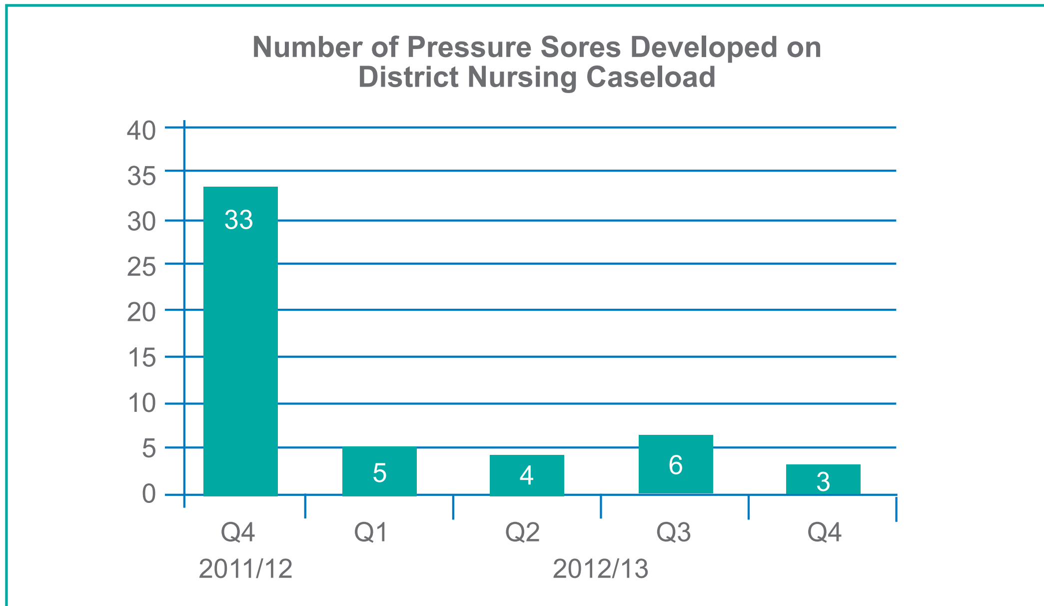
Hospital

The graph below shows the number of stage 3 and 4 pressure ulcers that developed in the hospital from quarter 1 in 2011/12, including all four quarters of this year (2012/113).



It can be seen that the numbers of pressure ulcers continue to fall compared to last year. We set ourselves the ambitious target of reducing them by half from last year after successfully reducing them by half from the year before. It can be seen that last year we had 110 of these ulcers but only 51 this year and so we are very pleased to note that we have managed to achieve this ambitious target again due to the efforts of all the staff involved.

Community



The community target of a reduction of 10% in the second quarter from the final quarter of 2011/12 was exceeded considerably with a reduction of over 85%. This means that, in effect, both the half year and end of year targets were met together and in advance.

New Priority 2 for 2013/14

PRESSURE ULCERS	
Hospital	**Community**
Reduce avoidable grade 4 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50 per cent in 2013/14. Reduce avoidable grade 3 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.	Reduce avoidable grade 3 and 4 acquired pressure ulcers that occur on the district nurse caseload so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.

Rationale for Inclusion

- Pressure ulcers are difficult to treat and slow to heal and prevention is therefore a priority.
- Although the Trust achieved its targets in 2012/13, it realises there is still much to do and moving to a zero tolerance of pressure ulcers in hospital should be the aim
- Feedback from our patients, staff, community groups and Governors indicate this should remain a target.

> "They help me move around and they told me that would help"

Developments planned for 2013/14

Actions being undertaken to achieve the Trust target include:

- Continue to promote the "50 Day Dash campaign
- Tissue Viability are planning a trolley dash for the hospital to continue the message of Zero tolerance, highlight the importance of elevating patients heels off the surface with a suggestion box on the day for staff to inform the Trust how we can improve pressure ulcer prevention. This trolley dash will also be to spread the message of a different staging tool to assess the severity of pressure ulcers.
- Regular equipment sessions have been organised to inform community nursing teams about the correct use of equipment and fault finding.
- Education sessions will continue for all trust staff.
- The team will continue to work with private care agencies and organise education sessions and updates as required.
- Tissue viability team to support nursing homes with the formulation of a mattress selection guide.

Board Sponsor: Denise McMahon, Director of Nursing

Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

Priority 3 for 2012/13

INFECTION CONTROL
Reduce our MRSA and Clostridium difficile (C. diff) rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than 2 post 48hr cases; C.diff is no more than 77 post 48hr cases in 2012/13.

How we measure and record this priority

MRSA Bacteraemia and C.diff numbers are divided into pre and post 48 hours cases. Only the post 48 hours cases are attributed to the Trust, meaning the patient acquired it in hospital. Pre 48 hours cases mean the patient was already developing the infection before they were admitted to hospital. The Trust as part of the local health economy has to record both pre and post 48 hours cases.
MRSA and C. diff – when our Pathology laboratory has a positive result the information is fed into the MESS (Mandatory Enhanced Surveillance System) national database. From here the data for all trusts is collated and sent to the Health Protection Agency (HPA) for publication.

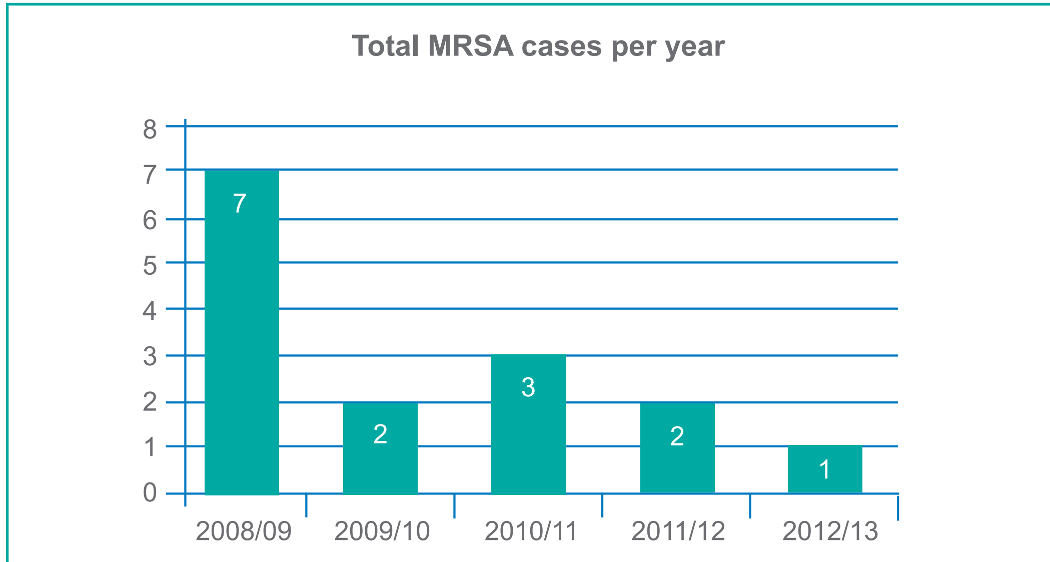
Developments that occurred in 2012/13

- Introduced hydrogen peroxide 'fogging' for the inpatient areas when patients are discharged to reduce cross contamination
- Improved access to training for anti-microbial (drugs that destroy disease-carrying micro-organisms) prescribing by the development of an online package
- Agreed competencies for the nursing element of cleaning the environment
- Agreed and report competencies of contracted cleaning staff
- Improved information gathering including feedback and changes in practice regarding anti-microbial prescribing, bringing more senior medical input into the root cause analysis process
- Introduced the new Department of Health testing algorithm for C. diff
- Expanded the National Patient Safety Agency (NPSA) infection prevention project into the surgical and high dependency areas
- Introduced a more systematic process for the usage of protein pump inhibitors medication used for patients with stomach problems
- Monitored and recorded the time it takes to place patients into side rooms once an infection has been identified

- Appointment of an analyst to assist with the management of all the information required to closely monitor and reduce infection rates
- Monitoring of mortality rates when infections are involved

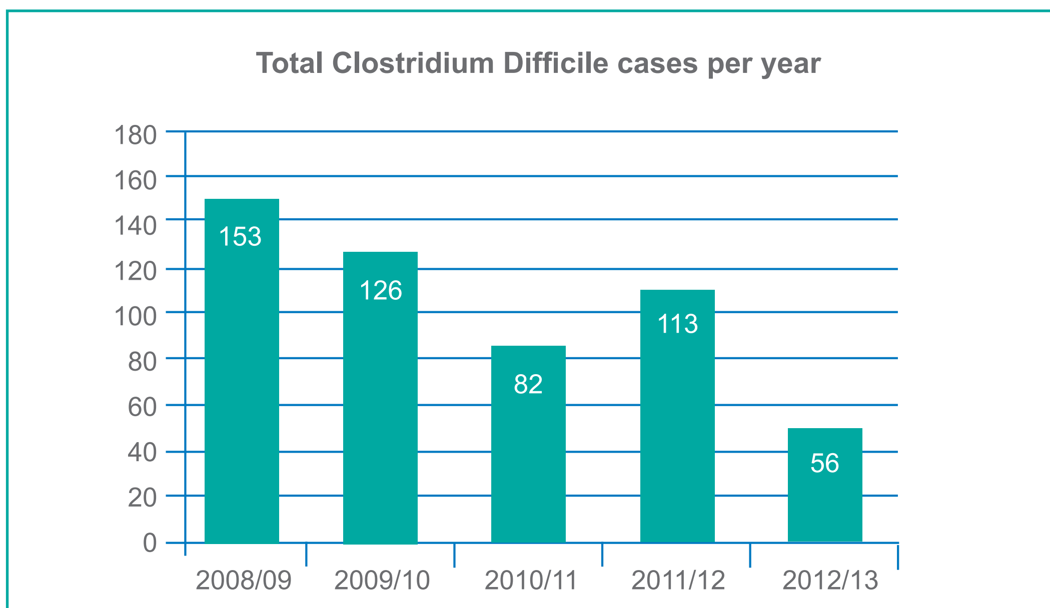
Current status MRSA

We continue our good work to maintain a low level of MRSA Bacteraemia. The graph below shows the continued reduction of MRSA bacteraemia cases (post 48 hour, i.e. patients who acquired it whilst in hospital) from a total of 7 in 2008/9 to a total of one in 2012/13.



Current status C. diff

In addition, we have managed to reduce our Clostridium Difficile (C. diff) cases both from last year and our previous lowest annual figure (2010/11). This year we have come in under target having had 53 in 2012/13 (at March 15th). The graph below shows the total number of C.diff cases recorded greater than two days after admission, showing the reduction from a total of 238 in 2007/08 to a total of 56 in 2012/13.



New Priority 3 for 2013/14

INFECTION CONTROL
Reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C.diff is no more than 38 post 48hr cases in 2013/14.

Rationale for Inclusion

- The drive to reduce healthcare associated infections, which includes MRSA Bacteraemia and C.diff, continues to get more and more challenging.
- The reduction of infection remains a key priority across the NHS
- Feedback from our patients, staff, community groups, Governors indicate this should remain a target.

Developments planned for 2013/14

Actions planned to achieve the above aims include:

- Continue to develop education programmes and improve the attendance of staff at the relvant sessions
- Increase the rate of MRSA screening for emergency patients
- Promote effective antimicrobial prescribing
- Roll out the availability of the 'fogging' service that contributes to the prevention of cross infection

Board sponsor: Denise McMahon, Nursing Director/Director of Infection Prevention and Control

Operational lead: Dawn Westmoreland, Consultant Nurse, Infection Prevention & Control

"They have given me lots of information about what will happen and what other support I can get. I am reading through this"

Priorities 4 and 5 for 2012/13

NUTRITION

Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission.

By September 2012 at least 90% of patients will have the risk assessment completed and this will continue for the rest of the year.

HYDRATION

Increase the number of patients who have their fluid balance charts fully completed.

By September 2012 at least 70% of patients will have their fluid balance chart fully completed and this will rise to at least 90% by the end of the year (March 2013).

How we measure and record this priority

Every month 10 observation charts are checked at random on every ward at the Trust as part of the wider Nursing Care Indicators (NCI) monitoring (see Section 3.3.4). This process includes checking the MUST assessment which is a rapid, simple and general procedure commenced on first contact with the patient so that clear guidelines for action can be implemented and appropriate nutritional advice provided. The 'Malnutrition Universal Screening Tool' ('MUST') has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. Locally, the tool has been in use at the Trust for a number of years. The NCI monitoring also includes checking the recording of fluid input and output of patients. The completion rates of each ward are fed back to the Matrons and ward managers for action where necessary. Each ward and the whole Trust is RAG (Red/Amber/Green) rated. In 2012/13 a 'Green' was given for a 90% or greater score, an 'Amber/Yellow' for 89-70% scores and a 'Red' for scores 69% or less. Due to the overall improvement in scores across the board, for 2013/14 a 'Green' will be given for a 93% or greater score, an 'Amber/Yellow' for 92-75% scores and a 'Red' for scores 74% or less.

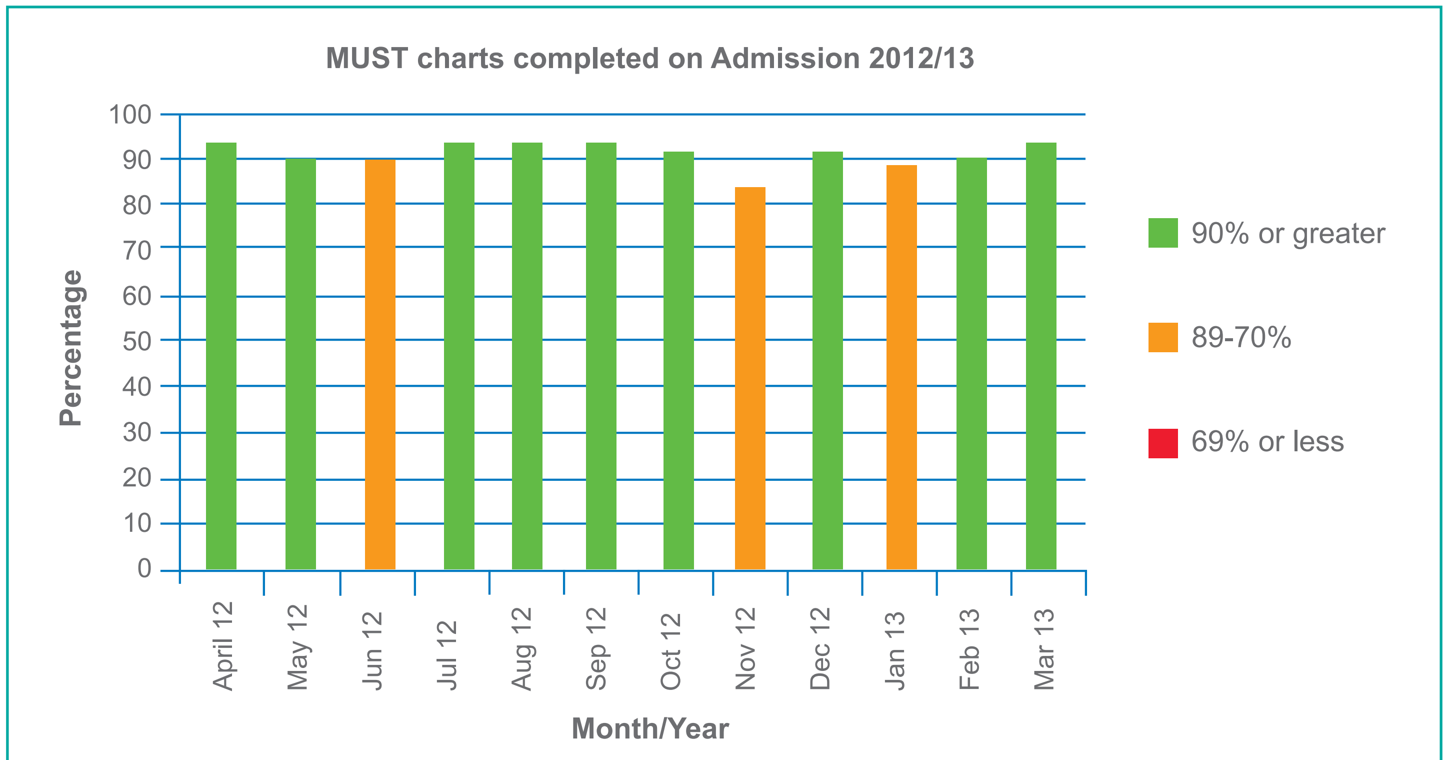
> "I have a physiotherapist who has helped me. I think their kindness and support is brilliant and they've shown me how to change my dressing and everything"

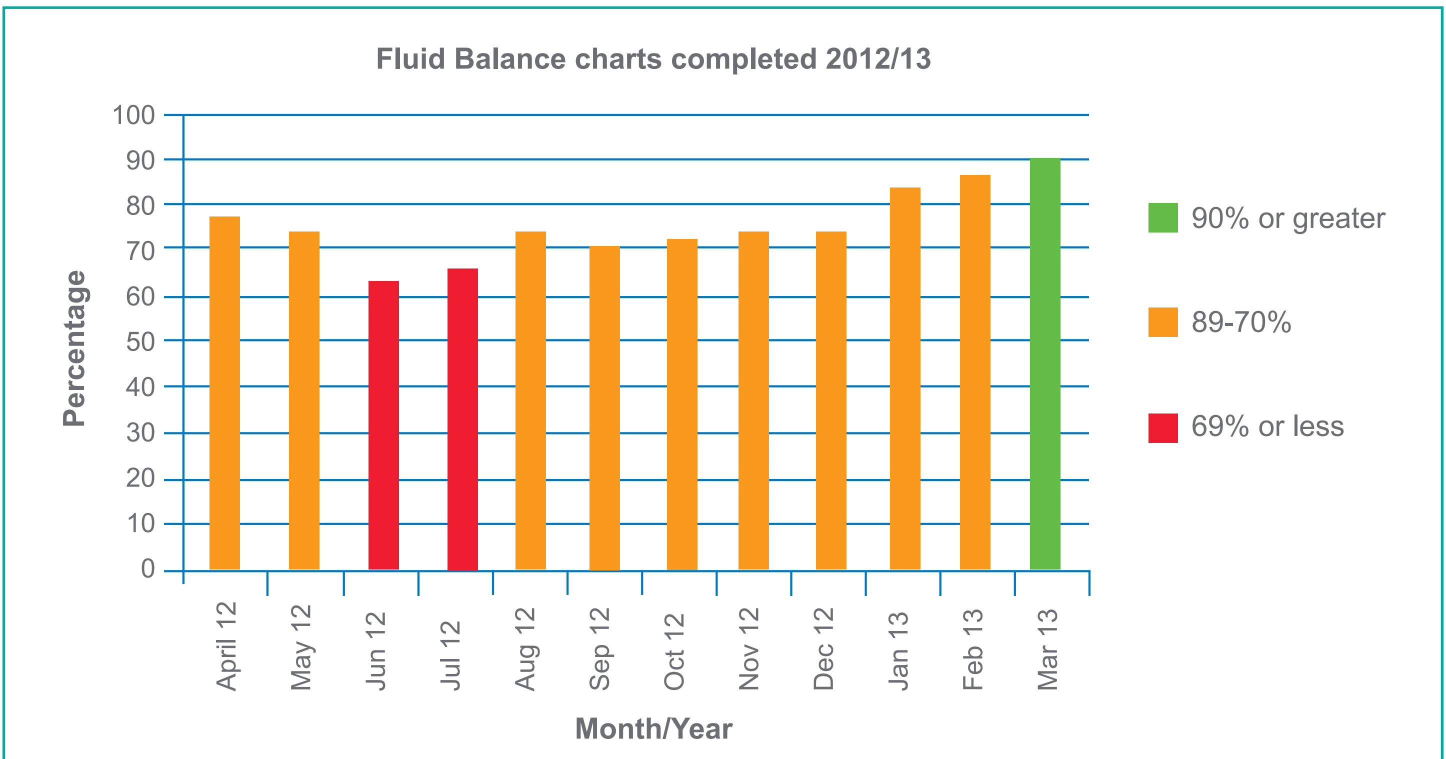
Developments that occurred in 2012/13

- Education sessions on MUST delivered in targeted areas
- Screen saver developed to promote MUST screening on admission to Trust
- Essence of Care Link nurses re enlisted
- Fluid balance charts redesigned and introduced and now include lunch time evaluation requiring a qualified nurse signature
- Education package for fluid balance developed and delivered to all ward areas
- Competency document for fluid balance developed for all staff to sign
- New fluid balance criteria included in the Nursing Care Indicator (NCI) audit
- Hand held bells now sounded 15mins before each meal time to indicate the importance of the forthcoming mealtime, the need to get patients ready for the meal and to ensure the feeding of patients is a priority
- Signs introduced behind every bed to indicate the nutritional needs of patients
- Introduction of a monthly mealtime audits that includes observations and the patient perspective

Current status

The graphs below shows the overall Trust results for 2012/13:





It can be seen that the target of having 90% of patients being risk assessed for their nutritional status was achieved by the target of September 2012. Since that date, there have been two monthly scores (November 2012 and January 2013) that have just dipped below the 90% figure but for the whole of the six months the score has been on average over 90% and so the target was achieved.

With regards to hydration, the 70% completion of fluid balance charts was achieved in September 2012. Following an intensive campaign to improve this figure, it can be seen that the target of 90% was achieved in March 2013.

New Priorities 4 and 5 for 2013/14

NUTRITION

Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status.

Through the year on average at least 90% of patients will have the weekly risk assessment completed and this will rise to at least 93% by the end of the year (March 2014).

Increase the number of patients having a food recording chart and a fluid balance chart in place if the MUST score is 1 or above.

Through the year on average at least 90% of patients will have the charts in place and this will rise to at least 93% by the end of the year (March 2014).

HYDRATION

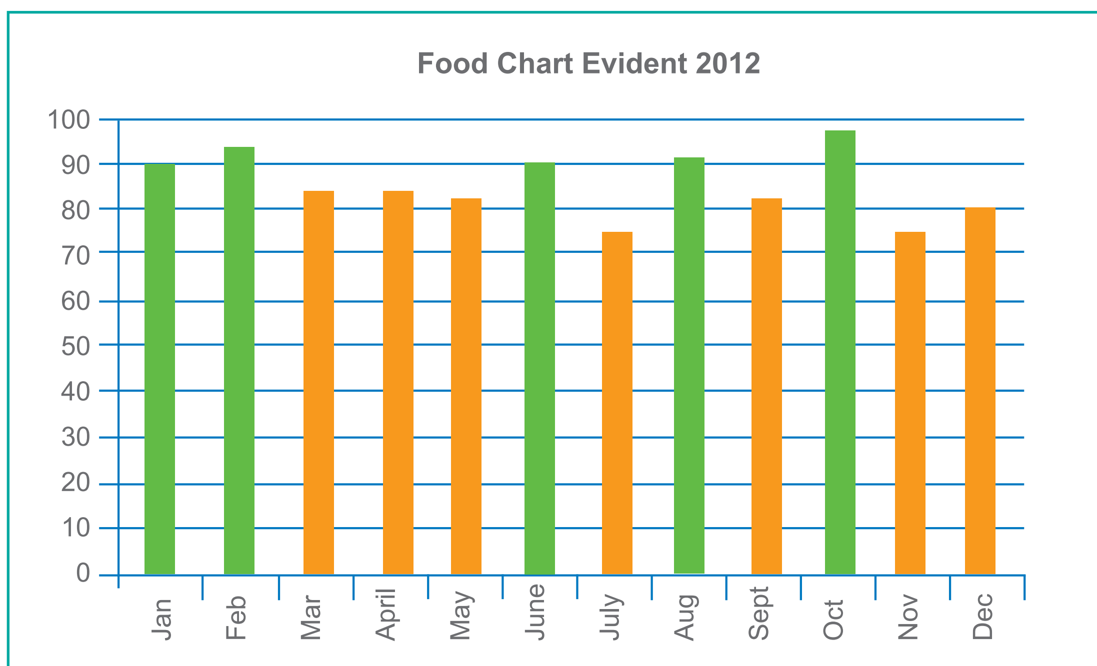
Increase the number of patients who have their fluid balance charts fully completed.

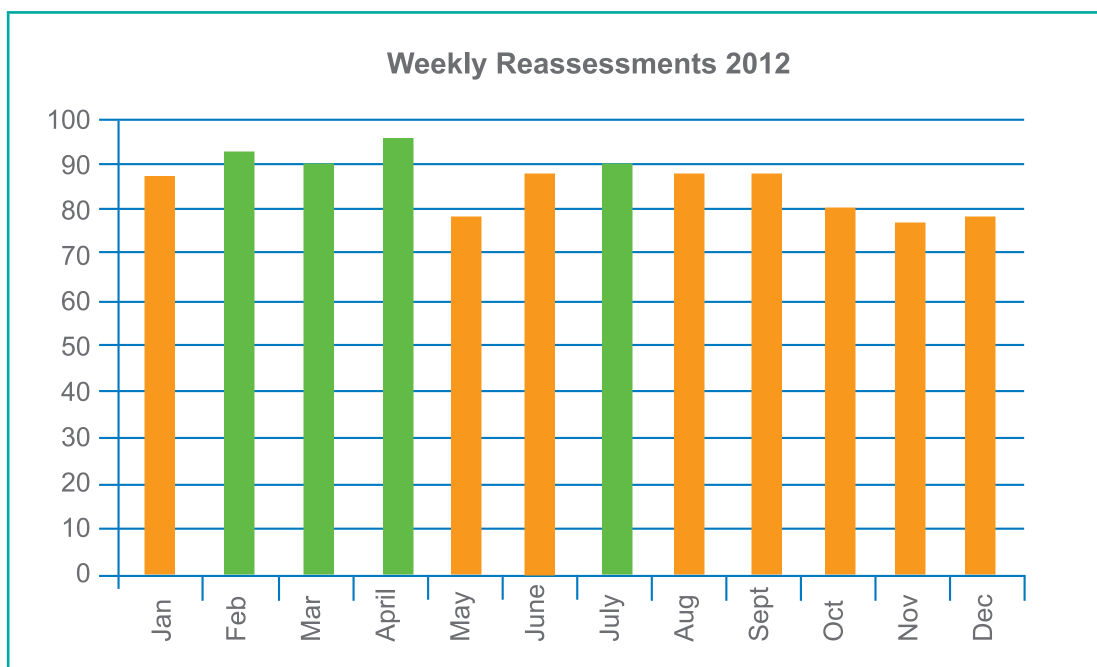
Through the year on average at least 90% of patients will have their charts fully completed and this will rise to at least 93% by the end of the year (March 2014).

Rationale for inclusion

- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The consequences of 24 poor nutrition and hydration are well documented and include increased risk of infection, poor skin integrity and delayed wound healing, decreased muscle strength, depression and, sadly, premature death. Put simply poor nutrition and hydration causes harm.
- A number of national reports, from Age UK, the CQC etc, have questioned the state of practice on these topics across hospitals generally.

In 2012/13 we ensured that in the main MUST assessments are completed within 24 hours of admission. This is a good starting point for effective nutritional care. It is important that these assessments are continued on a weekly basis to monitor that if deterioration occurs appropriate action is taken to counteract this when possible. In addition, the purpose of the MUST assessment is that standard actions (e.g. referral to a Dietician) occurs dependant on the score obtained from the assessment. One of the standard actions is that Food and Fluid recording charts are commenced if the score is more than 1. It is thought useful therefore to include these targets to ensure that monitoring continues after admission and to ensure that the correct actions are being taken following assessment. It can be seen from the charts below that considerable work is required to match the 90 and 93 per cent targets set for 2013/14.





> “The food is OK and I get vegetarian meals as I had requested”

Dehydration has been shown to increase by two-fold the mortality of patients admitted to hospital with a stroke and to increase the length of hospital stay for patients with community acquired pneumonia. Improving hydration brings well-being and better quality of life for patients. It can allow reduced use of medication and prevent illness. It is good healthcare and dietary practice – and the right thing to do. For optimal hydration of the patient, the need for accurate recording of fluid input and output cannot be underestimated. Although the Trust made great progress in improving the monitoring of fluid balance in 2012/13, it is appreciated that good scores were only achieved at the end of the year and so it has been decided to continue to target a good performance throughout 2013/14.

Developments planned for 2013/14

- System of monthly mealtime audits to be reviewed to have a more robust system of ensuring appropriate action is taken dependent on the audit results.
- Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells.
- Explore the introduction of an e-learning package.
- Develop a strategy for ensuring the importance of nutrition/hydration is a priority issue by such means as further screensavers, articles in newsletters and other appropriate mechanisms

Board Sponsor: Denise McMahon, Director of Nursing

Operational Leads: Dr S. Cooper, Consultant Gastroenterologist, Sheree Randall, Matron, Karen Broadhouse, Quality Project Lead

> "I have had enough to eat and drink here and they help me when I need it"

2.2 Statements of assurance from the Trust Board

2.2.1 Review of services

During 2012/13 The Dudley Group NHS Foundation Trust provided and/or sub-contracted 59 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2012/13 represents 99.4 per cent of the total income generated from the provision of relevant health services by The Dudley Group NHS Foundation Trust for 2012/13.

The above reviews were undertaken in a number of ways. With regards to patient safety, the Trust Executive and Non Executive Directors have been undertaking Patient Safety Leadership Walkrounds (see Section 3.3.2). Also covering patient safety, but including the second element of quality (effectiveness), are the morbidity and mortality reviews undertaken by the Chairman, Chief Executive, Medical Director and the Non Executive Director who is chair of the Audit Committee. External input is provided by the GP Clinical Executive for Quality and Safety from Dudley Clinical Commissioning Group (CCG). These occur on an 18 month rolling programme, covering all services. Each service presents information from a variety of sources including: internal audits, national audits, peer review visits, as well as activity and outcome data such as readmission rates, day case rates and standardised mortality rates (see Sections 2.2.7 and 3.3.6 for more detail on our hospital mortality figures).

We also monitor safety, clinical effectiveness and patient experience through a variety of other methods:

- Nursing care indicators – monthly audits of key nursing interventions and their documentation. The results are published, monitored and reported to Trust Board monthly by the Director of Nursing;
- 'Productive' series – part of our Transformation programme looks at 'releasing time to care' by making time and productivity changes in theatres, the wards and the community. It results in clinical staff having more time directly with patients;
- Ongoing patient surveys that give a feel for our patients' experiences in real-time so that we can quickly identify and problems and correct them
- Every other month, senior medical staff attend the Trust Board to provide a report and presentation on performance and quality issues within their speciality areas
- Every other month, a Matron attends the Trust Board to provide a report and presentation on nursing and quality issues across the whole Trust
- The Trust has an electronic dashboard of indicators for Directors, senior managers and clinicians for monitoring performance. The dashboard is essentially an on-line centre of vital information for staff
- The Trust works with its local commissioners scrutinising the Trust's quality of care at joint monthly Clinical Quality Review Meetings
- The Trust monitors the Midlands and East NHS Acute Trust Quality Dashboard, comparing all the Trusts on a number of quality indicators, some of which are discussed in this report.

- External assessments, which included the following key ones this year:
    - Following a visit on site, in June 2012 the Care Quality Commission (CQC) declared the Trust compliant with the regulated activity of terminations of pregnancy. In July 2012, it also reviewed the Trust following a previous inspection to check the progress being made on its cleanliness and infection control standard. It declared the Trust compliant with that standard also. In addition, the CQC undertook a routine unannounced visit in February 2013, and inspectors visited five wards and two departments. The results of that visit were that the Trust is compliant with the following six standards: care and welfare of people who use the services, meeting nutritional needs, management of medicines, supporting workers, assessing and monitoring the quality of service provision and complaints.
    - In July 2012, NHS Dudley undertook an unannounced visit to review our emergency services. An action plan was drawn up which included improving systems of monitoring staffing levels and listening to the concerns of staff, actions which all have been completed.
    - NHS Dudley continued its series of Appreciative Enquiry Visits by reviewing in October 2012 the arrangements for patients who had sustained falls. NHS Dudley staff which included general practitioners interviewed staff and visited wards and departments to look at practice and talk with patients. The results of the visit were very positive and an action plan was drawn up for the minor points of concern raised.
    - In addition, Clinical Pathology Accreditation (UK) Ltd, which is the authority which approves laboratories, visited the following departments: Clinical Biochemistry (Nov 2012), Haematology (December 2012) and Microbiology (December 2012). Action plans have been formulated prior to final approval and the Microbiology Department will be inspected further in July 2013. The Human Tissue Authority (HTA) inspected in March 2012 and the Trust was approved for the procurement and distribution of human tissues and cells. A Cancer Services Peer review of the Upper Gastro-Intestinal Department was made (March 2012) and the one key recommended action was implemented. Similar reviews of Acute Oncology and Clinical Chemotherapy took place in March 2013 and results are awaited. With regards to education and training, the University of Birmingham College of Medical and Dental Sciences undertook a visit reviewing Foundation Year Training (November 2012) and West Midlands Postgraduate Medical Education and Training Deanery inspected the ophthalmology (March 2013), radiology (November 2012), Maxillofacial (November 2012) and Obstetrics/Gynaecology (March 2012) departments. NHS Quality Control North West assessed the Aseptic Preparation of Medicines (April 2012). Where recommendations were made, action plans have been put into place.

2.2.2 Participation in national clinical audits and confidential enquiries

During 2012/13, 41 national clinical audits and 5 national confidential enquiries covered relevant health services that the Trust provides.

During that period the Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1. National clinical audits that the Trust was eligible to participate in, actually participated in during 2012/13 and the percentage of the number of registered cases submitted by the terms of the audit

Name of Audit	Type of Care	Audit Participation	Submitted %
ICNARC Case Mix Programme Database	Acute care	Yes	100%
National Joint Registry	Acute care	Yes	95%
CEM Renal Colic Audit 2012	Acute care	Yes	100%
Trauma Audit & Research Network Audit (TARN)	Acute care	Yes	85%
BTS Emergency Use of Oxygen Audit	Acute care	Yes	100%
BTS Community Acquired Pneumonia Audit	Acute care	Yes	In progress - ends 31.5.13
BTS Adult NIV Audit	Acute care	Yes	100%
NHS Blood & Transplant Potential Donor Audit	Blood & Transplant	Yes	100%
National comparative audit of blood transfusion - Audit of the use of Anti-D	Blood &Transplant	Yes	Delayed nationally
National Lung Cancer Audit (LUCADA)	Cancer	Yes	100%
National Bowel Cancer audit Programme (NBOCAP)	Cancer	Yes	100%
Head & Neck Cancer Audit (DAHNO)	Cancer	Yes	100%
National Oesophago-gastric Cancer Audit	Cancer	Yes	100%
ICNARC National Cardiac Arrest Audit	Heart	Yes	100%
VSSGBI National Vascular Database	Heart	Yes	99%
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Heart	Yes	100%
National Heart Failure Audit	Heart	Yes	100%

Name of Audit	Type of Care	Audit Participation	Submitted %
Heart Rhythm Management (pacing / devices)	Heart	Yes	100%
RCPCH National Paediatric Diabetes Audit (NPDA)	Long term conditions	Yes	100%
National Diabetes Inpatient Audit (NaDIA) 2012	Long term conditions	Yes	100%
UK Inflammatory Bowel Disease Audit - biologics	Long term conditions	Yes	Currently 45% running until 2014
National Pain Audit	Long term conditions	Yes	100%
Renal Registry Renal Replacement Therapy Audit	Long term conditions	Yes	100%
BTS Adult Asthma Audit	Long term conditions	Yes	100%
BTS Bronchiectasis Audit	Long term conditions	Yes	100%
National Review of Asthma Deaths (NRAD)	Long term conditions	Yes	100%
National Carotid Interventions Audit	Older people	Yes	97%
National Hip Fracture Database	Older people	Yes	100%
National Parkinson's Audit 2012	Older people	Yes	100%
National Dementia Audit (NAD) 2012	Older people	Yes	100%
CEM Fractured NOF Audit 2012	Older people	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Older people	Yes	In progress – expected 100% May 10th
Hernia / Varicose veins / Hip replacement / Knee replacement	Other	Yes	92% - current published figures
(PICAnet) Paediatric intensive care	Women's & Children's health	Yes	Data collated centrally at BCH
(MBRRACE-UK) Perinatal Mortality	Women's & Children's health	Yes	100%
(NNAP) Neonatal intensive and special care	Women's & Children's health	Yes	100%
BTS Paediatric Pneumonia Audit	Women's & Children's health	Yes	100%
BTS Paediatric Asthma Audit	Women's & Children's health	Yes	100%
RCPCH National Childhood Epilepsy 12 Audit	Women's & Children's health	Yes	Delayed Nationally
RCPCH Child Health (CHR-UK)	Women's & Children's health	Yes	100%
CEM Fever in Children Audit 2012	Women's & Children's health	Yes	100%

Table 2. National confidential enquiries that the Trust was eligible to participate in, actually participated in during 2012/13 and the percentage of the number of registered cases required by the terms of the enquiry

Name of Enquiry	Type of Care	Audit Participation	Submitted %
Time to intervene	NCEPOD	Yes	Complete
Bariatric Surgery Study	NCEPOD	Yes	Organisational data only
Alcohol Related Liver Disease Study	NCEPOD	Yes	Complete
Subarachnoid Haemorrhage Study	NCEPOD	Yes	Complete
Tracheostomy related complications	NCEPOD	Yes	In progress - Organisational data submitted
Death following lower limb amputation	NCEPOD	Yes	In progress

As well as the national clinical audits in Table 1 above, from the Healthcare Quality Partnership (HQIP) list, the Trust has also taken part in these 4 further national audits:

Table 3. Additional National Clinical Audits that the Trust is participating in during 2012/13.

Name of Audit	Type of Care	Audit Participation	Submitted %
National Audit Project (NAP5) Accidental Awareness during \ General Anaesthesia	Anaesthetics	Yes	In progress - ends 31.5.13
National Obstetric Anaesthetic Database (NOAD) Anaesthetics	Anaesthetics	Yes	100%
Audit of Blood Sampling and Labelling	Haematology	Yes	Complete
National Insulin Pump Audit	Diabetes & Endocrinology	Yes	100%

They are very, very good. I get great care 24/7. The nurses are wonderful They showed me how to give myself pain relief and told me all about it. I just have to push the button and get what I want

The reports of 10 national clinical audits were reviewed in 2012/13 and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

ICNARC Case Mix Programme Audit

The 2011/12 National ICNARC Case Mix programme report was reviewed. No specific actions were identified from this report as the Trust's practice, as captured in the well-validated audit, is shown as very good. Ongoing changes in practice reflect the critical care unit's continued efforts to stay abreast of best practice as recommended from other sources.

ICNARC National Cardiac Arrest (NCAA) Audit

The audit results show the Trust has maintained the level of cardiac arrest calls without any significant increase in the survival to discharge rates. The Trust continually looks at reducing events further.

National Heart Failure Audit

- Introduction of a new Trust Heart Failure service
- Employment of new senior Heart Failure Nurse
- Outreach to all patients with heart failure in the Trust, especially those that are being cared for by genera physicians
- Improvement in the number of heart failure patients referred to the Community Heart Failure Team on discharge

National Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) Audit

Prescribing for secondary prevention medication, is currently at a high level (>90%), but slightly lower than the national average so there is a need for the Trust to see whether there is accurate exclusion of all patients with clinical contra-indications from the analysis. It was also identified that Coronary angiography rates appear to be lower than the national average. Actions include:

- To educate nurses regarding appropriate coding of medications
- To discuss coronary angiography rates at future QPDT meeting
- To improve communication of findings

BTS Emergency Oxygen Audit

The audit identified that there needs to be changes in the way oxygen prescriptions are recorded therefore commencing in May 2013 there will be a pilot of a new system of oxygen prescribing for all patients on Ward C5.

BTS Community Acquired Pneumonia (CAP) Audit

The audit showed low antibiotic compliance with guidelines therefore actions have been implemented to improve adherence to the guidelines.

BTS COPD Discharge Audit

Actions include:

- All patients to be assessed for pulmonary rehabilitation
- All patients to have an emergency pack at discharge

BTS Non Invasive Ventilation (NIV) Audit

Actions include:

- Clear indications for the initiation of NIV have been attached to all portable NIV machines.

National Bowel Cancer (NBOCAP) Audit

The National Bowel Cancer (NBOCAP) Audit was reviewed and previous weaknesses in the data collection were highlighted. These are to be addressed by involving clinicians more closely and quarterly meetings are to be introduced to analyse data prior to submission

National Diabetes Inpatient Audit (NaDIA)

The audit shows that overall there is evidence of continuing improvements in diabetes care across the Trust and nationally, the Trust ranks highly on the majority of outcomes. This can be attributed to the impact of the Front door Diabetes Team and the protocols developed in the Trust as part of the Think Glucose project. The impact that a new systematic approach to skin assessment and management and the Diabetes Foot Team has had on screening and management of diabetic foot disease is also very dramatic. Further work is required to improve on care planning and choice of meals.

Local Clinical Audit

The reports of 25 completed local clinical audits were reviewed in 2012/13 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

- Design and construction of an 'e-learning module' on critical incidents and risk reporting
- Introduction of a more comprehensive discharge plan for older and vulnerable patients following elective orthopaedic procedures
- Introduction of Hypo boxes for all diabetic patients
- A change of Trust guidance to the use of Novorapid instead of Actrapid in the management of hyperglycaemia in adults with diabetes mellitus
- All doctors and pharmacists to complete the Safe use of Insulin e-learning training module
- All patients undergoing bowel surgery for malignancy not having anti-thrombotic therapy to receive 28 days of enoxaparin post operatively
- Introduction of a new section in the Surgical Assessment Unit (SAU) clerking sheets to include Best Medical Therapy (BMT) checklist
- Introduction of a standardised format for pre and post operative clinical documentation for Pterygium Surgery
- Further develop the Emergency Department (ED) electronic patient record to promote the better use of the electronic sedation record
- Introduction of formal training in sedation technique by anaesthetists
- Refinement of the existing proforma for improved documentation of NIV pathway
- Development of a generic PowerPoint presentation on Do Not Attempt Resuscitation (DNAR) and Medical Emergency Team (MET) status for junior doctor induction training.
- Deliver supplementary Non Invasive Ventilation (NIV) teaching sessions for improved recognition of patients unsuitable for NIV
- Introduction of appointments for investigations (e.g. visual fields tests) before consultation with the doctor
- Follow up appointment dates to be issued on the day of the procedure for Ozurdex Injection in patients with Macular Oedema
- Introduction of a yellow card (for easier recognition) with clinic contact telephone numbers
- Ensure improved pain relief is prescribed 30 minutes before Ozurdex Injection Procedure
- Initiation of testing of Procollegen III for the screening for significant liver disease, as there is good evidence that this substantially reduces the number of patients requiring liver biopsy
- Development of a local guideline and implementation of epilepsy teaching sessions for relevant junior doctors
- Formal CTG training introduced by the Obstetrician to Anaesthetists
- Sign up to phase 2 of the Transform Programme developed by the National End of Life Care Programme.

> "Staff are cheerful and help you if you need it.
> They always check to see if I am okay"

2.2.3 Research and Development

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 2591. 7.1% were recruited to commercial studies. This represents an increase in annual recruitment of over 100% compared to 2011/12.

The dermatology department has joined cancer, cardiology and musculoskeletal medicine as a research active specialty by taking part in several large multicentre studies during 2012/13, both academic and commercial studies. This success continues to be due to the services of a research nurse employed by Birmingham & Black Country Comprehensive Local Research Network (BBC CLRN) and the Clinical Research Unit's laboratory facilities. Diabetes and neurology have also started to recruit to academic clinical studies.

Dudley Group hosts three research fellows, one funded by Arthritis Research UK, another funded by BBC CLRN. Rheumatology staff submitted three grant applications.

Some of the improvements in clinical practice brought about by participating in clinical trials and other research studies are:

- Further use of targeted Systemic Anti-Cancer Therapies, which have less associated toxicity and improved efficacy;
- Switching of some Systemic Anti-Cancer Therapies which were previously given intravenously are now given subcutaneously which leads to swifter administration (an advantage for patients and staff alike) and a lower side-effect profile;
- More targeted use of prophylactic medications to prevent infection.

Trust publications, including conference posters, increased to 120 during the calendar year 2012, the largest contribution coming from the rheumatology department.

2.2.4 Commissioning for Quality and Innovation Payment (CQUIN) framework

A proportion of the Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:

https://commissioning.supply2health.nhs.uk/eContracts/Documents/cquin-guidance.pdf

CQUIN is a quality increment that applies over and above the standard contract. The sum is variable based on 2.5% of our activity outturn and conditional on achieving quality improvement and innovation goals. The estimated value in 2012/13 was £6.5m as part of our contracts with PCTs for acute and community services, and with specialised services commissioners. We have not yet agreed the final settlement figure for 2012-13 as some targets are still contingent upon outstanding information. However, for the purpose of the year end accounts, we have assumed 90% achievement of both the PCT and specialised services schemes. This would equate to approx £5.8m. In 2011/12 the payment was £3.56m.

There is one CQUIN scheme per contract, made up of several goals. Goals for venous-thromboembolism, responsiveness to personal needs, dementia and NHS Safety Thermometer are nationally determined, and the remainder are locally agreed. We have rated last year's CQUINS on a red/amber/green basis dependent on achievement to date. We will fall short of meeting the five goals for patient experience, dementia screening, smoking and alcohol, making every contact count and peritoneal dialysis and we have actions in place to ensure the quality of care in these areas is improved.

Acute

Goal No.	Targets and topics	Quality Domain(s)
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Dementia Screening, Risk Assessment and Referral for Specialist Diagnosis	Safety/Effectiveness
4	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
5	Medicines Management – Antimicrobial Stewardship	Safety/Effectiveness
6	Alcohol and Smoking	Effectiveness

Community

Goal No.	Targets and topics	Quality Domain(s)
1	Improve responsiveness to personal needs of patients	Patient Experience
2	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
3	Tissue Viability – Pressure Ulcers	Safety/Effectiveness
4	Virtual Ward	Safety/Effectiveness
5	Making Every Contact Count	Effectiveness

Specialist Services

Goal No.	Targets and topics	Quality Domain(s)
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety
2	Improve responsiveness to personal needs of patients	Patient Experience
3	Dementia Screening, Risk Assessment and Referral for Specialist Diagnosis	Safety/Effectiveness
4	NHS Safety Thermometer	Patient Experience/Safety/Effectiveness
5	Clinical Dashboards	Safety/Effectiveness
6	Renal Dialysis – Peritoneal Dialysis Therapyy	Effectiveness Patient Experience
7	Renal Dialysis – Home Haemodialysis Therapy	Effectiveness Patient Experience
8	Neonates – Pathway for Therapeutic Hypothermia	Safety/Effectiveness
9	Neonates – Discharge Planning	Effectiveness

"They are very helpful and friendly staff
and they make sure my bell is there. I feel respected."

CQUINS report 2013/14

In 2013/14 the amount the Trust will be able to earn is 2.5% on top of the actual outturn value. The estimated value of this is £6.2m. The nationally mandated CQUIN goals for venous-thromboembolism, dementia screening and the NHS Safety Thermometer will continue and in addition there will be 3 indicators within the Friends and Family Test.

Acute and Community

Goal No.	Targets and topics	Quality Domain(s)
1	Friends and Family Test (3 parts)	Patient Experience
2	NHS Safety Thermometer – Pressure Ulcers	Patient Experience/Safety/Effectiveness
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	Safety/Effectiveness/Patient Experience
4	VTE Risk Assessment (2 parts)	Safety
5	Safe and Timely Discharge	Effectiveness
6	Staff Well Being	Effectiveness
7	Patient Experience for Learning Disability Patients	Patient Experience
8	Ambulatory Care Pathways	Effectiveness
9	Letters returning to the referring Clinician	Effectiveness
10	Choose and Book	Effectiveness
11	Senior Clinician Review	Effectiveness

Specialist Services

Goal No.	Targets and topics	Quality Domain(s)
1	Friends and Family Test (3 parts)	Patient Experience
2	NHS Safety Thermometer – Pressure Ulcers	Patient Experience/Safety/Effectiveness
3	Dementia screening, risk assessment and referral for specialist services (3 parts)	Safety/Effectiveness/Patient Experience
4	VTE Risk Assessment (2 parts)	Safety
5	Quality Dashboards	Safety/Effectiveness/Innovation
6	Renal dialysis – Renal Patient View	Effectiveness/Innovation/Patient Experience
7	Reducing incidence of preventable acute kidney injury (AKI)	Safety/Effectiveness/Patient Experience
8	Bone Marrow Transplants – donor acquisition measures	Patient Experience
9	HIV – registration and communication with GPs	Safety/Effectiveness
10	Neonatal Intensive Care – Improved access to breast milk; TPN in preterm infants; timely discharge; retinopathy of prematurity	Safety/Effectiveness/Patient Experience

2.2.5 Care Quality Commission (CQC) registration and reviews (see also Section 2.2.1)

The Dudley Group NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2011/12.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Following the September 2011 visit to review our compliance against the 16 Essential Standards of Quality and Safety set out by the CQC, we submitted an action plan to the CQC for one of the standards. The CQC revisited the Trust in July 2012 to review the progress of the required actions and as these were all complete we were found to be compliant. In addition, the CQC made a further unannounced visit in February 2013 and, again, we were found to be compliant with the standards.

2.2.6 Quality of data

The Trust submitted records during 2012/13 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data:

which included the patient's valid NHS number was:

- 99.9% for admitted patient care; National average was 99.3%
- 99.7% for outpatient care; National average was 99%
- 99.1% for accident and emergency care, National average was 94.7%

which included the patient's valid General Practitioner Registration Code was:

- 100% for admitted patient care; National average was 99.9%
- 100% for outpatient care; National average was 99.9%
- 100% for accident and emergency care. National average was 99.7%

The Trust's Information Governance Assessment Report overall score for 2012/13 was 78 per cent and was graded 'Green'.

The Trust was subjected to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were [percentages].

These results should not be extrapolated further than the xx (specialities) samples audited.
During 2012/13 there were 14 incidents relating to data loss. These included letters sent to incorrect and old addresses. Actions taken from these incidents included:

The Trust will be taking the following actions to improve data quality:

- Audits have commenced to review the secure movement and storage of case notes and person identifiable information.
- Meetings have taken place between the Trust and our private partners to ensure that there is a Standard Operating Procedure, training and awareness, audit and easy access to reporting incidents for all staff with the responsibility of either moving or holding case notes.
- Crib sheets have been produced to remind reception staff to thoroughly check patient demographic details
- Manual processes have been reviewed and standardised for the input of documents into patient case notes/hand held notes and for ensuring postal addresses are accurate and complete and checked against the hospital main computer system if previously using stand alone systems
- A review of training has taken place so Face to Face sessions as well as computer based training are now organised.

2.2.7 Core Set of Quality Indicators

This is the first year that all Trusts have been mandated to insert this section which includes a stipulated number of measures. Due to the time it takes central bodies to collate and publish some of the data, not all of it is uptodate and sometimes comparative figures are not available at all (N/A). It should also be appreciated that some of the 'Highest' and 'Lowest' performing Trusts on some of the data may not be directly comparable to an acute general hospital e.g. specialist eye or orthopaedic hospitals that have very specific patient groups.

MORTALITY			
Topic and detailed indicators	**Immediate Reporting period: July 2011- June 2012**	**Previous Reporting Period: Apr 2011-Mar 2012**	**Statements**
Summary Hospital-level Mortality Indicator (SHMI) value and banding	*Value* Trust: 1.036 National Av: 1 Highest: 1.26 Lowest: 0.71 *Banding* Trust: 2 Average: 2 Highest: 3 Lowest: 1	*Value* Trust: 1.07 National Av: 1 Highest: 1.25 Lowest: 0.71 Banding Trust: 2 Average: 2 Highest: 3 Lowest: 1	The Trust considers that this data is as described for the following reasons: The Trust acknowledges that its SHMI is within the expected range The Trust has taken the following action to improve this value and so the quality of its services by: Monitoring our hospital deaths in detail and thoroughly investigating each case
Percentage of admitted patients whose treatment included palliative care	Trust: 0.9% National Av: 1.0% Highest: 3.3% Lowest: 0%	Trust: 0.7% National Av: 1.0% Highest: 3.3% Lowest: 0%	The Trust considers that this data is as described for the following reasons: The Trust acknowledges that these percentages are within the expected range The Trust has taken the following actions to improve these percentages, and so the quality of its services by: -Working closely with the specialist palliative care team -Improving access to the expertise of the palliative care team and recording their input accurately
Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (Context indicator)	Trust: 21.65% National Av: 18.4% Highest: 46.3% Lowest: 0.3%	Trust: 16.5% National Av: ? Highest: 44.2% Lowest: 0%	

PROMS – PATIENT REPORTED OUTCOME MEASURES			
Topic and detailed indicators	**Immediate Reporting period: 2011/12 Provisional**	**Previous Reporting Period: 2010/11 Finalised**	**Statements**
Groin Hernia Surgery,	Trust: 0.046 National Av: 0.087 Highest: 0.143 Lowest: -0.002	Trust: 0.069 National Av: 0.085 Highest: 0.156 Lowest:-0.020	The Trust considers that this data is as described for the following reasons: The Trust acknowledges the results vary across the four procedures; for Groin Hernia surgery it's below average, for Varicose Vein surgery it's above average and for Hip and Knee replacements it's in the region of the National average. With regards to Groin Hernia we have noted that '94% of patients said that their problems are better now when compared to before the operation' and '87% of patients describe the results of their operation as excellent, very good or good'. The Trust has taken the following actions to improve these scores, and so the quality of its services by: The Trust regularly monitors and audits the pre and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures. The health gains that PROMs measure are of a more generic nature and are not exclusively linked to secondary healthcare provision and will need the consideration of a health economy-wide group to influence, comprising GPs, community services, social services, welfare benefit services and Public Health.
Varicose Vein Surgery	Trust: 0.123 National Av: 0.094 Highest: 0.167 Lowest: 0.047	Trust: 0.097 National Av: 0.091 Highest: 0.155 Lowest: -0.007	
Hip Replacement Surgery	Trust: 0.398 National Av: 0.416 Highest: 0.532 Lowest: 0.306	Trust: 0.381 National Av:0.405 Highest:0.503 Lowest:0.264	
Knee Replacement Surgery	Trust: 0.302 National Av: 0.313 Highest: 0.385 Lowest: 0.180	Trust: 0.311 National Av: 0.299 Highest: 0.407 Lowest: 0.176	

READMISSIONS			
Topic and detailed indicators	**Immediate Reporting period: 2010/11**	**Previous Reporting Period: 2009/10**	**Statements**
% Readmitted within 28 days Ages 0-14	Trust: 9.34 National Av: 10.15 Highest: N/A Lowest: N/A	Trust: 8.88 National Av: 10.18 Highest: N/A Lowest: N/A	The Trust considers that this data is as described for the following reasons: Since the national published figures (across) are considerably historical, we have looked at our recent data and in 2012/13 the overall Trust average for all ages groups is 6.2% which compares to our peer group of similar hospitals of 6% (from CHKS) The trust is in the top 10% of Trusts within the Midlands & East SHA cluster for low readmissions to the same speciality. The Trust intends to take the following actions to reduce this percentage, and so the quality of its services by: -Continuing to develop its Paediatric Assessment Unit service. Rapid senior assessment for potential paediatric emergency admissions is undertaken and the principle of more senior and rapid assessment, will reduce admissions and readmissions. -Continuing to expand and develop the Acute Medicine and Acute Surgery service. By employing more senior decision makers in the initial assessment units, for longer, some unnecessary/avoidable admissions are prevented -The continued development of the community virtual ward service. More proactive, risk based management of virtual ward patients is already having an effect on avoidable admission reduction -Working with CCG and primary care practitioners to improve the medical and nursing support to local nursing homes. The LES for nursing homes and ENP service will work to appropriately manage "frequent attenders" and avoid hospital admission and readmission -A "flag" is being developed in our patient administration system to identify patients who are at risk of being readmitted, to aid staff decision making about alternative care pathways and care settings
% Readmitted within 28 days Ages 15 and over	Trust: 11.55 National Av: 11.42 Highest: N/A Lowest: N/A	Trust: 10.94 National Av: 11.16 Highest: N/A Lowest: N/A	

RESPONSIVENESS TO INPATIENTS' PERSONAL NEEDS			
Topic and detailed indicators	**Immediate Reporting period: 2012**	**Previous Reporting Period: 2011**	**Statements**
Average score (out of 100) from the five patient experience questions included in the national patient experience CQUIN	Trust: 64.9 National Av: Highest: Lowest:A	Trust: 63.8 National Av: 67.4 Highest: 85 Lowest: 56.5	The Trust considers that this data is as described for the following reasons: The Trust notes that is only slightly lower than the national average The Trust intends to take/has taken the following actions to improve this score, and so the quality of its services by: Asking these same five questions as part of our real-time surveys to enable results to be attributed to and acted upon at ward level. During 2012/13 more than 3000 patients have given us their feedback via our real-time surveys.

STAFF VIEWS			
Topic and detailed indicators	**Immediate Reporting period: 2012**	**Previous Reporting Period: 2011**	**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care (Acute Trusts)	Trust: 61% National Av: 60% Highest: 86% Lowest: 35%	Trust: 67% National Av: 62% Highest: 89% Lowest: 33%	The Trust considers that this data is as described for the following reasons: Whilst there is a small decline compared to the results of the 2011 survey, the latest score of 60% is in line with the National Average for Acute Trusts. The Trust intends to take/has taken the following actions to improve this percentage/ and score, and so the quality of its services by: -Commencing focus groups led by Executive Directors following the publication of the Staff Survey results. At which staff are asked about areas of engagement. -Breakdown of directorate results are made available for directorate leads and line managers. -The Trust involves and communicates with staff though adopting the Listening in Action programmes. This has covered a wide range of topics.

VENOUS THROMBOEMBOLISM (VTE)			
Topic and detailed indicators	**Immediate Reporting period: Q3 Oct- Dec 2012**	**Previous Reporting Period: Q2 Jul- Sep 2012**	**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism	Trust: 94.8% National Av:94.2% Highest:100% Lowest:83.3%	Trust: 95.9% National Av: 93.9% Highest: 100% Lowest: 80.9%	The Trust considers that this data is as described for the following reasons: The Trust is pleased to note that it is above the national average in undertaking these risk assessments due to, in particular, the work of a dedicated specialist nursing team and the promotional work they undertake on this important topic. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: -Continuing the educational sessions with each junior doctor intake -Continuing with a variety of promotional activities to staff and patients -Implementing the use of technology to assist in the recording of the risk assessments

INFECTION CONTROL			
Topic and detailed indicators	**Immediate Reporting period: 2011-12**	**Previous Reporting Period: 2010-11**	**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care (Acute Trusts)	Trust: 44.8 National Av: 21.8 Highest: 51.6 Lowest: 0	Trust: 32.1 National Av: 29.6 Highest: 71.8 Lowest: 0	The Trust considers that this data is as described for the following reasons: The Trust acknowledges it needs to improve its rate and has done so this year (2012-13) (please see Section 2.1.3 which shows a reduction by more than 50% from 2011-12). The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services by: -Reviewing in detail all cases to see what lessons can be learned to prevent further cases -Further promoting effective antimicrobial prescribing -Introducing more intensive cleaning methods and expanding its use -Improving the guidance to clinicians on the prevention and treatment of C.diff

CLINICAL INCIDENTS			
Topic and detailed indicators	**Immediate Reporting period: Apr 12 – Sep 12**	**Previous Reporting Period: Oct 11 – Mar 12**	**Statements**
Number and rate of patient safety incidents (incidents reported per 100 admissions) (compared to 49 medium acute Trusts)	Trust: 7.5 Average: 6.7 Highest: 14.3 Lowest: 3	Trust: 8.1 Average: 6.7 Highest: 10.2 Lowest: 2.1	The Trust considers that this data is as described for the following reasons: As organisations that report more incidents usually have a better and more effective safety culture, the Trust is pleased to note it has higher than average reporting rates. The Trust has taken the following actions to improve this rate, and so the quality of its services by: -Continual raising of awareness of what constitutes as an incident and how to report. -Continual improvement of quality investigations and learning.
Number and percentage of patient safety incidents resulting in severe harm or death	Trust: 1% National Av: 0.8%	Trust: 1.2% National Av: 0.8%:	

"I felt comfortable complaining.
I told them what they did wrong and they got better"

PART 3 OTHER QUALITY INFORMATION

3.1 Introduction

The Trust has a number of different Key Performance Indicators (KPI) reports which are available and used by a wide variety of staff groups monitoring quality on a day-to-day basis. The main repository for the reporting of the Trust's key performance measures is a web based dashboard, which is available to all senior managers and clinicians and currently contains over 130 measures, grouped under the headings of Quality, Performance, Workforce and Finance. In addition, constant monitoring of a variety of aspects of the quality of care include weekly reports being sent to senior managers and clinicians which include the A&E, Referral to Treatment, Stroke and Cancer targets. Monthly reports are also sent to all wards, which include a breakdown of performance by ward based on Nursing Care Indicators, Ward Utilisation, Adverse Incidents, Governance and Workforce Indicators and Patient Experience scores.

To compare ourselves against other Trusts, we use CHKS Ltd, which is a leading UK provider of comparative healthcare information, as a Business Intelligence monitoring tool. Some senior managers have access to the West Midlands SHA comparative performance tables to enable the Trust to benchmark itself against other trusts.

The following three sections of this report provide an overview, with both statistics and examples, of the quality of care at the Trust, using the three elements of quality as outlined in the initial chief executive's statement:

- Patient experience: Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?
- Patient safety: Are patients safe in our hands? and,
- Clinical effectiveness: Do patients receive a good standard of clinical care?

The fourth section includes general quality measures which have remained the same for 2011/12 as the Trust Board and our stakeholders believe these take into consideration both national and local targets which will be important to patients and give a further perspective of the Trust's quality of care.

PATIENT EXPERIENCE

3.2 Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

3.2.1 Introduction

This section includes the various methods of gaining a picture of patients' views of the Trust and examples of changes made based on those views.

3.2.2 Trust-wide Initiatives

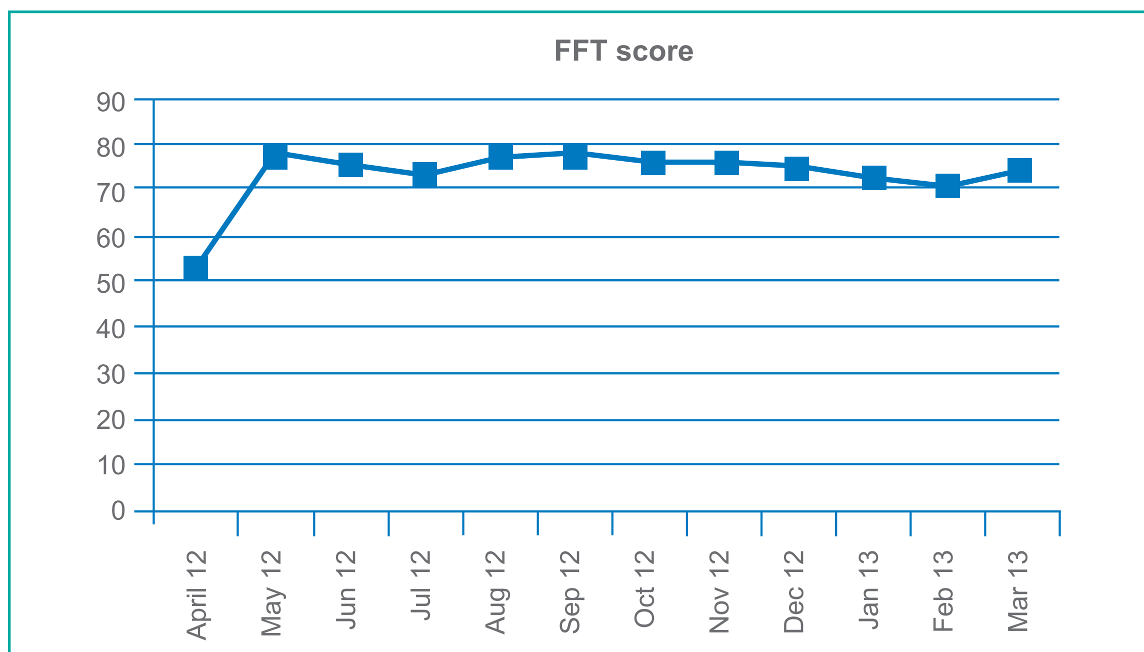
a) Friends and family test

We have been running the Friends and Family Test (FFT) on our wards since April 2012, asking all inpatients when leaving the ward whether they would recommend the service they had received to a friend and family in their hour of need. Patients were asked to rate us on a scale of 0-10 and offer suggestions where they think improvements could be made.

"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

Average FFT score for 2012/13	Average % of patients completing the FFT
73	21%

Actual monthly FFT score 2012/13



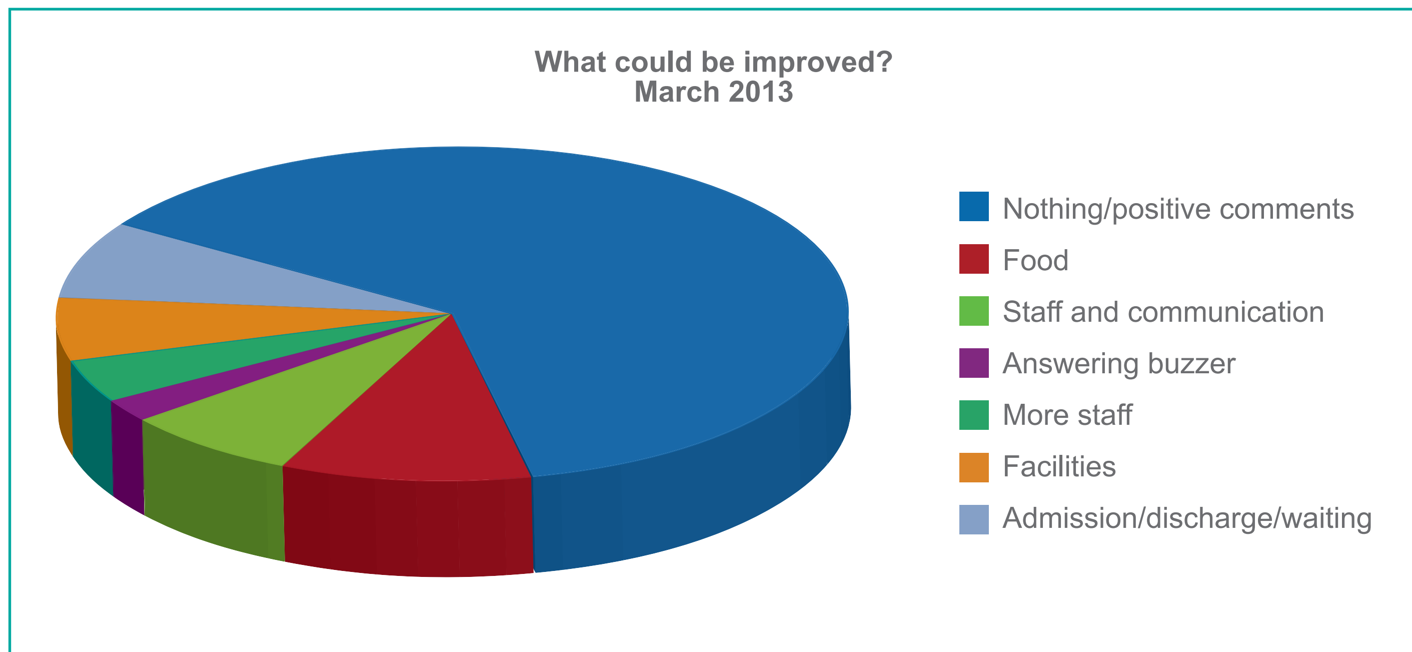
We are pleased that patients have been rating our services highly with scores mainly in the 70s, and we are using comments left to make improvements.

What have patients told us so far?

Around 70 per cent of the comments we have received from patients completing the Friends and Family Test are positive. It is really great for our staff to hear such positive feedback to know that they are providing a good service.

However, there is always room for improvement and below the chart below shows the most requested items for improvement during March 2013, food is a common response from an average of 14 per cent of patients during the year (12% in the chart below for March).

All feedback from patients is shared with the wards to help them to make improvements locally, as well as bigger issues being tackled on a Trust-wide basis.



From April 2013 all UK hospitals will be using the Friends and Family Test for inpatients and those patients who have visited A&E as part of a national roll out programme. Patients will be invited to respond to FFT question by choosing one of six options, ranging from 'extremely likely' to 'extremely unlikely' (for 2012/13 we used a 0-10 scale).

The Friends and Family Test is one way we gather patient feedback to help us drive improvements in services.

b) Real-time surveys

During 2012/13 our real-time surveys have gone from strength to strength gaining important feedback from patients in a timely manner. This allows us to react quickly to any issues and to use patient views in our service improvement planning.

An example of surveys undertaken during the year are shown below, these range from large-scale Trust-wide surveys, to smaller departmental surveys:

Survey	Responses
Inpatient survey	3069
Discharge survey	780
Outpatient survey	529
Eye Clinic survey	37
Maternity environment survey	67

c) Patient stories

We have continued using patient stories during 2012/13 to enable the patient voice to be heard at the highest level. Stories have been heard at Board meetings and used for service development planning and training purposes.

d) Community volunteers – making our patients smile

During 2012/13 the Trust has worked with the Kissing it Better charity to invite community volunteers and groups into the hospital to entertain our patients. Entertainment has included:

- Gospel singers
- Face painting, hand massage, manicures and make up from Dudley college beauty students
- Regular visits from Buster the dog (and his owner Anthea) from Pets as Therapy

It is a pleasure to see the reaction of patients and staff to these activities; smiles, tears of joy and happiness, laughter and conversation. Priceless! We cannot thank the volunteers enough for their time and effort given to brighten our patients' day.

These activities have been so successful that we plan to develop this initiative during 2013/14.

e) I am the patient experience video

We also wanted to express to staff how each and every one of them contributes to a good experience for our patients. With staff from a variety of roles we produced a motivating and uplifting video to promote good patient experience and raise awareness of the Trust's vision "Where People Matter".

The video can be viewed on our website www.dudleygroup.nhs.uk

Example of actions taken as a result of patient feedback

Inpatient mealtimes

Following patient feedback from our surveys, patient panel and also our Friends and Family test, we have been reviewing the way we deliver our inpatient meal service.

In January 2013 we visited the supplier of an alternative food system called 'Steamplicity' and liked what we saw. Following this we have run a Steamplicity pilot on one of our wards during March, we have also held taste tests for our Governors, patient panel members and also for staff to sample the food.

We are gathering as much feedback as possible to help us in our decision-making process around how we can improve our mealtime service.

Accessibility

Feedback from patients has also informed us that we could make improvements around accessibility. With patients' help we have drawn up an action plan and have, so far, ordered 30 more wheelchairs for main reception at Russells Hall Hospital and worked on our hearing loops system (including a number of portable hearing loops that departments can access as and when needed).

Information

Patients told us that they didn't always receive enough information about the ward they were staying on. During the year our 'Welcome to the Ward' booklets were launched giving useful information to patients and relatives relating to visiting and meal times, contact numbers and general ward routines.

3.2.3 National Survey Results

In 2012 we took part in two national patient surveys, one for inpatients and one for Accident and Emergency patients. The Trust chose Picker Institute Europe as our independent survey coordinator and participants were selected against the sampling guidance issued. For the national surveys 850 patients were selected to partake in a survey from the sample months indicated in the table below.

A further 1000 participants were selected to partake in the Accident and Emergency survey as part of a national pilot offering the survey in an online format.

Survey	Sample month	Response rate	National average response rate
Inpatient survey	July 2012	51.7%	48%
A&E survey (including online pilot)	March 2012	33%	33.7%

What the results of the surveys told us

Inpatient Survey

Things we are good at:

- Having all of the necessary information relating to the patients' condition/illness
- Answering patients' queries about the operation or procedure
- Privacy when being examined or treated
- Availability of hand gel for use by patients and visitors

Areas where improvements could be made:

- Inpatient meals
- Information about condition in A&E
- The wait to get a bed on the ward
- Information about condition or treatment

A&E survey

Things we are good at:

- Staff not talking in front of patients as if they weren't there
- Explaining results of tests in an understandable way
- Advising when normal activities such as driving or working can be resumed

Areas where improvements could be made:

- Length of time to first speak with a nurse or doctor
- Length of time to be examined by a nurse or doctor

Actions plans have been drawn up to make improvements in the areas identified.

"My neighbours speak highly of this hospital.
It has been as good as I expected."

3.2.4 Examples of Specific Patient Experience Initiatives

a) Kidney dialysis patients access tests online

Patients can now keep track of their treatment and test results from the comfort of their homes, or even while on holiday abroad. A new computer system, called Renal PatientView is more convenient, can save time and will also allow patients to have more control and involvement in their care.

It means they will no longer have to wait for an appointment or travel to hospital to get the latest news about their progress or advice on any worries. Important personal details are easily available to doctors outside the Trust using the patients login details if a patient is taken ill away from home. “Renal PatientView will allow them to see their results as soon as they become available and enable them to monitor their progress,” says Helen Perkins, Renal Unit, Lead Nurse. “It allows them to manage their information, be better informed on their results and medications and attend their appointments armed with more knowledge about their treatment.”

b) Assessment of patients prior to surgery

A number of changes in the surgical pre-assessment process have taken place this year resulting in improvements in the quality of care and patient feedback. Both staff, ensuring that patients are fully assessed for their surgery, and patients themselves, knowing what to expect, have been shown to reduce the risk of complications leading to quicker recovery and a better outcome for the patient.

The depth of the pre assessment is now based on the patient’s graded risk so ensuring that more time is spent with those at greater risk. Cancellations prior to surgery have also been radically reduced. A survey of 115 patients between September-November 2012, has shown a high satisfaction with the new system with 98% indicating they were as involved as much as they wanted to be in decisions about their care and treatment, 90% definitely happy with the care they received from the pre-assessment service and the same number agreeing that they had received enough information about their operation and anaesthetic.

c) Rheumatology outpatients survey

This year the Rheumatology Department repeated a survey of outpatients it had previously undertaken in 2008. Approximately 550 patients attending the clinic during January 2013 completed the questionnaire. Overall, the majority of patients reported excellent levels in the quality of care received and in their experience of the clinic.

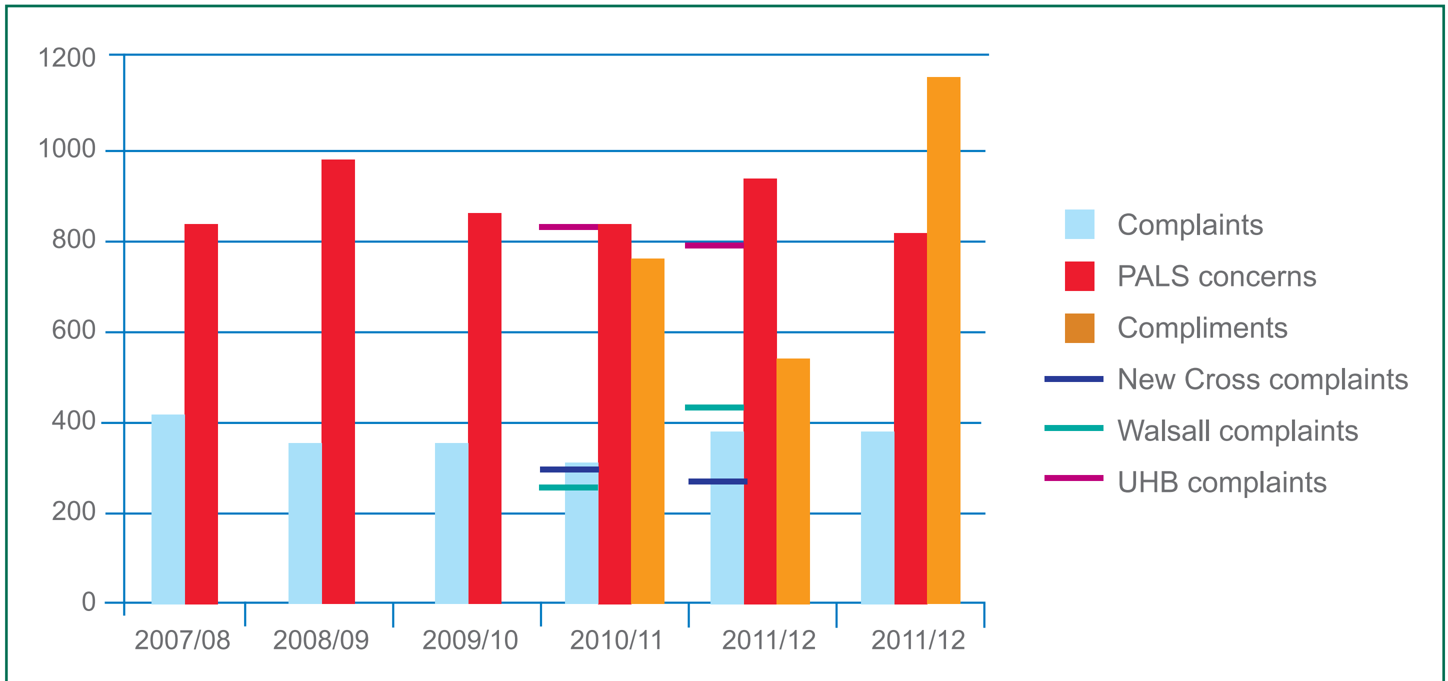
For instance, 89% of patients thought they were definitely involved as much as they wanted to be in the clinical decisions being made (6% - Yes to some extent, Unanswered – 4%, No – 0%) and 91% had complete confidence and trust in the examining/treating doctor/nurse (3% - Yes to some extent, Unanswered – 6%, No – 0%). When asked to rate on a scale of 0-10 how likely is it that you would recommend this service to family and friends? (10= very likely, 0= not at all) 93% rated the service at ≥ 8 (56% =10; 16%=9; 21%=8) and only one (0.2%) patient rated the service at < 5.

There were two areas for improvement: Although 80% were seen within 30mins of their appointment (41% on time) and there had been a 50% reduction of patients waiting more than an hour compared to 2008, the department is looking to see how it the rheumatology outpatient department completed the questionnaire. Overall, the majority of patients reported excellent levels in the quality of care received and in their experience can increase these numbers as well as reducing rescheduling of appointments which had occurred in 15% of cases.

3.2.5 Complaints and Compliments

This summary contains three tables showing a) the total number of complaints, concerns raised with the patient and liaison service and compliments during the year, compared to both previous years and where possible compared with local trusts b) the total and top five types of complaints this year compared to last year c) the percentage of complaints compared to the total number of patients visiting the Trust d) some examples of changes in practice made from complaints.

a) Total numbers of complaints (with local trust benchmarks), PALS concerns and compliments



b) Total number and five main types of complaints

Categroy	Year end 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13	Year end 2012/13
TOTAL	375	75	101	108	89	373
All aspects of clinical treatment	238 (63%)	51	86	88	74	299 (80%)
Attitude of staff	36 (10%)	8	1	2	4	14 (4%)
Communication /information to patient	26 (7%)	2	4	8	4	18 (5%)
Admission, Discharge & Transfer	19 (5%)	1	1	4	2	8 (2%)
OPD appointment delay/cancellation	29 (8%)	6	5	3	3	17 (5%)

c) Percentage of complaints against activity

ACTIVITY	Total year ending 31/3/11	Total year ending 31/3/12	Total year ending 31/3/13
Total patient activity	714519	753469	735247
% Complaints against activity	0.05%	0.05%	0.05%

d) Examples of changes in practice from complaints

Emergency, Specialty Medicine & Elderly Care

- Medical staff to check if ongoing psychiatric medication is continued to be prescribed during hospital admission.
- Review of mandatory training undertaken relating to care of a vulnerable adult
- Patients sitting in GP area to be reassessed if their condition deteriorates.
- Information regarding Hickman lines being updated and will be available for patients very soon.
- Aftercare information to be provided on discharge
- Measures put into place to reduce capacity, with some activity moved outside of the hospital, which has subsequently reduced waiting times within the Oncology unit.
- A record of telephone calls made directly to the district nurse team for those discharges that are complex is now maintained to ensure appropriate information has been communicated in a timely manner.
- Emergency Assessment Unit (EAU) discharge process being reviewed to improve communication between staff and family members
- EAU reviewing the availability of senior nursing staff, posters advising patients and relatives to speak to a member of the nursing staff if they have any concerns whilst awaiting assessment and the provision of information booklets explaining the systems in operation within the area
- Review of seating within Emergency Department being undertaken

Women and Children

- Posters to be developed to inform women of staff to be approached regarding waiting times in maternity OPD
- Process to be changed so that women are informed of all results, whether normal or abnormal. Leaflet to be changed to reflect this.
- Process for contacting the rapid response team in the event of a child death made available to all staff.
- Additional information added to bereavement box which contains information for the parents of a child who dies on the ward now available to staff.
- In the event of a child death, staff will arrange transport home for relatives and carers, if required.
- All community midwives to ensure women make an appointment at their local community phlebotomy service for their blood sugar tests to prevent any delays occurring.
- Re-develop gastro-oesophageal reflux (GOR) guidelines and design a GOR patient advice leaflet
- Information leaflets to be reviewed and additions made regarding water birth, as required; community midwives to give advice about age parameters for water in labour/birth.
- Midwives to encourage women to administer their own Enoxoparin whilst an inpatient to build confidence before being discharged.
- A surrogate policy to be produced

Diagnostics

- MRI scan appointment letter amended to include additional information for patients
- Senior clinical midwife manager to discuss ethnic origin codes for postnatal newborn screening to avoid any confusion.
- Review of service enabled Sonographers to add extra women onto their lists.
- Patients who have common variable immunodeficiency disorders require long-term replacement treatment with immunoglobulins. It is recognised that home therapy minimises hospital attendance for infusions and a business plan was submitted to the PCT in January 2013 and approved by the HENIG (Dudley health economy NICE implementation group) and forwarded to the commissioning team. Once agreed, Trust to start the process of training and transfer to home care.

Surgery & Anaesthetics

- Portering staff to make ad hoc deliveries if urgent notes are required in clinic
- Staff to offer pain relief medication before commencing mobilisation
- Review practice of instructing patients to be nil by mouth prior to surgery and divide lists into AM/PM to minimise time patients are without diet and fluids.

Ambulatory medicine

- An inpatient care plan currently being developed and dialysis prescription that will help in communication between specialities and subsequently improve the patient journey.

Trauma, Orthopaedics & Plastics

- Patients with metal on metal hips will be monitored and provided with appropriate guidelines regarding their management.

3.2.6 PEAT Scores

Patient Environment Action Team (PEAT) is an annual assessment of inpatient healthcare sites in England. It is carried out in accordance with guidance and the team is made up of Trust staff, PFI partners and an external validator. Patient representatives are also involved in the audit which is carried out on a single day once per year. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care, including environment, food and privacy and dignity. The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

Comparative PEAT assessment results 2009-2012:

Year	Site Name	Environmental Score	Food Score Score	Privacy and Dignity Score
2012	Russells Hall Hospital	Excellent	Good	Good
2011	Russells Hall Hospital	Excellent	Good	Good
2010	Russells Hall Hospital	Excellent	Good	Good
2009	Russells Hall Hospital	Good	Good	Good

> The compassion the ward staff showed to my sister and I during mother's final hours was nothing short of extraordinary.

From 2013 the way the assessment is carried out is changing. The assessments will be 'patient-led' to ensure that the patient voice is given the highest priority and patient assessors will make up at least 50% of the assessment team. The following elements will be assessed:

- Cleanliness
- The condition of the buildings and fixtures (inside and out)
- How well the building meets the needs of those use it, e.g. signage
- The quality and availability of food and drinks
- How well the environment protects people's privacy and dignity

Training will be given to the team of volunteer patient assessors who will be made up from members of our local community.

3.2.7 Patient experience measures:

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Comparison with other Trusts 2012/13
Patients who agreed that the hospital room or ward was clean	87%	87%	88%	8.7	8.8	About the same
Patients who would rate their overall care highly	79%	76%	74%	7.4		About the same
Rating of overall experience of care (on scale 1-10)					7.6	
Patients who felt they were treated with dignity and respect	89%	86%	86%	8.6	8.7	About the same

Data from national inpatient surveys conducted for CQC – Initially scores expressed as percentages but from 2011 scores reported out of 10 (Previously this table was compiled from raw data scores).

There has been a change to these three measures this year. The first measure is new this year. Previously we published the score for 'Patients that would recommend the hospital to a relative/friend', in this table, however, due to the introduction of the mandatory 'Family and Friends' test this year (see Section 3.2.2) this would have been a duplication and so it has been removed from here. In addition, the wording of the second question has changed in this year's national survey, hence we are unable to make a direct comparison with previous years scores.

PATIENT SAFETY
3.3 Are patients safe in our hands?

3.3.1 Introduction

Ensuring patient safety is undertaken in many diverse ways from the quality of the training staff receive to the quality of equipment purchased. This section includes some examples of the ways we try to prevent things going wrong and what we do on those occasions when things unfortunately do not go to plan.

3.3.2 Directors Walkrounds

These Patient Safety Leadership Walkrounds consist of directors hearing first hand the safety concerns of front line staff.

All wards, therapy and community departments are visited throughout the year by an Executive Team. The team consists of, as a minimum, one Executive Director, one Non Executive Director and a Senior Clinician (i.e. Nurse).

The Team observe practice by being shown around the ward by a ward representative who also provides a verbal summary of the ward activity, specialty and ways of working. It meets informally with the ward/clinical areas representatives to discuss the staff members areas of concern related to patient safety issues. In response a report and action plan is produced to address areas of concern identified. Some actions taken from these visits include:

- Purchase of further specialist equipment e.g. medical monitoring equipment, chairs, commodes, wheelchairs for overweight patients
- Introduction of training of Junior Doctors in relation to timely prescriptions of medication to take home.
- Completion of minor works for example: blinds, shelving etc
- Process put in place for volunteers to locate and return wheelchairs to main reception for use by patients.
- Introduction of an additional Oncology outreach service from the Brierley Hill clinic
- Further development and introduction of training programmes to increase healthcare professionals' knowledge and skills within specialties.
- Review of visiting times to ensure patient safety during drug administration

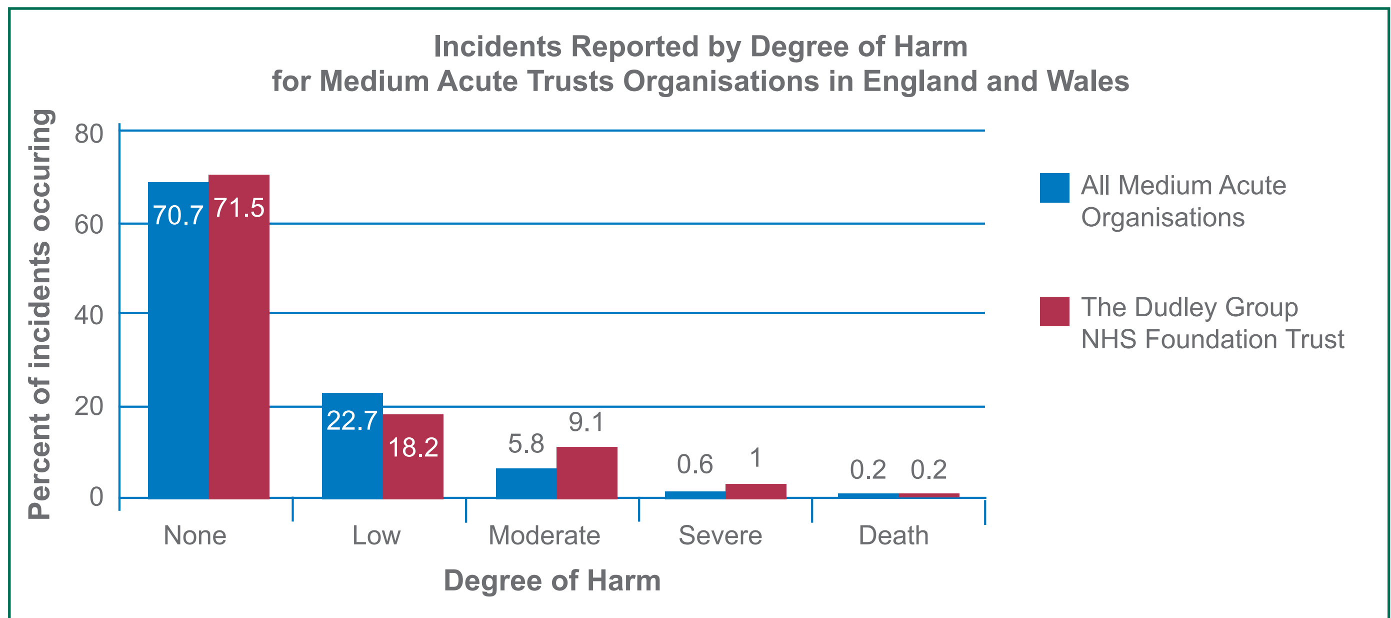
3.3.3 Incident Management

The Trust actively encourages its staff to report incidents, believing that to improve safety it first needs to know what problems exist. This reflects the National Patient Safety Organisation which has stated:

'Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are'.

The latest national comparative figures available are for the period 1 October 2011 to 31 March 2012. Organisations are compared against others of similar size. The Trust is the twelfth highest reporter of incidents in its class of medium size acute Trusts.

With regards to the impact of the reported incidents it can be seen from the graph below, for the same period stated above, that the Trust is similar to other medium sized Trusts. Nationally across all Trusts, 68% of incidents are reported as no harm (the Trust 71.5%) and just under 1% as severe harm or death (Trust 1.2%)



During the period April 2012 to the end of Jan 2013, the Trust has had one 'Never Event' (these are a special class of serious incident that generally are preventable) which resulted in no patient harm. It did have 162 serious incidents all of which underwent an internal investigation and, when relevant, action plans were initiated and changes made to practice ('Serious Incidents' are a nationally agreed set of incidents which may not necessarily have resulted from error but need investigating to check the circumstances of their occurrence).

Some examples of changes made in practice in response to the above incidents have been:

- Development of a new procedure for theatre staff and anesthetists when throat packs are used.
- Implementation of the paediatric Early Warning Score in the Paediatric Department
- Use of fax machines limited to essential use to ensure more robust process to reduce breaches in confidentiality
- Purchase of medical equipment e.g. bed chair alarms and increase the number of patients these are used with
- Development and introduction of a more systematic consistent approach for fluid management and prevention and management of falls
- Implementation of formal Clinician Led Ward Rounds
- Development of care pathways to support clinical practice

> All involved in looking after me were very sensitive to my situation, very polite, very attentive and above all professional. The ward felt like a well oiled machine, I could not have wished for a better experience

3.3.4 Nurse Care Indicators

Every month 10 nursing records and other documents are checked at random in all general wards and departments at the hospital and in every nursing team in the community (in effect, approximately 400 records are audited in total per month) to ensure that nurses are undertaking activities that patients require and documenting that activity. The initial themes looked at were: Patient observations (Temperature, Pulse, Respirations etc), Pain management, Manual handling and falls risk assessment, Tissue viability – prevention of pressure ulcers, Nutrition assessment and monitoring, Medications and Prevention of infection. Further themes have been added or amended: a) in September 2011, 'ThinkGlucose' programme to monitor diabetes, Documentation and Bowel Function Assessments were added and b) In July 2012, Fluid Balance was added and the infection control section amended.

The completion rates of each ward and team are fed back to the Matrons and ward managers for action where necessary. Each ward/team and the whole hospital and community service is RAG (Red/Amber/Green) rated with initially a 'Green' given for a 90% or greater score, an 'Amber/Yellow' 89-70% scores and a 'Red' for scores 69% or less. Due to overall general improvements in scores, it has recently been agreed to make the criteria stricter in that, for example a 'Green' score will only be given for 93% and above. This change will be adopted into next year's Quality Account results.

Hospital Results

The table below shows the end of calendar year position for each of the criteria assessed and changes from year to year. In 2012 we have improvements in 7 of the 11 criterion. Infection control figures (*) show a fall however the questions for this assessment have been totally changed in July 2012 and so a direct comparison with 2011 is not possible.

Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control	Think glucose	Documentation	Bowels	Fluid Balance
2010	77%	70%	71%	86%	68%	92%	95%				
2011	83%	80%	79%	93%	77%	94%	97%	53%	88%	78%	
Difference	↑6%	↑10%	↑8%	↑7%	↑9%	↑2%	↑2%				
2012	86%	88%	85%	95%	82%	94%	91%	79%	88%	81%	77%
Difference	↑3%	↑8%	↑6%	↑2%	↑5%	0	*	↑26%	0	↑3%	

Community Results

The table below shows the end of calendar year position and changes from last year for Community Services for each of the criteria assessed. In 2012 we have improved in 3 of the 9 criterion (Manual Handling, Tissue Viability and Infection Control). During October and November 2012 a more systematic approach to assessing skin care and making correct care and treatment decisions was introduced which will have helped increase the score on Tissue Viability. Due to the high levels of compliance the details of all of the indicators are being reviewed to set higher performance targets so ensuring the highest possible standards of care.

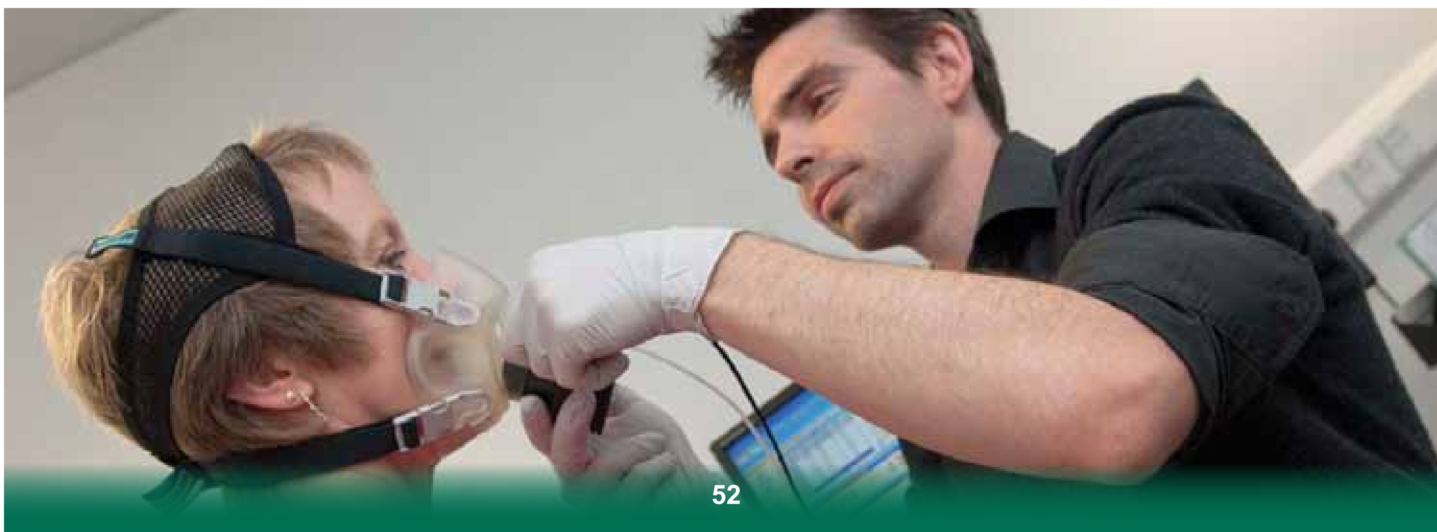
Criterion	Patient Observations	Pain	Manual Handling	Tissue Viability	Nutrition	Medications	Infection Control	Documentation	Privacy and Dignity
2011	97%	98%	94%	95%	97%	99%	97%	98%	99%
2012	97%	98%	97%	97%	97%	99%	98%	98%	99%
Difference	=	=	↑3%	↑2%	=	=	↑1%	=	=

3.3.5 'Harm Free' Care and NHS Safety Thermometer

The NHS Safety Thermometer has been developed as a 'temperature check' on four key harm events - pressure ulcers, falls that cause harm, urinary tract infections in patients with a catheter and new venous thromboemboli. It is a mechanism to aid progress towards 'harm free' care and is being adopted across all of the NHS.

Each month on a set day, an assessment is undertaken which has covered on average 650 inpatients (with exceptions being day case patients, those attending for renal dialysis and well babies) and 620 patients being cared for in the community. The assessment consists of interviews with the patients, accessing the patient's bedside nursing documentation and, when required, examining the main health record.

The trust regularly monitors its performance on these measures and although direct comparisons need to be made with caution it is pleased to note its harm events fall below th national averages.



We aim to reduce these rates to zero percent. Some examples of actions being taken as a result of the assessments:

- Continue to ensure staff are trained and updated by the Tissue Viability Nurse and Link Nurses in the definition and recognition of pressure ulcers
- Enact a verification system to ensure that pressure ulcers are being correctly assessed and recorded
- Adopt a new 'falls bundle' (a clear systematic approach to assessing patients for the risk of falls and putting into place appropriate preventative measures) which is being trialled on specific ward for later roll out and implementation in all clinical areas.
- Ensure staff are aware of the new definition for new VTEs to improve accurate recording.

3.3.6 Mortality

The different indices of mortality measure "excess deaths" in different ways and the Trust now monitors the three most used figures: SHMI (Summary Hospital Mortality Indicator), RAMI (Risk Adjusted Mortality Index) and HSMR (Hospital Standardised Mortality Ratio) via Healthcare Evaluation Data (HED), a system that allows us to monitor, compare and evaluate hospital performance. The Trust is not presently an outlier on the new nationally mandated SHMI (see Section 2.2.7).

To date, all internal investigations of outlier alerts generated from HSMR figures have confirmed no patient care problems and all alerts have been closed by the Care Quality Commission, which oversees these.

Recognising that whatever indices are used nationally, all mortality should be audited, the Trust has a systematic internal mortality monitoring process, which includes monthly presentations to the Chairman, Chief Executive and Medical Director.
The Trust is also part of the West Midlands Mortality Group where knowledge and experience is shared

3.3.7 Examples of Specific Patient Safety Initiatives

a) Gold standard service to cut infection risk

Upgrade work is now complete on a new suite with four of the latest decontamination machines for cleaning equipment used in the Gastroenterology (GI) Department. It uses advanced technology to clean and disinfect endoscopes used to investigate small and large intestines, take biopsies and even treat some digestive disorders. The cleaning process ensures that dirty and clean scopes are separated at all times and advanced technology speeds up the cleaning process, providing doctors with an almost instant supply of decontaminated instruments. The new facility ensures that the Trust remains fully accredited in terms of quality legislation, both now and for the foreseeable future. "We have a good system for decontaminating GI scopes," says Kerry Castle, GI Lead Nurse, "but the new suite is gold standard. It is a major advance and increases reliability. This will be of significant benefit to the 10,000 patients we see every year." The new suite is part of a project to rebuild the Trust's decontamination facilities and ensures that all flexible endoscopes in the Trust are decontaminated to the same standard.

> "The service received was fantastic.
> I was put at ease and well cared for and well informed"

b) Improved education and working between junior doctors and pharmacists

In August 2012 the Trust became a pilot site for the 'Better Training Better Care' (BTBC) initiative co-ordinated by the country's lead body in training, Health Education England (HEE). There were only 15 Trusts (and only two in the West Midlands) which were successful in getting funds to become a pilot. The purpose of this patient safety initiative at Dudley is improved education and working between pharmacists and junior doctors to ensure that patients, especially those with complex medicine requirements, receive correct medication. Training sessions with pharmacists and juniors together consist of simulated scenarios using dummy drug charts which aim at timely, accurate and effective prescribing so reducing the risk of medication errors and ensuring that patients stay in hospital is not lengthened by inappropriate medication. In a visit to the hospital, Patrick Mitchell, Director of National Programmes for HEE said: 'Post Francis, the need for professional groups, like here in Dudley, to work closer across professional boundaries to promote safe care and share training opportunities is crucial. The behavioural change here is as important, if not more so, than the training itself.'

3.3.8 Patient safety measures:

	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13
Patients with MRSA infection/1,000 bed days*	0.07	0.04	0.01	0.01	0.01
Never events – events that should not happen whilst in hospital Source: adverse incidents database	0	0	0	0	1
Number of cases of Deep Vein Thrombosis presenting within three months of hospital admission	48	48	35	143**	117**

*Data source: Numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system. NB MRSA figure may differ from data available on HPA website due to different calculation methods and Trust calculations using most current Trust bed data.

***Previous data collection of Hospital Acquired Thrombosis (HAT) was identified through clinical codes alone. We found that this information was not always a true reflection for a variety of reasons including the fact that the available clinical codes for thrombosis are confusing and, in practice, misleading. Also a majority of deep vein thrombosis (DVT) do not require readmission to hospital which results in further inaccuracies in data collection. To improve the accuracy of our data collection we now review all diagnostic tests for DVTs and pulmonary embolism (PE), cross referencing positive tests with past admissions. This methodology is only undertaken by relatively few hospitals as it is labour intensive, but is recognized as giving a more accurate figure for HAT. As a further check, we receive notification from the bereavement officer if PE was identified as the primary cause of death. As a result of amending our methods of identifying HAT, 2011/12 saw an increase in figures. As stated, this is down to better identification of cases.*

(There has been a change to these three measures this year. The measure 'Patients with C. Difficile infection/1,000 bed days' has been removed as it is now part of the mandatory measures that all Trusts have to report on (see Section 2.27). The measure on Never Events has been added to replace this as it is an important patient safety issue.)

CLINICAL EFFECTIVENESS

3.4 Do patients receive a good standard of clinical care?

3.4.1 Introduction

This section includes the various initiatives occurring at the Trust to ensure patients receive a good standard of care and where we excel compared to other organisations.

3.4.2 Examples of Awards received related to improving the quality of care

a) Nursing Standard Annual Awards 2013 - Ward Sister of the year award

Sara Davis from Ward C8 was presented with the above award In March 2013 for initiating a variety of improvements which included increased staff morale, the number of complaints and serious incidents have been reduced, the nursing care indicator scores have gone up, sickness rates have gone down, staff training is up-to-date and working relationships with colleagues in other disciplines and services have improved. A member of Sara's team said: 'Sara has completely altered the ward to make the patient journey the priority here and she cares about her staff just as much'

b) Recognising Excellence in Medical Education (REME) Teaching Award for the academic year 2011-12

At a prize giving ceremony held at the University of Birmingham Medical School in December 2012 the above award was presented to Dr. A Whallett, Consultant Rheumatologist. REME is a student-led, medical school endorsed organisation that aims to identify teachers who have contributed significantly toward medical education. All students are invited to provide nominations and feedback, all of which is entirely on a voluntary basis. All nominations are reviewed, and winners chosen on the basis of number of nominations and the comments received. Dr Whallett was one of only 11 individuals given this award.

3.4.3 Examples of Innovation

a) State of the art facilities for interventional radiology and endovascular investigation and treatment

This £1.5million development was opened in March 2012 and allows surgical and radiological teams to perform elective and emergency endovascular aortic aneurysm repairs and in the last 12 months, 68 patients from across the Black Country have benefited from this minimally invasive technique to treat what is a life threatening condition. The suite comprises state of the art equipment enabling real time three dimensional imaging and allows complex vascular and other interventions to be performed to the highest standards of precision and patient safety whilst ensuring the lowest possible patient radiation dose. In addition to the vascular work, the suite is used for conventional interventional radiology techniques and is also now being used to undertake other major interventions such as vertebroplasty, an imaging guided technique that brings together a multidisciplinary team to treat painful spinal collapse of various causes.

b) Community Adult Continence Service

The community adult continence service has been involved in a number of collaborative partnerships to ensure that the patient is seen speedily by the correct expert as close to home as possible. For instance, a clear process is in place for all male patients with lower urinary tract systems so, dependent on the severity of their symptoms, they are seen and treated by the appropriate experts either in the community or in the hospital. This reduces unnecessary visits to the hospital and allows those with the appropriate symptoms to be seen quicker at the hospital. This has come about due to partnership working between the community clinical nurse specialist, hospital care (Urology service), GP's (Wychbury Medical Centre) and pharmaceutical advisors. Local services from, for example, Wolverhampton and Birmingham have all approached the Clinical Nurse Specialist (CNS) on setting up such a service.

Similar innovative work for those patients with constipation has been developed. For this service the Clinical Nurse Specialist has worked with the hospital (Gastroenterology) and Worcester St Practice. One outcome has been more effective prescribing and the reduction in the use of unnecessary laxatives. Shropshire Trust has approached the CNS for advice in setting up a similar service. The next initiative that has commenced is to look at more appropriate use of aids for bladder and bowel dysfunction in the hospital.

c) Out of Hospital Parenteral Antibiotic Team (OPAT)

In the past, patients requiring intravenous antibiotics always had to come into hospital for their therapy but from January 2012 a joint service with hospital and community commenced. Patients are assessed in hospital and then discharged for the community nurses to administer the intravenous antibiotics. Patients sometimes return to the hospital for a review in a specialist clinic. The service was initially started for patients with cellulitis but then extended to those with complex urinary tract infections, including pyelonephritis. A further service for those with diabetic foot problems was also commenced in October 2012 and there are plans to extend this service. During 2012 over 150 patients were successfully treated in the community setting whether this was in the patient's own home or in the community clinic at Brierley Hill Health and Social Care Centre. This is estimated to have saved over 1,385 bed days, increasing the capacity within the hospital for more appropriate patients whilst providing excellent care for patients nearer to home. A survey of the patients treated found they were all satisfied with the service, rating it 9.2 of 0-10.

3.4.4 Examples of Specific Clinical Effectiveness Initiatives

a) Abdominal Aortic Screening Service

A new Abdominal Aortic Aneurysm (AAA) screening service based at Russells Hall Hospital has screened 4140 men across the Black Country since the programme started in April 2012. The programme is part of a national roll out, inviting all men, registered with a GP in The Black Country, turning 65 in the financial year. In addition men over 65 years may self-refer by phoning the office. Posters have been distributed to all GP Practices and Health Centres in the Black Country for display and a local newspaper articles on the programme have been published.

Screening takes place five days a week at clinics and GP practices in Walsall, Wolverhampton and Dudley and all scans are uploaded to our secure picture archive at Russells Hall Hospital. "No individual has to travel more than a few minutes. We've made sure we are screening people on their doorsteps," said Mr Rajiv Pathak, Consultant Vascular Surgeon and Black Country AAA Screening Programme Director. Mr Pathak said the large majority of men (98 per cent) will have a normal result with no aneurysm. A small aneurysm means the aorta is between 3cm and 5.4cm wide and if detected will continue to be monitored with a regular scan. To date, we have detected 42 men with a small aneurysm. A large aneurysm is over 5.5cm wide and, if one is detected, the patient will be referred to a consultant for treatment. "Only a few aneurysms will be large enough to require urgent treatment and cause a risk to a person's health," said Mr Pathak. We have detected 12 patients so far who have required referral to a Consultant for treatment.

Patient Story:

Dudley resident Roger Davies says he would not be alive today if he had not attended a routine scan for an abdominal aortic aneurysm as part of the national screening programme.

The chemical plant worker from Woodsetton had no idea he had an aneurysm in his abdomen let alone one measuring 10.5cm, the largest found so far on the screening programme. “I am so relieved I went for the scan and didn’t ignore the letter inviting me to attend a clinic – if it had burst, it would have killed me,” said father of two Mr Davies. “It’s a very good screening programme; I would say to anyone who gets a letter to go for a scan to get it done – it doesn’t cost anything. Without it I would be dead.”

b) Hyper Acute Stroke Ward

At Russells Hall Hospital the aim is to get the patient to our specialist acute stroke ward within four hours of arrival at our Emergency Department (ED). This increases the chance of a full recovery. The 12-bedded hyper acute stroke ward provides continuous monitoring and therapy. Ongoing care is provided at the 28-bedded stroke ward. For patients who arrive at hospital very quickly, and have a certain type of stroke, we provide 24/7 thrombolysis with the clot busting drug to reopen blocked blood vessels. If a stroke is confirmed prior to arrival, the ambulance crew will phone ahead to alert the specialist team who, in turn, pre-warn staff that a scan is required. We have machines that monitor real time blood flow from the heart as 40 per cent of strokes under the age of 55 are related to the heart. In addition, we use specialist equipment that goes into the throat to provide images of the heart to help in the diagnosis of the cause of the stroke. Following discharge from hospital, hospital staff work with the community Early Support Discharge team to provide further rehabilitation, if needed.

Patient Story:

Stanley Pearce aged 55 from Kinver, has said about the care he received at Russells Hall Hospital.

“I was in A&E with my daughter when I suddenly felt the room sliding and the feeling had gone out of my left leg. My arm was flinging everywhere,” said Stanley. “A doctor knew straight away I was having a stroke.”
“It was very frightening and you think the worst. But I was on the ward within two hours of it happening.
“The drugs were given to me really quickly and I got the feeling back in my leg and arm. It was brilliant. I was so frightened but the staff were ace. They saved my life.”

Clifford Palmer also was admitted to the Hyper Acute Stroke Ward. His son Wayne said: “The care at Russells Hall Hospital has been phenomenal, especially how fast he had thrombolysis. I’m over the moon for dad.”

c) Blood Borne Virus Service

From December 2012 the community clinical nurse specialists have introduced a new treatment for patients with hepatitis C, a potentially serious disorder. The drug Telaprevir, used in combination with pegylated interferon and ribavirin, has in trials improved the clearance rates of hepatitis C by a further 20% for genotype 1 patients. Currently the first eight patients, who require weekly monitoring to detect possible severe side effects, have had excellent results and any side effects have been well managed in conjunction with the dermatology team so there is high hope that those who have previously experienced treatment failures will go on to be successfully treated with this additional therapy. The final results will not be known for 18months when treatment and follow up are complete. The team of staff have worked closely to involve pharmacy and microbiology to ensure safe and efficient patient care is delivered in a timely fashion. It is hoped that once this group of patients have been safely managed through the first few months of treatment further patients will be able to start on this new therapy.

3.4.5 Clinical effectiveness measures:

Categroy	Actual 2007/08	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13
Trust Readmission Rate for Surgery Vs Peer group West Midlands SHA Source: CHKS Signpost	4.6% Vs 4.1%	3.9%* Vs 4.3%	4.1% Vs 4.2%	4.4% Vs 4.7%	5.6% Vs 5.0%	5.4%^ Vs 6.3%
Number of cardiac arrests Source: logged switchboard calls	397	250	170	145	119	126
% of elective admissions where the planned procedure was not carried out (not patient decision) Source: CHKS Signpost	xx	xx	xx	xx	0.67% Vs 1.2%	0.55%^ Vs 1.2%

*3.8 per cent for 2008/09 in the 2009/10 report was April 2008 to February 2009 only

^To end of Dec 2012

(There has been a change to these three measures this year. The measure 'Never Events' has now been given its more appropriate categorisation and moved to Patient Safety (see Section 3.3.8) so the Trust has added a new clinical effectiveness measure of when planned procedures are not undertaken.)

3.5 Our performance against key national priorities across the domains of the NHS outcomes framework

National targets and regulatory requirements	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2012/13	Target 2012/13	Trust 2012/13	Target Achieved/ Not Achieved
1. Preventing People from Dying Prematurely								
A maximum wait of 31 days from diagnosis to start of treatment for all cancers	100%	99.3%	99.8%	99.7%		96%	99.5%	X
All cancers: 31 day wait for second or subsequent treatment: surgery			99.6%	99.6%		94%	99.2%	X
All cancers: 31 day wait for second or subsequent treatment: anti-cancer drug treatments			100%	100%		98%	100%	X
A maximum wait of 62 days from urgent referral to treatment of all cancers	99.9%	86.5%	87%	88%		85%	88.7%	X
All cancers: 62 day wait for first treatment from consultant screening service			99.6%	96.6%		90%	99.4%	X
3. Helping people to recover from episodes of ill health or following injury								
Maximum time of 18 weeks from point of referral to treatment (admitted patients)	92.4%	95.8%	97.03%	95.7%		95%	96.1%	X
Maximum time of 18 weeks from point of referral to treatment (non-admitted patients)	96.15%	99.1%	99.25% Apr-Jan	99.2%		90%	99.5%	X
Maximum time of 18 weeks from point of referral to treatment (incomplete pathways)	N/A	N/A	N/A	N/A		92%	98.1%	X

National targets and regulatory requirements	Trust 2008/09	Trust 2009/10	Trust 2010/11	Trust 2011/12	National 2012/13	Target 2012/13	Trust 2012/13	Target Achieved/ Not Achieved
1. Preventing People from Dying Prematurely								
A/E: Percentage of patients admitted, transferred or discharged within 4 hours of arrival	95.9%	98.1%	98.8%	97.27%		95%	95.4%	☺
Two week maximum wait for urgent suspected cancer referrals from GP to first outpatient appointment	100%	98%	96.8%	97.2%		93%	96.2%	☺
Two week maximum wait for symptomatic breast patients		69%	98.2%	99%		93%	98.1%	☺
5. Treating and caring for people in a safe environment and protecting them from avoidable harm								
MRSA – number of post 48hour bacteraemia infections	7	2	3	2	N/A	No more than 2	1	☺
Data Completeness for community services: Referral to treatment information						50%	97.3%	☺
Data Completeness for community services: Referral information						50%	65.6%	☺
Data Completeness for community services: Treatment activity information						50%	99.1%	☺
Certification against compliance with requirements regarding access to healthcare for people with a learning disability				Compliant		Compliant	Compliant	☺

N/A applies to targets not in place at that time.

☺ = Achieved target ☹ = Not achieved target

3.6 Glossary of Terms

AAA	Abdominal Aortic Aneurysm
A & E	Accident and Emergency
ADC	Action for Disabled People and Carers
Bed Days	Unit used to calculate the availability and use of beds over time
BBC CRLN	Birmingham and Black Country
BHF	British Heart Foundation
BTS	British Thoracic Society
CCG	Clinical Commissioning Group
C. diff	Clostridium difficile
CNS	Clinical Nurse Specialist
CQC	Care Quality Commission
COPD LES	Chronic Obstructive Pulmonary Disease Local Enhance Services
CHKS Ltd	A national company that works with Trusts and provides healthcare intelligence and quality improvement services
CQUIN	Commissioning for Quality and Innovation payment framework
CEM	College of Emergency Medicine
DAHNO	DAta for Head and Neck Oncology
DUBASCO	Dudley Bariatric Surgery Co-morbidity Score
DVD	Optical disc storage format
EAU	Emergency Assessment Unit
ENT	Ear, Nose and Throat
ED	Emergency Department
FCE	Full Consultant Episode (measure of a stay in hospital)
Foundation Trust	Not-for-profit, public benefit corporations which are part of the NHS and were created to devolve more decision-making from central government to local organisations and communities
GP	General Practitioner
HASC	Health and Adult Social Care Scrutiny Committee
HAT	Healthcare Acquired Thrombosis
HED	Healthcare Evaluation Data
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HQIP	Healthcare Quality Improvement Partnership
HSMR	Hospital Standardised Mortality Ratios
HTA	Human Tissue Authority
IBD	Irritable Bowel Disease

ICNARC CMPD	Intensive Care National Audit & Research Centre Case Mix Programme Database
LINK	Local Involvement Network
MUST	Malnutrition Universal Screening Tool
MBC	Metropolitan Borough Council
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MINAP	Myocardial Ischaemia National Audit Project
Monitor	Independent regulator of NHS Foundation Trusts
MRSA	Meticillin-resistant Staphylococcus aureus
MESS	Mandatory Enhanced Surveillance System
MUST	Malnutrition Universal Screening Tool
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCI	Nursing Care Indicator
NICE	National Institute for Health and Clinical Excellence
NHS	National Health Service
NNAP	National Neonatal Audit Programme
NOF	Neck of Femur
NPSA	National Patient Safety Agency
NIV	Non Invasive Ventilation
NVQ	National Vocational Qualification
OSC	Overview and Scrutiny Committee
Ofsted	Office for Standards in Education, Children’s Services and Skills
PALS	Patient Advice and Liaison Service
PEAT	Patient Environment Action Teams
PFI	Private Finance Initiative
PROMs	Patient Reported Outcome Measures
PCT	Primary Care Trust
RAG	Red/Amber/Green
RCOG	Royal college of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
REME	Recognising Excellence in Medical Education
RAMI	Risk Adjusted Mortality Index
SHMI	Summary Hospital Mortality Indicator
SINAP	Stroke Improvement Audit Programme
SKIN	Surface, Keep Moving, Incontinence and Nutrition
SUS	Secondary Uses Service
SLT	Speech and Language Therapy
VCF	Vertebral Compression Fractures
VSGBI	Vascular Society of Great Britain and Ireland
VTE	Venous Thromboembolism

ANNEX

Comment from NHS Dudley (received xx/xx/2012)

Comment from Dudley Local Involvement Network (received xx/xx/2012)

Comment from the Dudley MBC Health and Adult Social Care Scrutiny Committee

Our Committee is responsible for health scrutiny and engages respective Quality Accounts as a useful device for considering operational improvement across the sector. They also present an opportunity to ensure priorities are representative of the quality of services provided; and cover areas of importance across Dudley's communities.

We are encouraged to see evidence indicating staff increasingly involved in supporting patients at meal-times; along with data suggesting patients now having access to more information about services on ward arrival - these are among a number patient experience priorities we have collaborated on arising from our 2011/12 dignity in care review.

The favourable trend in MUST assessments signals improved nutritional practice. On hydration, however year end compliance for fluid balance disguises a variable performance throughout the year - we will wish to remain watchful on this care issue in 2013/14.

Strengthening the Single Assessment process across patient pathways will further promote effective monitoring of care needs. This coupled with a greater awareness amongst patients, carers and families on how to raise concerns about care and treatment may also result in even better outcomes and experiences.

We commend the achievement of reducing hospital acquired pressure ulcers by 50% and exceeding quarterly community targets; we will be keen to see this good practice implemented consistently across all services for long-term success.

Practically, in terms of the document's future development, greater use of case studies and stronger performance base-lining would be welcomed with the aim enabling the public and scrutiny bodies to better identify with patterns and trends over time.

The Committee welcomes the opportunity to comment on the Trust's QA; and overall supports the direction of travel endorsed by the Council of Governors for priorities going into 2013/14.

Comment from the Trust's Council of Governors (received xx/xx/2012)

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2012 to June 2013
- Papers relating to Quality reported to the Board over the period April 2012 to June 2013
- Feedback from the commissioners dated XX/XX/20XX
- Feedback from governors dated XX/XX/20XX
- Feedback from Local Healthwatch organsiations dated XX/XX/20XX
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
- The national patient survey June 2012
- The national staff survey conducted between September and December 2012
- The Head of Internal Audit's annual opinion over the trust's control environment dated 31/03/2013
- CQC quality and risk profiles dated 28/2/2013, 31/1/2013 and 30/11/2012

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
-the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the Board

NB: sign and date in any colour ink except black

..............................Date...Chairman

..............................Date..Chief Executive

Date xxxx Chairman

Date xxxx Chief Executive

Independent Assurance Report to the Council of Governors of The Dudley Group of Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of The Dudley Group of Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of The Dudley Group of Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 201 I (the "Quality Report").

This report, including the conclusion, has been prepared solely for the Council of Governors of The Dudley Group of Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Dudley Group of Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 20 II , to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Dudley Group of Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 20 I 0111 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 201 0 to March 20II.
- Papers relating to Quality reported to the Board over the period April 20 I 0 to March 20II.
- Feedback from the Commissioners dated 29/04/20 II.
- Feedback from the Council of Governors dated 07/04/2011.
- Feedback from LINKS dated 20/04/20 II
- The Trust's 2010111 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. (Due to the timing of our work we have reviewed Quarter I (June 20I0), 2 (September 20I0) and 3 (December 20I0) for 2010/11).
- The 20I0 national patient survey and local patient survey dated 31/03/20 II.
- The 20I0 national staff survey.
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 31 /03/20 II.
- Care Quality Commission quality and risk profiles dated March 20 II.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - ‘ Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‚ISAE 3000’). Our limited assurance procedures included:

- Making enquiries of management.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 3 I March 20II, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP
Chartered Accountants
Birmingham
I June 20II

The Dudley Group NHS

NHS Foundation Trust

Enclosure F€

Paper for submission to the Board of Directors on 2nd May 2013

Finance & Performance

TITLE	Finance & Performance Report for year ending 31st March 2013		
AUTHOR	Paul Assinder Director of Finance and Information	**PRESENTER**	David Badger Chairman of Finance & Performance Committee

CORPORATE OBJECTIVE: SO 10 Enabling Objective

SUMMARY OF KEY ISSUES:

- The Trust has posted a year end surplus of £2.9m for 2012-13
- We continued to perform well against the long list of access and waiting target set by the NHS nationally and locally. However, in Q4, the Trust marginally failed performance targets for A&E 4 hours waiting and Cancer 62 days treatment target.
- Overall this performance still places the Dudley Group amongst the strongest performers in Birmingham and the Black Country and we are amongst the best nationally in many respects.
- During 2012-13, in common with much of the NHS acute sector, the Trust has experienced significant increases in emergency admissions and A&E attendances. This has placed both operational and business strain on performance.
- The CCG in Dudley has recognised this by making additional 'one off' payments of £3m at the year end.

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score** Y	**Details:**
COMPLIANCE	**CQC**	N	**Details:**
	NHSLA	N	**Details:**
	Monitor	Y	**Details:** Directors have rated Trust at 'Amber/Red' for Governance & '3' (good) for Finance at Q4. The Trust remains on quarterly monitoring by Monitor.
	Other	N	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR 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

Finance and Performance Committee held on 25th April 2013

1. Background

The Finance & Performance Committee of the Board met on 25th April 2013. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered year end performance reports. The Committee noted in particular the following matters:

2. Performance Targets and Standards (Appendices 1&2)

Directors reported strong performance against all measures for the month of February and the Year to Date. During 2013-14, the Trust has experienced unprecedented levels of demand for emergency admissions to Russells Hall, 3.9% above 2011-12. However, the vast majority of national and local access and waiting targets were met or exceeded in Dudley.

Notwithstanding this excellent overall performance, the Committee noted the following areas of non-compliance:

a) A&E 4 Hour Waits

The Trust hit this important target overall for 2012-13. However, in common with virtually all other hospitals in England the Trust operated under unprecedented emergency pressures during the last quarter of the year and achieved a 92.6% performance for the Quarter (target 95%).

b) Cancer target of 62 days maximum wait for treatment following an urgent GP referral

The Trust has traditionally had an exemplary record against this target but marginally failed to meet it (84.6% against a target of 85%) in Quarter 4. This was in part due to extremely low numbers of attendances during the poor weather in February. The target will be achieved in March and it appears that February was an isolated breach of performance.

3. Monitor's Compliance Framework

The Trust currently has no outstanding CQC Compliance Issues or concerns. The Board of Directors has rated its performance for Quarter 4:

Finance; '3' rating (good);

Governance; 'Amber /Red' due to the breaches of the A&E and Cancer targets

4. Income & Expenditure Position – Year to 31st March 2013 (Appendix 5)

The Trust has posted a strong income and expenditure surplus of £2.9m for the financial year. This performance exceeds the Plan for the year by some £2.3m and is largely the result of a significant one off payment of £3m by NHS Dudley in March, mainly in recognition of the additional pressures on emergency services at Russells Hall during the winter months.

During the year, the Trust has invested in front line staff, with headcount up, on average, by 53 staff compared with the previous year. Most of this investment is in front line nursing posts (+31 WTE) and medical staff (+ 23 WTE).

Staff bank and agency costs have also increased above 2011-12, by £2.8m (40%) and £0.4m (15%) respectively, reflecting the increased propensity to flex staffing up to reflect increases in demand on capacity.

During the year, the Trust delivered efficiency savings of £10.2m, broadly in line with plan.

Overall, whilst the 2012-13 financial outturn is commendable, given the increased pressures on the Trust to meet increased demand and deliver challenging Treasury savings targets, the Board of Directors is conscious that the Trust benefitted from total 'one off' funding sources of c£4m overall. It carries into the new financial year the need to improve efficiency further still, to meet:

- An underlying recurrent funding gap (Non-recurrent funding over non-recurrent spending) of c£1.1m
- The need to realise recurrent savings to replace 'one off' cost savings in 2012-13 of c£4m
- Reductions to the value of NHS Tariff prices for required Treasury 3013-14 efficiency of 4%, £10m.

5. **Balance Sheet (Statement of Position)**

The Trust's Balance Sheet (Statement of Position) at 31st March 2013 remains strong;

- £32.9m cash balance.
- 37.8 days liquidity margin.
- Debtor and Creditor days remain broadly on plan for the year.

6. **Capital Programme**

Capital spending for the year was £9.1m, on plan for the year. Spend included Day Theatres £1m; replacement medical equipment ££2.1m and IT £4.4m.

7. **Facilities and Estates Report**

The Committee received a report from the Associate Director of Estates and Facilities for the Quarter.

8. **Business Cases**

The Committee considered progress reports on the following:

a. Acute Medical Unit Business Case – Progress Report
b. Allocate Scheduling System Business Case – Progress Report
c. Paediatric Diabetes Business Case – The Committee approved a business case for the achievement of best practice tariffs for these procedures

9. **Workforce**

Performance at year end for workforce targets were noted:

- Absence year to date 4.13%
- Turnover constant at 7.60%
- Mandatory Training improving to 71.6%
- Professional regulatory Checks 100%
- 'Live' vacancy rate 192 WTE

The Committee considered detailed reports for the improvement of performance in respect to mandatory training and appraisals within clinical directorates.

10. **Losses and Write Offs for 2012-13 Accounts**

The Committee, under delegated authority, approved the write off of irrecoverable debts totalling £7,342, noted awards by NHSLA for 6 cases totalling £32,710 and obsolete stocks and equipment of £33,886.

PA Assinder
Director of Finance & Information
Secretary to the Board

2012/13 NHS OPERATING FRAMEWORK MEASURES & NATIONALLY SPECIFIED EVENTS

The Dudley Group NHS
NHS Foundation Trust

Appendix 1

Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	A&E	2% of the Actual Outturn value of the service line revenue	A&E 4 hour wait	87.4%	95%		
5	Cancer		14 Day – Urgent GP Referral to Date First Seen	95.7%	93%		
5	Cancer		14 Day – Urgent GP Breast Symptom Referral	99.3%	93%		
5	Cancer		31 Day – Diagnosis to Treatment for All Cancers	98.3%	96%		
5	Cancer		31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs	100%	98%		
5	Cancer		31 Day – 2nd/Subsequent Treatment – Radiotherapy	-	-	-	-
6	Cancer		31 Day – 2nd/Subsequent Treatment – Surgery	100%	94%		
6	Cancer		62 Day – Referral to Treatment after a Consultant upgrade	100%	85%		
6	Cancer		62 Day – Referral to Treatment following National Screening	100%	90%		
6	Cancer		62 Day – Urgent GP Referral to Treatment for All Cancers	81.2%	85%		
9-10	Diagnostics		Percentage of diagnostic waits less than 6 weeks	99.9%	99%		
-	MSA	Retention of £250 per day the patient affected	Mixed Sex Sleeping Accommodation Breaches	0	0		
7	RTT	Deduction of 0.5% for each 1% under-achievement, to a max of 5%*	Admitted % Treated within 18 Weeks	94.4%	90%		
7	RTT		Non-Admitted % Treated within 18 Weeks	99.5%	95%		
7	RTT		Incomplete % waiting less than 18 Weeks	97.7%	92%		
4	HCAI	Deduction of 0.1% for each 1% under-achievement, to a max of 2%*	C Diff – Post 72 hours *(77 breaches allowed)*	7	8		
-	Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payments*)	Failure to publish a Declaration of Compliance of Non-Compliance pursuant to clause 4.24. *Retention of monthly sums will continue for each month or part month until either a Declaration of Compliance or Declaration of Non-Compliance is published.*	Annual – Trust Compliant			
-	Compliance		Publishing a Declaration of Non-Compliance pursuant to clause 4.26.				
-	Diagnostics	2% of the Actual Outturn value of the service line revenue	COMMUNITY - Percentage of diagnostic waits less than 6 weeks	100%	99%		
-	RTT		COMMUNITY – for Direct Access Audiology Treatment	100%	95%		
-	RTT	**	COMMUNITY – Non Admitted	100%	90%		

One month behind

** See Standard Contract for Acute Services Schedule 3 Part 1 for more details*
*** Set out in clause 43. of Core Legal Clauses and Section B Part 8.4 of the Standard Contract for Community Services*

Page	Item		Value
11	Never Events		0
12-13	CQUIN – Acute & Community		
14-15	Monitor Summary Report	Governance Risk Rating	2
16-17	Mortality Reports	2012/13 Qtr 2 SHMI	1.04

Position Deteriorating | Position Improving | Position Unchanged
Within Target | Outside Target | Position Unconfirmed

NEVER EVENTS

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

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

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

Dudley Group FT

Governance Targets and Indicators

	Threshold	Weighting	Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements			**0**	**0**	**0**	**2**	N/A
INFECTION CONTROL (SAFETY)							
HCAI - Clostridium Difficile - meeting the C Diff objective	77	1.0	14	8	21	13	**56**
HCAI - MRSA – meeting the MRSA objective	2 (6)	1.0	0	0	1	0	**1**
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%	0.5	96.8	95.9	96.3	97.7*	**96.2**
Max waiting time of 2 weeks from urgent GP referral to date first seen for symptomatic breast patients.	93%		97.9	97.7	97.9	98.5*	**98.1**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	0.5	99.3	100	99.4	99.2*	**99.5**
Maximum waiting time of 31 days for second of subsequent treatments – Anti Cancer Drug Treatments	98%	1.0	100	100	100	100*	**100**
Maximum waiting time of 31 days for second of subsequent treatments – Surgery	94%		97.5	100	100	100*	**99.4**
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	88.7	89.5	90.2	84.6*	**88.9**
Maximum two month (62 days) wait from referral to treatment for all cancers – From National Screening Service Referral	90%		97.3	100	100	100*	**99.4**
							** Contains unvalidated data for March.*
A&E (QUALITY)							
% Patients Waiting Less than 4 hours in A&E	95%	1.0	97.3	95.9	95.06	92.9	**95.4**
REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)							
RTT – Admitted % Treated within 18 weeks	90%	1.0	95.9	96.3	96.5	95.3	N/A
RTT – Non-Admitted % Treated within 18 weeks	95%	1.0	99.4	99.6	99.4	99.5	N/A
RTT – Incomplete pathways % waiting within 18 weeks	92%	1.0	97.5	98.1	98.6	98.0	N/A
Community Services (Effectiveness)							
Referral to treatment information	50%	1.0	94.2	97.2	99.5	98.2	N/A
Referral information	50%		66.7	66.7	65.9	63.1	N/A
Treatment activity information	50%		100	99.8	100	96.4	N/A
Patient identifier information (*The inclusion of further data items may be introduced later in 2012/13)*	TBC		88.4	88.6	88.5	88.5	N/A
Patients dying at home/care home (*The inclusion of further data items may be introduced later in 2012/13)*	TBC		62.3	96.2	49.0	41.0 **	N/A

*** provisional data*

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			**0**	**0**	**0**	**2**	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	Yes	Yes	N/A
THIRD PARTIES & MANDATORY SERVICES							
Risk of, or actual, failure to deliver mandatory services	Yes/No	4.0	No	No	No	No	N/A
CQC Compliance action outstanding	Yes/No	2.0	No	No	No	No	N/A
CQC enforcement notice currently in effect	Yes/No	4.0	No	No	No	No	N/A
Moderate CQC concerns regarding the safety of healthcare provision	Yes/No	1.0	No	No	No	No	N/A
Major CQC concerns regarding the safety of healthcare provision (Review of Compliance December 2011 – Outcome 08: Cleabliness and Infection Control)	Yes/No	2.0	No	No	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	No	No	N/A

Indicator (see Appendix B)	Monitor may apply a red governance risk rating and escalate an NHS foundation trust for consideration as to whether it is in significant breach if the trust:
Meeting the MRSA objective	• Has greater than six cases in the year to date, and either: • breaches the cumulative year-to-date trajectory for three successive quarters; or • breaches its full year objective.[1]
Meeting the Clostridium Difficile objective	• Has greater than 12 cases in the year to date, and either: • breaches the cumulative year-to-date trajectory for three successive quarters; or • breaches its full year objective;[1] or • Reports important or significant outbreaks of C. difficile, as defined by the Health Protection Agency
Referral to Treatment (RTT) waiting times	• Breaches: • the admitted patients 18 weeks waiting time measure for a third successive quarter;[2] • the non-admitted patients 18 weeks waiting time measure for a third successive quarter;[2] or • the incomplete pathway 18 weeks waiting time measure for a third successive quarter.[2]
A&E clinical quality indicator	• Fails to meet the A&E target twice in any two quarters over a twelve month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.
Cancer waiting times	• Breaches either: • the 31-day cancer waiting time target for a third successive quarter; or • the 62-day cancer waiting time target for a third successive quarter.
Ambulance response times	• Breaches either: • the category A 8-minute response time target for a third successive quarter; or • the category A 19-minute response time target for a third successive quarter.
Community services data completeness	• Fails to maintain the threshold for data completeness for: • referral to treatment information for a third successive quarter; • service referral information for a third successive quarter; or • treatment activity information for a third successive quarter.
Any indicator weighted 1.0	• Breaches the indicator for three successive quarters.

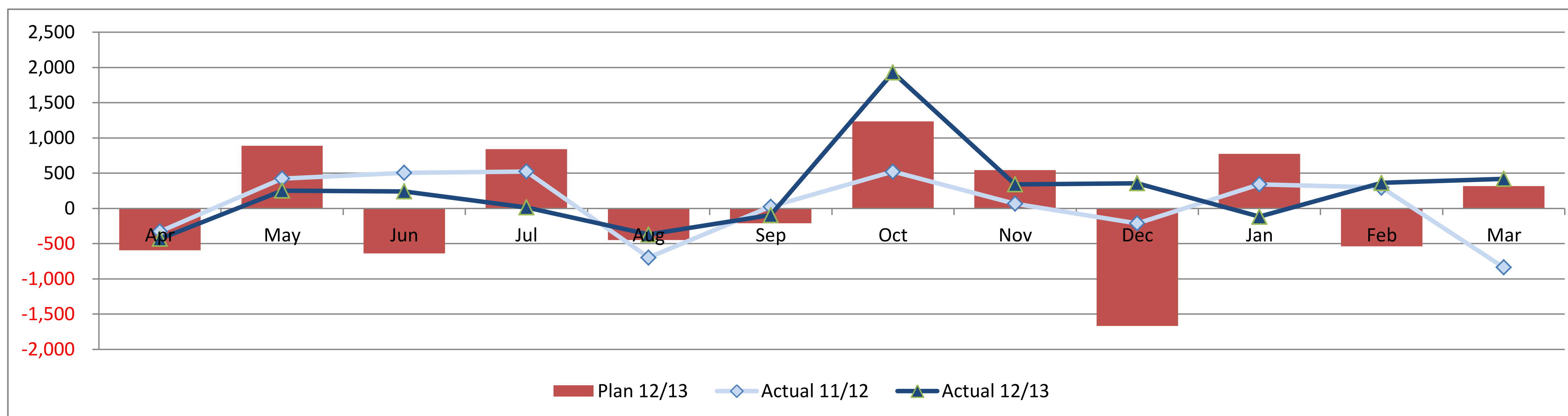
THE DUDLEY GROUP NHS FOUNDATION TRUST

Appendix 3

FINANCIAL SUMMARY **MARCH 2013**

	CURRENT MONTH					CUMULATIVE TO DATE					YEAR END FORECAST			
	BUDGET £000	ACTUAL £000	VARIANCE £000			BUDGET £000	ACTUAL £000	VARIANCE £000			BUDGET £000	ACTUAL £000	VARIANCE £000	
INCOME	£25,424	£27,093	£1,669	green	INCOME	£293,503	£298,329	£4,826	green	INCOME	£293,503	£298,329	£4,826	green
PAY	-£14,922	-£15,556	-£634	amber	PAY	-£173,511	-£174,347	-£836	amber	PAY	-£173,511	-£174,347	-£836	amber
CIP	£199	£0	-£199	red	CIP	£539	£0	-£539	red	CIP				
NON PAY	-£8,594	-£9,330	-£737	red	NON PAY	-£98,756	-£100,000	-£1,244	red	NON PAY	-£98,217	-£100,000	-£1,784	red
EBITDA	**£2,107**	**£2,207**	**£100**	green	**EBITDA**	**£21,775**	**£23,982**	**£2,207**	green	**EBITDA**	**£21,775**	**£23,982**	**£2,207**	green
OTHER	-£1,791	-£1,788	£3	green	OTHER	-£21,275	-£21,084	£191	green	OTHER	-£21,275	-£21,084	£191	green
NET	**£317**	**£419**	**£103**	green	**NET**	**£500**	**£2,898**	**£2,398**	green	**NET**	**£500**	**£2,898**	**£2,398**	green

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



Key Comments

£419k surplus in March (£103k ahead of plan). Cumulative outturn of a £2.898m surplus represents a positive outcome (£2.398m better than plan).

Strong income position reflects postive year end settlements with PCTs (majority being full and final and assume 90% CQUIN). The final outturn is lower than previously estimated due to a reduction in the provision for incomplete spells of £592k.

All pay categories represent the highest in-month spend during March but the outturn is only fractionally higher (£88k) than the February estimate. The pay outturn included a sum of £263k for MARS and prudent provisions for bank/agency and waiting lists.

The final CIP achievement falls short by £539k and is in line with previous forecasts.

The outturn for non-pay deteriorated in March due to increased pass through drugs and prudent provisions made within Estates for known risks.

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board of Directors on 2 May 2013

TITLE:	**Research & Development Directorate 6-Monthly Report**		
AUTHOR:	**M J Marriott, R&D Facilitator; Prof GD Kitas, R&D Director**	**PRESENTER**	**Dr Paul Harrison, Medical Director**

CORPORATE OBJECTIVE: **SO1 – SO6**

SUMMARY OF KEY ISSUES:
Financial position for research funding for 2013/14
Comparison with neighbouring Acute Trusts
Research governance and adverse event reporting for studies
Staffing, training, publications

IMPLICATIONS OF PAPER:

RISKS	**Risk Register** **N**	**Risk Score**	**Details:**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Other	**Y**	

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

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE COMMITTEE: The Committee is requested to receive the report, note the key issues arising and identify any further actions required.

The Dudley Group NHS
NHS Foundation Trust

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS ON 2ND MAY 2013

RESEARCH AND DEVELOPMENT UPDATE REPORT

Summary

As expected, Birmingham & Black Country Comprehensive Local Research Network (CLRN) funding for 2013/14 has been determined by recruitment activity alone, based on study complexity. There has been strong recruitment to observational studies at Dudley during the latter half of 2012/13, resulting in a larger allocation of funding than the £300K forecasted in June 2012 – an increase of 46% - although this is still a reduction on 2012/13 funding. The CLRN's funding has been reduced by 8.8% for 2013/14.

BBC CLRN NHS Acute Trusts	Recruitment units* target for 2012/13	Recruitment units 12/13 as of 06/08/12	Recruitment units 12/13 as of 08/04/13	Funding for 2012/13	Funding for 2013/14
Dudley Group	9000	3465	9163	525,094	439,236
Heart of England	20293	12150	20532	1,616,732	1,117,027
Sandwell & West Birmingham	9158	4480	10365	758,567	725,971
University Hospitals Bham	19000	12982	22376	2,070,098	1,347,556
Walsall Healthcare	1851	918	2354	149,509	110,954

NIHR recruitment data not yet complete for 2012/13. *Weighted for complexity of study

Activity (from 01/04/2012 to 31/03/2013); National Institute for Health Research portfolio studies only:
Number of recruiting studies as of 31/03/2013: 126: 78 academic; 5 commercial; Closed studies still collecting data: 54 (A) 10 (C).
Publications for 2012 calendar year: 120 – this figure includes conference posters and articles.

Education and Training: the Trust will host a Good Clinical Practice (GCP) Foundation training day on 18/04/2013 for 24 researchers/ research nurses and a half day refresher course on 15/10/2013. Online GCP training and in-house GCP training for staff otherwise unable to attend the day long course continue to be offered. Research office staff have been completing e-learning modules dealing with relevant research legislation such as the Human Tissue Act and Ionising Radiation.

Research Governance Implementation: A total of 41 studies were assessed by the Protocol Review Sub-committee between 02/10/2012 and 08/04/2013.
Reported Serious Adverse Events: Oncology/Haematology: 25; Cardiology: 28; Midwifery: 1; Chemical Pathology: 9; Rheumatology: 1
TRACE RA co-sponsored study: 3004 recruits; 894 SAEs of which 107 are primary and 63 secondary endpoints up to study closure 31/01/2013.

Further information: A 2-year fixed term post of Research & Development Facilitator (Portfolio & Finance) has been created to work strategically within the R&D Directorate, complimenting the role of the existing Research & Development Facilitator (Governance & Operations). Savings have been made by replacing two of three oncology research nurses who resigned in 2012. One full time oncology data manager resigned in 2013 and has not been replaced. Another data manager has returned from maternity leave on reduced hours. Pharmacy staffing has been reduced from 3.5 WTE to 2.4 WTE.

Recommendations

The Board is requested to receive the report, and note the key issues arising.

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 2nd May 2013

TITLE:	**Non Executive Director Lead Responsibilities Report.**		
AUTHOR:	**Elena Peris-Cross Apprentice Administrator**	**PRESENTER**	**John Edwards Chairman**

CORPORATE OBJECTIVE:

Good Governance.

SUMMARY OF KEY ISSUES:

This report sets out the appointed responsibilities of Non Executive Directors of the Trust on 1st April 2013. In accordance with normal procedure such roles may be varied during the course of 2013-14 and in particular, with reference to NED appraisals.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			×

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the report.

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The Dudley Group NHS
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS 2 MAY 2013

NON EXECUTIVE DIRECTORS' LEAD RESPONSIBILITIES

ANNUAL REPORT 2013/14

1. BACKGROUND

It is good practice to disclose the lead responsibilities of Non Executive Directors in the Trust's Annual Report. These are currently as follows:

- **MR DAVID BADGER**

  Deputy Chairman
  Chair of Finance and Performance Committee
  Senior Independent Director
  Board Representative – Contract Efficiency Group
  Lead NED for liaison with Council of Governors
  Member and Link to Trust Board – Organ Donation Committee
  Member of Risk and Assurance Committee
  Member of Clinical Quality, Safety and Patient Experience Committee
  Member of CoG Governor Development Group
  Member of the Remuneration Committee
  Member of the Nominations Committee
  Member of the Transformation Programme Board
  Assigned - CoG Appointments Committee
  Assigned - CoG Membership Engagement Committee

- **MR JONATHAN FELLOWS**

  Chair of Audit Committee
  Board Representative – Contract Efficiency Group
  Member of Finance and Performance Committee
  Member of Charitable Funds Committee
  Member of the Remuneration Committee
  Member of the Nominations Committee
  Assigned - CoG Governance Committee

- **MRS ANN BECKE**

  Chair of Risk and Assurance Committee
  Board representative - Internal Safeguarding Board
  Board representative - Dudley Children's Partnership
  Board representative - Arts and the Environment Panel
  Board Liaison for the West Midlands Ambulance Service
  Member of Audit Committee

Member of Quality, Safety and Patient Experience Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Member of the Dudley Clinical Education Centre (Charity)
Member of CoG Strategic Committee
Member of CoG Membership Engagement Committee

- **MR RICHARD MINER**

  Chair of Charitable Funds Committee
  Chair of Dudley Clinical Services Limited (Subsidiary of the Trust)
  Lead NED for Community Services
  Lead NED for Security Management
  Member of Finance and Performance Committee
  Member of Audit Committee
  Member of the Remuneration Committee
  Member of the Nominations Committee
  Assigned - CoG Governance Committee

- **MR DAVID BLAND**

  Chair of Clinical Quality, Safety and Patient Experience Committee
  Lead NED for Patient Experience
  Lead NED for Patient Safety
  Member of Risk and Assurance Committee
  Member of Charitable Funds Committee
  Member of the Remuneration Committee
  Member of the Nominations Committee
  Member of Dudley Clinical Services Limited (Subsidiary of the Trust)
  Assigned- CoG Strategy Committee

2. **RECOMMENDATION**

The Board is asked to note the report.

Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th March 2013

TITLE:	**Listening into Action Report**		
AUTHOR:	**Jackie Dietrich**	**PRESENTER**	**Jackie Dietrich**

CORPORATE OBJECTIVE:
SGO2 patient experience
SGO5 staff commitment

SUMMARY OF KEY ISSUES:

This report updates the Board on the Listening into Action (LiA) staff engagement programme, in particular on the progress of the current teams using LiA to make service changes and enhancements to improve the patient experience.

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

RISK	**NO**		**Risk Description:**
	Risk Register:		**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
		√	

RECOMMENDATIONS FOR THE BOARD

It is recommended that the Board of Directors:

i. Notes progress with the delivery of Listening into Action at the Dudley Group
ii. Reaffirms commitment to the promotion of Listening into Action as a key tool to improving staff engagement and patient experience

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

LISTENING INTO ACTION UPDATE	April 2013

- **INTRODUCTION**

This report updates the Board on the Listening into Action (LiA) staff engagement programme, in particular on the progress of the current teams holding an LiA to make service changes and enhancements to improve the patient experience.

LiA is a systematic approach to widespread staff engagement designed to empower leaders and staff around any change or challenge. It has been developed by a company called Optimise Limited and is outcome orientated designed to mobilise the full capability of the workforce to improve outcomes for patients and staff.

LiA is now embedded in the minds of staff since it launched in September 2010. Some 40 teams, wards and departments have utilised it to effect change. The current raft of teams have completed or are completing their LiAs.

With staffing levels in Communications back to full complement, a new launch will take place in the coming months to encourage the next wave of 20 teams to adopt LiA.

- **LiA TEAMS – PHASE 2**

The teams and leads currently going through the LiA process are:

- Cancer (Lead: Jane Gritton)
- Cardiology (Lead: Sharon Nash)
- Clinical Audit (Lead: Lisa Medhurst)
- Community Podiatry (Lead: Kelly James)
- Critical Care (Lead: Alison Perry)
- Dietetics (Lead: Ann Marsh)
- Finance: (Leads: Bes Hodo and Amanda Gaston)
- Inter-professional Learning (Lead: Claire Wilcox)
- Medical secretaries (Lead: Joanne Docherty)
- Main Outpatients (Lead: Andrew Boswell)
- Paediatric and neonatal community nurses
- Therapies (Lead: Clare Brown)
- Urology (Lead: Rachel Tomkins)
- Volunteers (Lead: Jane Fleetwood)

1. Clinical Audit

Raising the profile of Clinical Audit across the organisation and working with staff to review standards and capture changes in practice is now complete.

2. Critical Care

Improve flow through of patients from SHDU to a ward is in progress.

3. Community Podiatry

Changes to organising home visits to make best use of time in progress. A working group has been established to look at the department's educational needs and study days have been delivered. Changes are being made to improve the referral form and the access protocol document.

4. Dietetics

To improve the quality of referrals. In the process of launching new referral criteria, which will be supported by a change in the electronic referral form.

5. Finance – Customer LiA

Actions 73% complete including improvements to training sessions and a redesigned Hub page. The filming of an e-learning package aimed to giving all trust staff an overview of finance has been undertaken, a release date is anticipated for the end of the summer.

6. Finance – Staff LiA

33% of actions complete. Key outcomes achieved include lunch time learning sessions, the development of a finance training guide and an escalation process for resolving IT issues.

7. Inter-professional Learning

Raising awareness and embedding IPL into Trust culture is complete. Inter-professional learning work is ongoing.

8. OPD

LiA complete and benefits realised

9. Dudley Rehab Services LiA

LiA complete

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 Direct ors 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 responsibility is to ensure that the Board and committee assignments are done in the most efficient and effective way. John assigns the appropriate committee's to deal with certain roles of running the Trust and ensures the Committee chairs report the issues to the Board regularly. John is also Chair of the Council of Governors and Chair for the IT Project Board.

Paul Assinder – Director of Finance and Information

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

Richard Beeken – Director Strategy, Performance and Transformation

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

<u>Denise McMahon – Director of Nursing</u>
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.

<u>Paul Harrison – Medical Director</u>
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.

<u>Richard Cattell – Director of Operations</u>

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

<u>Annette Reeves – Associate Director of Human Resources</u>

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

Tessa Norris – Director of Community Services and Integrated Care

Tessa's remit at Board is an in attendance role to provide insight to Community services, integrated care and as lead for Governor Development. Tessa also brings an additional clinical voice to the Board as a Registered Nurse.

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